

NEWPORT HOSPITAL
Newport, Rhode Island 02840

MEDICAL STAFF
RULES AND REGULATIONS

Adopted: 11/08/06
Amended 06/11/07
Amended 03/11/2009

Medical Staff Rules and Regulations

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MEDICAL STAFF RULES AND REGULATIONS NEWPORT HOSPITAL Newport, Rhode Island 02840

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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 external regulatory agencies such as The Joint Commission and Centers for Medicare and Medicaid Services (CMS); and other 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 Where conflicts in requirements arise, these Rules and Regulations are superseded by external regulatory requirements.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.

A. ADMISSION AND DISCHARGE OF PATIENTS

1. A patient meeting admission criteria may be admitted to the Hospital by any member of the Medical Staff (or Staff Affiliate, who has been granted admitting privileges. All practitioners shall be governed by the official admitting policy of the Hospital.
2. A member of the Medical Staff (or Affiliate Staff, shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and, as appropriate, to relatives of the patients. Whenever these responsibilities are transferred to another Staff member, a note covering the transfer of responsibility shall be entered in the medical record and a corresponding order 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 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 or section will be assigned to the patient. The Chair, or designee, of each department shall provide a schedule for such call coverage assignments.

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 intervention process.

Patients admitted to the Hospital should be seen 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 urgent care requirements. This time interval should not exceed an outside limit of one hour for patients admitted to the ICU, 24 hours for vaginally delivered normal newborns or patients admitted to the Behavioral Health Unit or Acute Rehab Unit; and 12 hours for all other admissions.

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6. Patient entry into the hospital will occur according to the following priorities:
 - A. Emergency Department Inpatient Admissions
 - B. Pre-operative Inpatient Admissions - Including patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chief of Surgery may be involved with Case Management 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. Observation Status – Observation status is defined as those services furnished by a hospital on the hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing and other staff, which are reasonable and necessary to more thoroughly evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.
7. Areas of restricted bed utilization and assignment of patients are to be found in the policies of admission to special care areas. The registration representative will consult with the clinical nursing director before deviating from these admission policy restrictions. It is understood that when deviations are made from assigned areas as indicated above, the registration representative will correct these assignments at the earliest possible moment in keeping with transfer priorities.
8. Patient transfer priorities within the facility shall be as follows:
 - a. Emergency Department to appropriate patient bed.
 - b. From obstetric patient care unit to general care area, when medically indicated.
 - c. From Intensive Care Unit to general care area.
 - d. From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient.

No patient will be transferred without consultation with and approval by the responsible practitioner.
9. 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 transfer of a patient to another facility is in the patient's best interest, or if for any reason the hospital cannot admit a particular patient who requires inpatient care, the hospital and/or the attending physician shall assist the patient in making arrangements for care at another facility so as not to jeopardize the health and safety of the patient.
 - b. If the patient is to be transferred to another health care facility, the transferring physician shall enter all pertinent information on 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 stabilized for transport. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

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10. The admitting practitioner shall be held responsible for obtaining and conveying such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever a patient might be a source of danger from any cause.
11. For the protection of patients, the Medical and Nursing Staffs and the Hospital, certain principles are to be met in the care of the potentially suicidal patient :
 - a. Any patient known or suspected to be suicidal shall be evaluated to determine the degree and, if possible, the nature of the danger to him/herself or to others. The determination should include the patient's potential suicidal thoughts, feelings, or behaviors. This evaluation shall be conducted by a practitioner who has demonstrated current competence and clinical privileges to perform the assessment and to document the conclusions in the patient's health care record.
 - b. After evaluation and medical clearance, any patient over the age of eighteen determined to exhibit suicidal intent shall be admitted to the Behavioral Health Unit. If not medically cleared, the patient shall undergo close monitoring with 1:1 staffing ratio and pertinent environmental precautions. If these accommodations are not available, the patient shall be referred, if possible, to another institution where suitable facilities are available.
 - c. After evaluation and medical clearance, any patient under the age of eighteen determined to exhibit suicidal intent shall be referred to an appropriate facility for ongoing intervention and care. If the patient's condition permits retention for medical clearance, the patient shall undergo close monitoring with 1:1 staffing ratio and pertinent environmental precautions.
12. Admissions to Special Care Units -- If any question as to the validity of admission to or discharge from a Special Care Unit should arise, that decision is to be made through consultation with the Chair of the appropriate Department(s), or designee.
13. The attending practitioner must abide by the tenets of the Utilization Management Plan.
14. Patients shall be discharged only by order of the attending practitioner. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.
15. 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 discharge; 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.

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- b. Discharge planning shall include, but need not be limited to, the following:
- 1) Appropriate referral and transfer plans;
 - 2) Methods to facilitate the provision of follow up care, including communication of the following to the new organization or provider:
 - the reason for discharge;
 - the patient's physical and psychosocial status;
 - a summary of care, treatment, and services provided and progress toward goals;
 - community resources or referrals provided to the patient
 - 3) Information to be given to the patient or the patient's family or other persons involved in caring for the patient 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.
16. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner, or 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. Policies regarding the release of the body from the hospital shall conform to local law.
17. Medical Staff members have a duty to secure meaningful autopsies 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 (e.g., Administrative Manual Policy #1285).
18. The Medical Staff has determined the following indications for the performance of an autopsy:
- a. Unanticipated death for which there is no known medical or surgical condition which can account for or explain the death;
 - b. Death in which there is an unexplained medical or surgical finding(s) for which an autopsy might potentially yield useful information; and
 - c. Death in which there is significant medical information to be gained for the family, community, or as part of a continuing education program for staff physicians (e.g., confirmation of suspected pathologic process(es), evaluation of new or experimental therapeutic regimens, investigation of antemortem diagnostic maneuvers, etc.)

An autopsy is not indicated to merely document known medical conditions such as heart disease or cancer unless it meets one or more of the preceding guidelines. Criteria for reporting hospital deaths to the Rhode Island Medical Examiner are determined by state regulations and statutes. 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.

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An autopsy will be performed as a courtesy, free of charge, at the request of an attending staff physician and with the written consent of the next of kin, provided the patient died at Newport Hospital and/or has been followed and treated by a Newport Hospital Staff physician. When an autopsy is requested by the next of kin, but not deemed necessary by the Newport Hospital Staff physician, there will be a charge assessed to the next of kin to help defray part of the high cost of performing and completing the autopsy.

19. Guidelines to be used to determine which in-hospital deaths should be reported to the Medical Examiner are outlined in state regulations and reflected in Administrative Manual Policy #1410.

B. MEDICAL RECORDS

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- 1 The attending physician (or Staff Affiliate) 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 patient discharge. Each health care record shall be pertinent and current, and shall include all items required by state and federal regulations, The Joint Commission and CMS conditions and 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.

- 2 A complete history and physical by a physician member of the Medical Staff (or Staff Affiliate unless in conflict with regulation or contract) 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 complete 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, a brief summary of the patient's admission diagnosis, list of medications and treatment plan shall be placed in the progress notes.

Observation status patients do not require a full H&P but a documented medical history and examination pertinent to the reason for hospital evaluation and care. If an observation patient becomes an inpatient admission, a full H&P is required.

Ambulatory Surgery patients will have an H&P pertinent to the patient's level of complexity and proposed anesthesia as outlined in Section D, General Rules Regarding Surgical Care.

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History and Physicals (H&Ps) will be valid for 30 days. H&Ps greater than 24 hours old will require an interim note to update the H&P within 24 hours of hospital entry or prior to surgery. The interim note must delineate the patient's course since the H&P was completed and must be signed and dated by the practitioner.

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When a patient is readmitted within thirty (30) days for the same or related problem, an interval note reflecting subsequent changes in the H&P and clinical course may be used in the medical record, provided the original history and physical is available at the time of patient admission and included in the medical record. The interval note must be completed within 24 hours of hospital entry or prior to surgery.

If the patient re-enters the hospital for an unrelated problem, a new H&P is required.

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History and physical examination, such as those performed in the office of a member of the Medical Staff within 30 days prior to the patient's admission, is acceptable in a format approved by the Hospital, provided it is updated at the time of admission.

3. When the history and physical examinations are not recorded and entered into the patient record before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such a delay would be imminently detrimental to the patient's welfare.
4. Pertinent progress notes shall be recorded at the time of evaluation, sufficient to permit continuity of care and transferability. Wherever 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 at least daily, except on the Rehabilitation Unit which has specifically defined criteria. Progress notes should reflect a continuous documentation of the necessity of hospitalization and continuation of care.

Pertinent and timely progress notes also shall be recorded by others so authorized by the Medical Staff, such as practitioners who have been granted clinical privileges, and specified professional hospital personnel.

5. The medical record shall thoroughly document operative or other procedures, and the use of moderate or deep sedation or anesthesia. 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 automatically canceled:
 - a. verification of patient identity, the procedure to be performed and the site of surgery;
 - b. medical history and supplemental information regarding drug sensitivities 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;
 - g. an appropriately completed and signed consent form;
 - h. x-ray reports, if applicable, including those obtained from sources outside of the hospital;
 - i. other ancillary reports, if applicable.

A pre-operative note shall be documented in the medical record before the surgery is to be performed.

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

- a. a description of the surgery and related findings;
- b. the technical procedures used, including the surgical technique, use of drains, blood and blood components administered, if any, estimated loss of blood and other fluids and replacement;
- c. the specimens removed;
- d. the pre-operative and post operative diagnosis(es);
- e. any unusual events or complications, including blood transfusion reactions and the management of those events;
- f. gross pathology observed visually or by palpation;
- g. the names of the primary surgeon and any and all assistants; and
- h. the type of anesthesia used.

If the operative report is dictated, a brief postoperative note will be entered in the patient's medical record immediately following the procedure. The note will contain sufficient information to permit ongoing care until the dictated operative report is available.

Postoperative documentation shall also include the patient's vital signs, level of consciousness, and medications (including intravenous fluids).

Post operative 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.

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.

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.

6. 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 should be made a part of the current medical record within forty-eight (48) hours of request. When operative procedures are involved, the consultation report, except in emergency situations so verified in the record, shall be recorded prior to the operation or procedure.

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.

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7. The current obstetrical history shall include a complete prenatal record. The prenatal record may be a legible and durable copy of the attending practitioner's (or Staff Affiliate's) office records transferred to the Hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

To be acceptable, the prenatal record shall be in a form approved by the Hospital and compatible with its current medical records system.

8. All clinical entries in the health care record shall be accurately dated, timed, and authenticated.

Authentication means to prove authorship by written signature or electronic identification.

9. Official references defining approved abbreviations shall be kept on file in the Medical Library.

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 Medical Records Department and on the Medical Staff Services intranet site.

10. A discharge summary shall be dictated or written on all medical records of hospitalized patients except as outlined below. The discharge summary should include the reason(s) for admission, the significant findings, the procedures performed, final diagnosis(es), the condition and disposition of the patient on discharge, and the instructions given to the patient and/or family. A discharge summary is not required for normal newborns or uncomplicated obstetrical cases. All discharge summaries shall be authenticated by the responsible practitioner (or Staff Affiliate..)

11. The medical record is the property of the Hospital and is maintained for the benefit of the patient, the Medical Staff, and the Hospital. As such, medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute.

Written consent of the patient is required for release of medical information to persons not otherwise legally authorized to receive this information.

12. A medical record shall not be permanently filed until each clinical event is fully documented and authenticated. The records of discharged patients shall be completed within a period of time that will in no event exceed thirty (30) days following patient discharge.

In the event that a medical record cannot be completed, the respective department chair(s) will review the incomplete items and recommend to the Medical Executive Committee whether the incomplete record should be filed.

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13. Countersignature requirements.
 - a. All verbal orders must be authenticated as delineated in Section C. 3.
 - b. All Allied Health Professionals (AHPs) record entries must be authenticated by an appropriate supervising provider.
 - (1) Written entries will be directly countersigned.
 - (2) Electronic entries will require a separate note annotating concurrence with the AHPs record entry.
 - (a) Electronic orders entered by AHPs are not able to be directly countersigned. Countersignature or separate acknowledgement of the AHPs medical record entry that corresponds to the entered order(s) signifies “authentication” of the electronic order(s).
 - c. Other providers whose clinical privileges require countersignature will have those designated entries countersigned according to the mechanisms outlined above.
14. 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 24 hours of patient admission.
 - b. Operative report, immediately after surgery.
 - c. Consultation report, within 48 hours of notification of request.
 - d. Discharge summary, within 14 days.
 - e. Required record countersignatures within 30 days of patient discharge.

15. Medical Records Completion Process

The following procedure 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, Joint Commission standards, and policies of the Medical Staff and Health Information Services.

Health Information Services Responsibility

Every Friday, a notification letter will be sent to members of the Medical Staff and Affiliate Staff who have incomplete/delinquent records. This letter will indicate the total number of incomplete/delinquent records and whether these records require signatures or dictation.

If the delinquent records indicated in this letter are not completed by the following Thursday at 10:00 p.m., a second letter will be sent to the practitioner informing him/her that he/she is on the delinquency list and indicating the number of incomplete records. Neither the type (i.e., missing signature vs. missing dictation) nor the number (i.e., one missing item vs. 25 missing items) of deficiencies has a bearing as to whether or not a practitioner will appear on the delinquency list. A delinquency list (indicating the name of each delinquent

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physician, the number of records for which he/she is responsible, and the number of times he/she has appeared on the delinquency list that cycle. will be distributed to the following individuals:

- President and Chief Executive Officer
- Medical Staff Department Chairs (of those on the list)
- Medical Staff President
- Vice President of Medical Affairs

The notification letter to practitioners who are appearing on the delinquency list for the second time within a six (6) month cycle will be sent by certified mail and will remind the practitioner that the next time he/she appears on the delinquency list, his/her privileges may be suspended.

Practitioners appearing on the delinquency list for the third, and any subsequent, time in the same six (6) month cycle face automatic suspension. The details of this process are outlined in the Credentialing Procedures Manual 7.3-3.

Periods of Measurement: The six-month periods of measurement for delinquencies will run from October 1 to March 31 and from April 1 to September 30. Delinquencies will not be carried over from one six-month period to the next.

Extension of Record Completion Deadline: Vacation days, days spent in attendance at medical meetings or days lost due to illness will not be counted toward making a record delinquent. Any practitioner who is away for two or more days and provides appropriate notification to Health Information Services prior to his/her departure, will, upon return, receive an extension of one week (or more if appropriate. in which to complete any "due" records. Practitioners are requested to complete all "due" records before leaving on vacation. If a practitioner wishes his/her absence to be kept confidential, he/she should communicate directly with the Health Information Services Director or the Health Information Services Supervisor.

Health Information Services Error: Any practitioner who feels that his/her delinquencies are the result of error on the part of the Health Information Services staff may bring this matter to the attention of the Health Information Services Director or the Health Information Services Supervisor.

16. 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 or 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 or her password shall constitute his or 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 or her password, he/she immediately shall change the password immediately and report such unauthorized use or disclosure to the Hospital's Information Services Department.

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- b. Patient Information and Records. Members of the medical staff shall access patient information or records through Hospital's information systems either on-site or remotely only for the following purposes in accordance with state and federal law 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, in accordance with Hospital policy or with specific Hospital approval; and (iv) performing other administrative duties in accordance with these Bylaws. 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 or other storage device or any portable or wireless devices.
 - 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 otherwise directed by the Hospital or Medical Staff 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 or 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 access the Hospital's e-mail system and/or internet service provider shall abide by the Hospital's e-mail and internet usage policies.
17. Organized Health Care Arrangement

Medical staff members acknowledge that ["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") and regulations promulgated there under ("HIPAA Regulations") and that the Medical Staff is an integral component of the Hospital.

Effective April 14, 2003, the members agree that the Medical Staff and Hospital constitute an "Organized Health Care Arrangement" as defined and permitted by HIPAA and HIPAA Regulations and agree: (1) to use reasonable efforts to preserve the security and confidentiality of Protected Health Information that each receives from the other and shall be permitted only to use and disclose such information to the extent necessary to conduct the activities of the Hospital and to extent required or permitted by HIPAA, HIPAA Regulations, these Bylaws and Rules and Regulations and applicable state law and as set out in Rule 14; and (2) to comply with the terms of the Hospital's Joint Notice of Privacy Practices (as may be amended from time to time. with respect to the Protected Health Information created or received by each other in the course of participating in Hospital activities.

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C. GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. It shall be the practitioner's obligation to assist with proper consent procedures before the patient is treated in the Hospital. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure should be obtained. Appropriate forms for such consent will be adopted with the advice of legal counsel and standardized in the facility.
2. 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 available, the practitioner will enter all orders via computerized order entry.

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 or fully understood by the nurse.

An order to withhold or forego resuscitation treatment (Do Not Resuscitate order) shall be written by the responsible practitioner. If the practitioner is not present in the Hospital at the time the order is to be given, he/she may transmit a facsimile of the order with his/her signature to the Hospital or convey a verbal order that must be authenticated before the end of the next calendar day.

3. 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 sphere 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 it. 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. Except in urgent/emergent situations, verbal orders should not be given or accepted if the practitioner is physically present on the unit.

Only appropriately "licensed" personnel authorized by state agencies and Newport Hospital administrative policies may accept verbal orders related to their respective scopes of practice. These personnel include, but are not limited to, disciplines such as registered nurses, pharmacists, respiratory therapists, nutritionists, physical therapists, occupational therapists, and radiology technicians.

For example, radiology technicians may accept verbal orders effecting changes in diagnostic imaging orders. Pharmacists can accept verbal orders to add, delete, or otherwise modify medication orders.

In addition, clinical dietitians may:

- a. Take verbal orders for total parenteral nutrition or to change rate or strength of tube feedings;
- b. Draft orders for tube feedings and total parenteral nutrition which must be co-signed by a physician;
- c. Initiate or change orders for oral supplements which must be co-signed by a physician;
- d. Discontinue calorie counts; and
- e. Write clarifications of vague diet orders (e.g., "renal diet," "low sodium diet," "low potassium diet,") which must be co-signed by a physician.

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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. The practitioner who authenticates the verbal order acknowledges the presence of the order and its implications but does not take responsibility for the original order. Responsibility for the original order remains with the practitioner who originally created the order.

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

On units that have implemented the computerized order management system, practitioners will be electronically notified of unsigned orders and will authenticate the orders electronically. Practitioners are responsible to follow through and countersign their verbal orders.

4. With the capabilities of computerized physician order entry, all orders except "Do Not Resuscitate" orders remain in effect through the peri-operative interval. The active orders are reviewed after the procedure and modified according to the patient's condition as appropriate.
5. 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 and all regulations of the Federal Drug Administration.

A method to control the use of dangerous and toxic drugs shall be developed by the Medical Staff through its Pharmacy and Therapeutics Committee.

A method for control of drugs brought into the Hospital by patients shall be established by the Pharmacy and Therapeutics Committee.

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

The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant through entry of a valid order. The consultation order shall indicate the reason(s) for the request.

7. Consultation is required in the following situations:
 - a. when the patient is not a good risk for operation or treatment;
 - b. where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 - c. where there is doubt as to the choice of therapeutic measure to be utilized;
 - d. in unusually complicated situations where specific skills of other practitioners may be needed;
 - e. in instances in which the patient exhibits severe psychiatric symptoms;
 - f. when requested by the patient or family; and
 - g. in the event of an exposure to blood borne pathogens, when the source is known to be HIV positive. Expert consultation is mandatory in this situation for advice regarding the management of the exposed individual.

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8. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her supervisor who, in turn, may refer the matter to the Vice President of Nursing and Patient Care Services. If warranted, the Vice President of Nursing and Patient Care Services may bring the matter to the attention of the Chair of the department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the Chair of the department may request a consultation.
9. Administrative processing of all body fluids and tissue that are to be tested, whether at Newport Hospital or at some other testing site shall occur through the Newport Hospital Laboratory.

D. GENERAL RULES REGARDING SURGICAL CARE

1. Except in severe emergencies, the pre-operative diagnosis, valid H&P, signed and witnessed consent, and required laboratory and other pre-operative testing must be recorded on the patient's medical record prior to any surgical procedure. If these are not recorded, the operation shall be canceled. For elective cases, these items must be available in the pre-operative chart at least 48 hours prior to the scheduled procedure. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

A full H&P is required for all inpatients regardless of ASA classification or type of anticipated anesthetic.

An abbreviated H&P can be performed for ASA class I and II Ambulatory Surgery patients. The specifically designed format approved by the Medical Executive Committee is available through Surgical Services.

The clinical evaluation required for moderate sedation cases is delineated in the hospital's moderate sedation policy.

An abbreviated evaluation can be performed for minor procedures conducted in Surgical Services under local anesthetic. 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.

2. A patient admitted for dental care is the dual responsibility of the dentist and 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 H&P.
 - a. It is the dentist's responsibility to provide:
 - (1) A detailed dental history justifying the hospital admission or surgical procedure.
 - (2) A detailed description of the examination of the oral cavity and a pre-operative diagnosis.
 - (3) 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.
 - (4) Progress notes as are pertinent to the oral condition.
 - (5) Clinical summary.

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- b. It is the physician's responsibility to provide:
 - (1) Medical history pertinent to the patient's general health.
 - (2) A physical examination to determine the patient's condition prior to anesthesia and surgery and medical clearance to proceed.
 - (3) If admitted, supervision of the patient's general health status while hospitalized.
3. A patient admitted for podiatric care is a dual responsibility involving the podiatrist and 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 podiatrist's responsibility to provide:
 - (1) A detailed podiatric history justifying the hospital admission or surgical procedure.
 - (2) A detailed description of the examination of the feet and a pre-operative diagnosis.
 - (3) A complete operative report, describing finding(s) and technique(s). All tissue shall be sent to the Hospital Pathologist for examination.
 - (4) Progress notes as are pertinent to the condition of the feet.
 - (5) Clinical summary.
 - b. It is the physician's responsibility to provide:
 - (1) Medical history pertinent to the patient's general health.
 - (2) A physical examination to determine the patient's condition prior to anesthesia and surgery and medical clearance to proceed.
 - (3) 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. Written, 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. In emergencies involving a minor or unconscious patient in which 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.

Specific procedures related to obtaining informed consent are delineated in hospital policy (e.g., Administrative Manual Policy #4210).

Should a second operation be required during the patient's stay in the Hospital, a second consent specifically worded 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. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

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6. Major surgical procedures that require an assistant to be present and scrubbed will be defined by the Medical Executive Committee and approved by the Board of Trustees.
7. Except as provided below, 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. Unless otherwise requested by the surgeon, the following specimens are exempt from pathologic examination:
 - Cosmetic/plastic surgery specimens, other than those from the breast.
 - Arthroscopic joint debridement specimens.
 - Any placentas from routine uncomplicated deliveries lacking clinical indications for further examination.
 - Varicose veins.
 - Fingernails or toenails.
 - Scars.
 - Foreskin from infant circumcision.

At the discretion of the surgeon, the following specimens may be submitted for gross examination only:

Foreign objects; orthopedic hardware; cataracts; calculi (unless chemical analysis is requested), teeth.

Specimens from Resection of bunions (osteophytes), femoral heads or hips and knees resected for degenerative joint disease.

E. EMERGENCY SERVICES

1. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record. The record shall include:
 - a. identifying patient information;
 - b. information concerning the time of the patient's arrival, means of arrival and by whom transported;
 - c. pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to arrival at the Hospital;
 - d. description of significant clinical, laboratory and radiographic findings;
 - e. diagnosis;
 - f. treatment given;
 - g. condition of patient on discharge or transfer and whether the patient left against medical advice; and
 - h. final disposition, including instruction given to the patient and/or family, relative to necessary follow-up care.

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2. Each patient's medical record shall be signed by the practitioner in attendance that is responsible for its clinical accuracy.
3. The medical staff will support and fully participate in the Hospital's Emergency Preparedness Plan.