NEWPORT HOSPITAL
Newport, Rhode Island 02840

MEDICAL STAFF
RULES AND REGULATIONS

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These Rules and Regulations of the Newport Hospital Medical Staff are designed to augment and/or clarify requirements and provisions in the Medical Staff Bylaws and to expound on details related to clinical practice at the Hospital.

Care is also governed by Federal and state statutes and regulations; standards and conditions of accreditation organizations 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 Where conflicts in requirements arise, these Rules and Regulations are superseded by external regulatory requirements.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. The Rules and Regulations of the Medical Staff must conform with Federal and State requirements but may also have additional requirements as determined by the medical staff and the Board.

SECTION A: *ADMISSION OF PATIENTS*

1. A patient meeting admission criteria may be admitted to the Hospital by any member of the Medical Staff (or independent Allied Health Professional) who has been granted admitting privileges. All practitioners shall be governed by the admitting policies of the Hospital and must abide by the tenets of the Utilization Management Plan.

2. A member of the Medical Staff (or independent Allied Health Professional) 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 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.

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 which service is the more appropriate admitting service for the patient and the attendings cannot reach a mutually acceptable agreement within 30 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 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 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 patient care requirements. This time interval should not exceed 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.

9. 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.

    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 dentist may provide the abbreviated, general medical history and physical pertinent for the procedure.

10. 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.

11. 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 Chair of the respective surgical department may be consulted by Nursing Administration to decide the urgency of any specific admission.

   c. Direct Admissions from office settings. These patients may need to be routed through the Emergency Department if beds are not immediately available or if medical stabilization is necessary.

   d. Conversion from Observation Status. Patients who have been placed on observation status and are determined to require a higher level of care may be admitted to the hospital for further evaluation and treatment.

   e. Initial Observation Status. Patients for whom additional observation is required to determine if the patient can be safely discharged to a lower level of care or if the patient ultimately meets admission criteria and should be cared for in the acute inpatient setting.

12. 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.

13. 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.

    Questions regarding the validity of admission to or discharge from a Special Care Unit should be pursued through consultation with the appropriate unit Medical Director or Department Chair, or designee.

14. The admitting practitioner shall be 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.

    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 as delineated in pertinent Hospital policies.

SECTION B: *TRANSFER OF PATIENTS*

1. No patient will be transferred without consultation with and approval by the responsible practitioner.

2. Transfer within the facility. Patient transfer priorities within the facility shall be consistent with the individual patient's needs and shall generally be as follows:
    a. From general care unit to the Intensive Care Unit for critical care.
    b. From the Emergency Department to the Intensive Care Unit for critical care.
    c. From the Emergency Department to an appropriate patient bed.
    d. From obstetric patient care unit to general care area, when medically indicated.
    e. From Intensive Care Unit to general care area.
    f. From the Post Anesthesia Care Unit to the clinical service area appropriate for that patient.
    g. From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient.

3. Transfer from another facility. 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 Newport Hospital. 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 physician prior to admission or transfer to a patient care unit.

4. Transfer to another facility. 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 long as the patient is sufficiently stable for transfer. The patient and/or family members will be informed of the medical necessity for transfer and alternative(s), unless the transfer is requested by the patient and/or family members.

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.

SECTION C: *DISCHARGE OF PATIENTS*

1. 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 other independent practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

2. Discharge Planning. 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 need not be limited to, the following:

(1) Appropriate referral and discharge plans;

(2) Methods to facilitate the provision of follow up care, including communication of the following to the new organization or provider:

- The reason(s) for hospitalization;
- The patient's physical and psychosocial status;
- A summary of care, treatment, and services provided;
- Medication reconciliation of the admitting medications with those to be used after discharge; and
- 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 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.

3. In-hospital Death.

a. Pronouncement. In the event of a patient's death while in the hospital, 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, or designee. Policies regarding the release of the body from the hospital shall conform to state and federal law.

b. Medical Examiner Cases.

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

(2) An autopsy may be performed on a reportable death only upon completion of the

Medical Examiner's investigation or release of jurisdiction – and when the circumstances fulfill one of the designated indications.

c. Autopsy.

(1) Medical Staff members shall 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).

(2) The Medical Staff has determined the following indications for the performance of an autopsy:

i. Unanticipated death for which there is no known medical or surgical condition which can account for or explain the death;

ii. Death in which there is an unexplained medical or surgical finding(s) for which an autopsy might potentially yield useful information; and

iii. Death in which there is significant medical information to be gained for the family, community, or as part of a medical education program, such as confirmation of suspected pathologic process(es), evaluation of new or experimental therapeutic regimens, investigation of antemortem diagnostic maneuvers, and others.

(3) 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.

(4) An autopsy that meets the designated indications will be performed as a courtesy, free of charge, at the request of an attending physician and with the written consent of the next of kin, provided that 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 does not meet a designated indication or is not deemed necessary by a Newport Hospital Staff physician, the next of kin may be assessed fees for the service.

SECTION D: *MEDICAL RECORDS*

1. General Guidelines.

a. The attending physician (or independent Allied health Professional) shall be responsible for the preparation of a timely, accurate, complete and legible medical record for each of his/her patients within twenty (20) business days of patient 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.

b. 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.

c. 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.

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

e. 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 available in the Health Information Services Department and on the Medical Staff Services intranet site.

f. 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.

g. 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 twenty (20) business 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.

h. Countersignature requirements.

(1) All verbal orders must be authenticated as delineated in Section E.2.

(2) All non-independent Allied Health Professionals (AHPs) record entries must be authenticated by an appropriate supervising provider.

i. Written entries will be directly countersigned.

ii. 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).

(3) Other providers whose clinical privileges require countersignature will have those designated entries countersigned according to the mechanisms outlined above.

2. History and Physical Examinations

a. A complete history and physical (H&P) by a physician member of the Medical Staff (or independent Allied Health Professional unless in conflict with regulation or contract) shall be recorded within twenty-four (24) hours of inpatient admission.

b. 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 assessments or impressions drawn from the history and physical examination, and a statement of the plan of treatment.

c. When the history and physical is dictated, a brief summary of the impression and treatment plan shall be placed in the progress notes to permit ongoing care until the dictated document is available.

d. 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.

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

f. Obstetrical patients' current obstetrical history shall include a complete prenatal record. The prenatal record may be a legible and durable copy of the attending obstetrician's or certified nurse midwife's office records transferred to the Hospital before admission, but an interval admission note must be created that includes pertinent additions to the history and any subsequent changes in the physical findings.

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

g. Behavioral Health Unit patients have been medically cleared by an emergency department or acute medical/surgical unit. The H&P for these patients shall consist of a complete history as delineated above. The physical examination will consist of the following elements:

(1) General appearance and constitution

(2) Complete mental status exam

(3) Neurological exam pertinent to the patient's presentation

(4) Documentation of the following:

i. Obvious physical disability(s) affecting care (e.g., walker, wheelchair)

ii. Deformities or other physical issues that may have psychological importance (e.g., amputation, obvious scarring)

iii. Obvious abnormal movements (e.g., tardive dyskinesia)

Other physical exam elements would be optional depending on patient presentation.

h. History and Physicals (H&Ps) will be valid for 20 business days.

(1) 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.

(2) When a patient is readmitted within twenty (20) business 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.

i. 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 safety and welfare.

3. Progress Notes

a. 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.

b. Attending 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.

c. 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.

4. Consultations

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

b. A consultation may be requested through entry of a valid order. The consultation order shall indicate the consultant/service requested, the reason(s) for the request and its urgency. If the consultation is non-emergent, the clinical situation and reason for the consultation should be documented in the requesting practitioner's note at the time of the request, or the requesting practitioner and the consultant are encouraged

to discuss the clinical situation and questions prior to the performance of the consultation at the earliest convenient time.

c. Non-emergent consultations should be completed and documented within 48 hours of the time of the request. Each consultant's report shall include a brief written impression and plan in the progress notes, and a complete written or dictated consultation which contains a history and physical exam pertinent to the specialty; a review of laboratory, imaging, and other clinical data; the clinical impression; and recommendations. The consultant will then communicate the impression and recommendations to the primary attending practitioner by progress note or directly discuss the impression and recommendations, clarify who will initiate orders and follow-up testing results and follow the clinical course. The consultant is also expected to follow the specific clinical problem and document progress in the progress notes until the specific clinical problem is stable or resolved, and recommend/arrange appropriate post hospital clinical outpatient follow-up, as indicated.

(1) The full consultation report should be made a part of the current medical record within forty-eight (48) hours of consultation request.

(2) The brief impression and plan should be documented in the progress notes at the time of patient contact.

(3) 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.

d. Consultation is <u>required</u> in the following situations:
(1) When requested by any qualified practitioner with clinical privileges in the Hospital;
(2) When requested by the patient or family; or
(3) 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.

e. If a nurse has any reason to doubt or question the appropriateness or quality of care provided to any patient or believes that an appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of the attending physician. If he/she, in the interest of clinical care or patient safety, is not satisfied with the results of this interaction, he/she may alert his/her supervisor who, in turn, may refer the matter to the Chief Nursing Officer. If warranted, the Chief Nursing Officer may bring the matter to the attention of the Chair of the department wherein the practitioner has clinical privileges or the Vice President of Medical Affairs/Chief Medical Officer. Where circumstances are such as to justify such action, the Chair of the department or the Vice President of Medical Affairs/Chief Medical Officer may request a consultation.

5. Discharge Summary

a. A discharge summary shall be completed for all hospitalized patients except for normal newborns and uncomplicated obstetrical cases.

b. The discharge summary shall be completed at the time of patient discharge whenever possible, but, in all cases, within ten (10) business days of patient discharge.

c. 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, the instructions given to the patient and/or family, and provisions for follow up care, including specific pending tests, studies, or results that require further action.

d. All discharge summaries shall be authenticated by the responsible practitioner.

6. Medical Record Edits.

When an entry in a patient's medical record is amended or corrected in any way, the editing practitioner shall sign, date and time his/her entry at the point of amendment.

7. 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 24 hours of patient admission.

b. Operative report, immediately after surgery or within 24 hours.

c. Consultation report, within 48 hours of notification of request.

d. Discharge summary, within 10 business days.

e. Required record countersignatures within 20 business days of patient discharge.

8. 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 twenty (20) business days following patient discharge in accordance with the rules and regulations, accreditation standards, and policies of the Medical Staff and Health Information Services.

a. 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 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:

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

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 as outlined below.

b. 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.

c. 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.

d. 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.

e. Automatic Suspension for Medical Records Violations

If a practitioner appears on the delinquency list three times within a six-month cycle, his/her privileges will be administratively suspended until all incomplete records are completed. If a practitioner appears on the delinquency list a fourth, and any subsequent, time within a six-month cycle, his/her privileges will be administratively suspended until all incomplete records are completed AND the practitioner will be

referred to the Medical Executive Committee for collegial intervention.

Notification of suspension letters will be signed by the President of the Medical Staff. Suspension means that the practitioner will not be allowed to admit, treat or consult nor will he/she be permitted to see patients in the Emergency Department or anywhere within the hospital or NHCC Medical Associates offices. To provide the practitioner time to arrange for coverage or reschedule patients, the actual suspension of privileges will not occur until 1:00 a.m. on the second Monday following the date the notification of suspension letter is mailed.

The Medical Staff Services Office will send notification of suspension of privileges, including the beginning and ending dates and times of the suspension period, to those included on the Board privileging notification distribution list.

The suspended practitioner must abide by the terms of the suspension. If a practitioner's privileges are suspended, and he/she requests an admission, calls to schedule surgery (either elective, emergency or ambulatory) or requests to see a patient in the Emergency Department, he/she will be advised by the Patient Registration, Operating Room or Emergency Services personnel that he/she is on suspension and the request will be denied.

The suspended practitioner may request a special meeting of the Medical Executive Committee to consider factors that might warrant waiving the suspension period. The meeting will be held within one week of receipt of the letter indicating the third, any subsequent, delinquency and the practitioner will be required to attend this meeting to explain the circumstances to be considered. If the suspension period is not waived, suspension of privileges will begin at 1:00 a.m. on the Monday following the special Medical Executive Committee meeting.

The Health Information Services Director must be notified in writing of any decision made by the Medical Executive Committee that necessitates an action on the part of Health Information Services.

f. Medical Record Deficiencies and the Credentialing Process

The inability of a practitioner to complete his/her health care records within 20 business days of patient discharge is taken into consideration in the credentialing process at the time of reappointment to the Medical Staff.

g. Enforcement of Policy

The responsibility for enforcing this policy rests with the Medical Executive Committee and the Medical Staff Department(s) involved.

9. Electronic Medical Record Considerations: Confidentiality and Security of Patient and Organizational Information

a. Password, E-Signature or Other User Identification.

No Medical Staff Member 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 Medical Staff Member 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 Medical Staff Member 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.

b. Patient Information and Records.

Medical Staff Members 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:

(1) Providing health care to the patient or coordinating such care with other health care providers;

(2) Billing activities and filing claims for reimbursement for patient care;

(3) Conducting scientific or statistical research, management or financial audits, in accordance with Hospital policy or with specific Hospital approval;

(4) Conducting authorized quality assessments and peer reviews; and

(5) 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 policy 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, flash drive, CD, tape or other data 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 and health system policies, or as otherwise directed 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 or her obligations pursuant to these Bylaws, Rules and Regulations, or Hospital and health system 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.

SECTION E: *GENERAL CONDUCT OF CARE*

1. Patient Care Orders

a. All orders for treatment shall be in writing or entered in the computerized patient order management system in accordance with approved guidelines. The expectation is that, whenever possible and wherever available, the practitioner will enter all orders via computerized order entry.

b. When hand written, the practitioner's orders must be clear, legible, and complete. All orders must be dated, timed, and signed. Orders that are illegible or improperly written will not be carried out until rewritten or fully understood by the individual that must carry out the order.

c. An order to withhold or forego resuscitation treatment shall be written/entered by the responsible practitioner. If the practitioner is not present in the Hospital at the time the order is generated, 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.

2. Verbal Orders

a. A verbal order, regardless of the mode of transmission of the order, shall be considered to be in writing if conveyed to a duly authorized person functioning within his or her sphere of competence and countersigned by the responsible covering practitioner.

b. The verbal order shall be written or electronically entered upon receipt and shall include the date, time, 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.

c. Except in urgent/emergent situations, verbal orders should not be given or accepted if the practitioner is physically present on the unit and/or has access to a device that permits direct order entry.

d. Only appropriately "licensed" personnel authorized by state agencies and 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:

(1) Take verbal orders for total parenteral nutrition or to change rate or strength of tube feedings;

(2) Draft orders for tube feedings and total parenteral nutrition which must be countersigned by a physician;

(3) Initiate or change orders for oral supplements which must be co-signed by a physician;

(4) Discontinue calorie counts; and

(5) Write clarifications of vague diet orders (e.g., "renal diet," "low sodium diet," "low potassium diet,") which must be co-signed by a physician.

e. 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.

f. Authentication of special verbal orders such as those for withholding resuscitative services and for the use of restraints and/or seclusion, shall follow pertinent hospital policy.

3. Patient Care Orders – Status when going to surgery

a. Since computerized patient order management provides an accurate delineation of all active orders, all orders except resuscitation status 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.

b. Resuscitation status orders are automatically suspended when the patient is taken to the Operating Room for a procedure and are reinstituted after Stage 1 of the post anesthesia recovery period.

4. 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.

SECTION F: *ADDITIONAL RULES REGARDING SURGICAL CARE*

The following additional elements specifically apply to the conduct of care for surgical patients:

1. Pre-procedure Documentation Requirements

a. The medical record shall thoroughly document operative or other procedures, and the use of moderate or deep sedation or anesthesia. Except in severe 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:

(1) Verification of patient identity, the procedure to be performed and the site/side of surgery;
(2) History and Physical examination commensurate with the requirements below;
(3) Evaluation of the capacity of the patient to withstand the planned anesthesia and surgery;
(4) Provisional pre-operative diagnosis;
(5) Appropriately completed and signed consent form;
(6) Consultation reports, if applicable;
(7) Laboratory test results, if applicable, including those obtained from sources outside of the hospital;
(8) Diagnostic Imaging reports, if applicable, including those obtained from sources outside of the hospital;
(9) Other ancillary reports, if applicable.

b. 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.

c. For elective cases, all of these items except consents must be available in the pre-operative chart at least 48 hours prior to the scheduled procedure. If circumstances require, the consent can be completed the day of the procedure.

2. History and Physical Examinations

In addition to the general History and Physical Examination (H&P) requirements delineated in Section D.2 of these Rules and Regulations, the following considerations apply:

a. Inpatients.

A full H&P is required for all inpatients (including those arriving on the morning of the scheduled procedure) regardless of ASA classification or type of anticipated anesthetic.

b. Ambulatory Surgery Patients.

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

(2) ASA III and greater. A full H&P is required.

c. Moderate Sedation Cases (Surgical Services). The clinical evaluation required prior to moderate sedation cases is delineated in the Hospital's moderate sedation policy.

d. Minor Procedures (Surgical Services). 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 examination of the area in question. These requirements apply to all specialties that utilize this treatment area.

3. Consents

a. Written, signed, timed, dated, and witnessed informed consent shall be obtained prior to an operative procedure except in those situations in which the patient's life is in immediate jeopardy and suitable signatures cannot be obtained due to the condition of the patient.

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

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 in the patient's medical record. If time permits, a confirmatory consultation may be desirable before the emergency operative procedure is undertaken.

b. Should a second operation or procedure 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 that plan is known in advance, all procedures may be described and consented on the same form.

4. Anesthetist Documentation

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.

a. Pre-anesthesia note. 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 note. 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 and must be completed within 48 hours of the procedure end time.

5. Conduct of Care

a. When a significant medical abnormality is present, the final decision on whether to proceed with the surgery must be agreed upon by the provider, anesthesiologist, and/or additional consultants. In case of dispute, the Department of Anesthesiology Chair, or designee, will decide the issue of whether to proceed.

6. Operative Report

a. A detailed operative report shall be written or dictated immediately after surgery or other procedure and shall contain:
   (1) Name and hospital identification number of the patient;
   (2) Name(s) of the surgeon(s)/proceduralist(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
      i. In addition, surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/proceduralist (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
   (3) Preoperative and postoperative diagnosis(s);
   (4) Name of the specific surgical procedure(s) performed;
   (5) Type of anesthesia administered;
   (6) Any unusual events or complications, if any;
   (7) A description of surgery, surgical techniques, findings, tissues removed or altered, and specimens sent;
   (8) Estimated blood loss, fluid replacement, and use of bloods products;
   (9) Presence of drains;
   (10) Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

b. 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 the following information to permit ongoing care until the dictated operative report is available:
   (1) Name of the primary surgeon(s)/proceduralist(s) and assistant(s)

(2) Preoperative diagnosis
(3) Postoperative diagnosis
(4) Procedure(s) performed
(5) Findings
(6) Estimated blood loss
(7) Fluids administered
(8) Specimen(s)
(9) Complications

7. Pathology Specimens

a. Except as provided below, all tissues removed during a surgical procedure shall be sent to the Hospital Pathology Department to arrive at a tissue diagnosis and the authenticated report shall be made a part of the patient's medical record for that encounter.

b. Unless otherwise requested by the surgeon, the following specimens are exempt from pathologic examination:
(1) Cosmetic/plastic surgery specimens, other than breast or skin lesion specimens
(2) Arthroscopic joint debridement specimens
(3) Portions of bone and ligaments removed to enhance exposure
(4) Femoral heads or hips and knees resected for degenerative joint disease
(5) Resected bunions and other osteophytes
(6) Teeth
(7) Cataracts
(8) Any placentas from routine uncomplicated deliveries lacking clinical indications for further examination
(9) Varicose veins
(10) Fingernails or toenails
(11) Scars (revisions)
(12) Foreskin from infant circumcision

c. At the discretion of the surgeon, the following specimens may be submitted for gross examination only:
(1) Foreign objects
(2) Orthopedic hardware
(3) Calculi (unless chemical analysis is requested)

8. Postoperative Documentation

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

b. Postoperative documentation shall 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.

SECTION G: *EMERGENCY DEPARTMENT SERVICES*

1. An appropriate medical record shall be kept for every patient receiving care in the Emergency Department which will be incorporated in the patient's Hospital medical 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.

2. Each patient's medical record shall be signed/authenticated by the practitioner in attendance that is responsible for its clinical accuracy.

3. The Emergency Department physician shall decide when the services of a specialist are required for an adequate evaluation of 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 promptly respond by telephone to pages from the Emergency Department. The response times shall not exceed thirty (30) minutes. Physicians who for legitimate reasons cannot respond at that time must designate a proxy individual to respond.

c. Physicians who are on-call are expected to stay within a reasonable proximity to the Hospital such that they can generally be physically present within thirty (30) minutes after responding to a page.

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 to requests regardless of a patient's financial class or insurance coverage.

e. Those who are on-call to cover the Emergency Unit 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.

SECTION H: *ORGANIZED HEALTH CARE ARRANGEMENT*

a. 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" 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 as set out in Rule 14; 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 the Protected Health Information created or received by each other in the course of participating in Hospital activities.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Staff on November 26 , 2012

/s/ Randall Rosenthal, MD
Randall Rosenthal, MD
President of the Medical Staff
Newport Hospital

Approved by the Board of Trustees on December 10, 2012

/s/ Suzette Schochet
Suzette Schochet
Secretary, Board of Trustees
Newport Hospital

/s/ August B. Cordeiro, FACHE
August B. Cordeiro
President
Newport Hospital