

Rules and Regulations  
of the  
Medical/Dental Staff  
of  
St. Peter's Hospital

11/18/2015



ST PETER'S HEALTH  
PARTNERS

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**DEFINITIONS**

As used in these Rules and Regulations and unless otherwise provided:

“Board” means the Board of Directors of the Hospital or the Board’s delegated committee.

“Bylaws” means the Medical/Dental Staff Bylaws of the Hospital.

“Chief Executive Officer” or “CEO” means the Chief Executive Officer of the Hospital.

“Chief Medical Officer” or “CMO” means the Chief Medical Officer of the Hospital.

“Chief Nursing Officer” or “CNO” means the Chief Nursing Officer of the Hospital.

“Hospital” means St. Peter’s Hospital.

“Medical Executive Committee” or “MEC” means the Medical Executive Committee of the Staff.

“Responsible Staff member” means the admitting or assigned Staff member, unless the context clearly suggests otherwise.

“Staff” means the organized Medical/Dental Staff of the Hospital, except where indicated with respect to committees serving the Staff of the Hospital and the organized medical staffs of one or more other hospitals.

Other capitalized terms used herein shall have the meanings given to them in the Bylaws or in these Rules and Regulations, as applicable.

**1. COMMITTEES OF THE STAFF**

**1.1. *Duties of Committee Chairs.***

- a. *Preside at Committee Meetings.* Each committee chair shall preside at committee meetings.
- b. *Accountability.* Each committee chair shall be accountable to the MEC and to the President of the Staff for all professional and administrative activities within the committee and, particularly, for the quality of patient care rendered by appointees of the Staff by the effective conduct of patient care evaluation and monitoring functions delegated to the committee. Specific responsibilities include:
  - (1) Integrating the committee into the Hospital’s primary functions;
  - (2) Coordinating and integrating the committee’s functions;
  - (3) Developing and implementing policies and procedures that guide and support the provision of services;
  - (4) Continuously assessing and improving the performance of care and services provided;

- (5) Maintaining quality control programs, as appropriate;
  - (6) Participation in the selection of sources for needed services not provided by the Hospital;
  - (7) Responsibility for all clinical related activities of the committee; and
  - (8) Responsibility for all administratively related activities of the committee, unless otherwise provided by the Hospital.
- c. *Written Reports.* Each committee chair shall submit written reports to the MEC as requested concerning the performance of the committee's responsibilities.
  - d. *Guidance and Recommendations.* Each committee chair shall give guidance on medical policies of the Hospital and make specific recommendations and suggestions.
  - e. *Subcommittees.* Each committee chair shall appoint such sub-committees as may be necessary to conduct the functions of the committee.
  - f. *Enforcement.* Each committee chair shall enforce the Hospital's corporate bylaws and the provisions of the Bylaws and the rules and regulations and policies of the Staff with regard to the committee.
  - g. *Administration.* Each committee chair shall participate in most phases of administration of the committee through cooperation with the nursing service and administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders, and techniques.
  - h. *Other Duties.* Each committee chair shall perform such other duties commensurate with the office as may from time to time be reasonably requested by President of the Staff, the MEC or the Board.

1.2. ***General Provisions Applicable to All Committees (Standing, Ad Hoc or Special).***

- a. Except as otherwise provided in the Bylaws, these rules and regulations or the resolution creating the committee, each joint committee of the Staffs will elect a Chair. Each Chair will serve a two year term, and the committee will rotate Chairs among members from each participating hospital. All Staff members must accept committee appointments unless excused by the President or prohibited by the Bylaws from serving on the committee.
- b. Minutes shall be kept of all committee meetings. Transcribed copies of the minutes shall be transmitted to all members of the committee and through the CMO to the MEC for review and approval.
- c. The committee minutes shall reflect the absence of any committee member. The names of those members failing to attend at least 50 percent of their committee meetings each year shall be reported to the MEC. For the purposes of this section, the attendance requirement shall be measured from January 1 through December 31.
- d. Except as otherwise provided, the internal rules of procedure for each committee of the Staff shall be determined by a majority vote of the voting members of the committee.
- e. Those members of a committee, other than the MEC, who are present and entitled to vote shall constitute a quorum for the transaction of business by the committee, provided that

a quorum shall never consist of fewer than three voting members.

- f. Except as otherwise provided in these Bylaws, whenever any committee is required or permitted to take any action by vote, such action may be taken without a meeting, without prior notice and without a vote, if a consent or consents in writing, setting forth the action so taken shall be signed by at least a majority of the members of the committee entitled to vote. To be effective, such signed written consents must be signed, dated and returned to the chair of the committee within a single 30-day period. Electronically transmitted and signed consents shall be valid for this purpose.
- g. Any one or more members of any committee may participate in a meeting of such committee by means of a conference telephone or similar communications equipment allowing all persons participating in the meeting to hear each other at the same time. Participation by such means shall constitute presence in person at the meeting.

1.3. ***Additional Standing Committees.*** Standing committees of the Staff, in addition to the MEC and the Credentials Committee, are described below. Additional standing committees of the Staff may be created by the MEC, with the approval of the Board, as provided in the Bylaws.

- a. ***Bylaws Committee.*** There shall be a single, common Bylaws Committee of the Staffs of St. Peter's Hospital, Albany Memorial Hospital, Samaritan Hospital, and St. Mary's Hospital.
  - (1) **Composition.** The Bylaws Committee shall consist of three members of the Attending, Courtesy and/or Community-Based Staff of each Hospital, appointed by the President of the Staff of such Hospital. The CMO of each Hospital and Hospital counsel shall be non-voting members of the Committee. The members of the Bylaws Committee shall elect the chair of the Bylaws Committee.
  - (2) **Duties.** The Bylaws Committee shall:
    - (a) Review, on a regular basis, the need for changes in the Bylaws, the rules and regulations and policies of the Staff, and the credentials and Allied Health Professional Staff policies; and
    - (b) Make recommendations to the MEC regarding timely and appropriate changes in the above.
    - (c) In the event the Bylaws Committee makes a recommendation that would apply to all the Hospitals and the MEC of one or more of the Hospitals disagrees with the recommendation, a joint conference consisting of representatives of the Bylaws Committee and each of the MECs shall be convened to discuss the matter and seek to resolve the disagreement; provided that nothing herein shall prevent the adoption at any Hospital of a Bylaw amendment, rule, regulation or policy that has been approved in accordance with such Hospital's Bylaws.
  - (3) **Meetings, Reports and Recommendations.** The Bylaws Committee shall meet as often as necessary to transact its business, but at least annually, shall maintain a permanent record of its findings, proceedings and actions and shall make a report thereof to the MEC.
- b. ***Pharmacy and Therapeutics Committee.*** There shall be a single, common Pharmacy and Therapeutics Committee of the Staffs of St. Peter's Hospital, Albany Memorial Hospital, Samaritan Hospital, and St. Mary's Hospital.

- (1) **Composition.** The Pharmacy and Therapeutics Committee shall consist of two or three members of the Attending, Courtesy and/or Community-Based Staff of each Hospital, appointed by the President of the Staff of such Hospital; the CMO and the CNO of each Hospital; the Director of Pharmacy for St. Peter's Health Partners; and up to three pharmacists appointed by the Director of Pharmacy with the approval of the Presidents of the Staff of each Hospital. The members of the Pharmacy and Therapeutics Committee shall elect the chair of the Pharmacy and Therapeutics Committee.
- (2) **Duties.** The Pharmacy and Therapeutics Committee shall:
  - (a) Examine and survey all medication utilization policies and practices in the Hospital in order to assure optimal clinical outcomes and maximum safety;
  - (b) Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to therapeutic agents within the Hospital;
  - (c) Serve as an advisory group to the Staff and the pharmacy on matters pertaining to the choice and ordering of available therapeutic agents;
  - (d) Make recommendations concerning therapeutic agents to be maintained in stock on the nursing units and in other locations in the Hospital;
  - (e) Develop and review on a periodic basis a formulary or medication list for use in the Hospital;
  - (f) Prevent unnecessary duplication in stocking of therapeutic agents that have similar or identical pharmacologic or therapeutic properties;
  - (g) Evaluate clinical data and other information concerning new medications or preparations for use in the Hospital and make proposals for inclusion in the approved formulary;
  - (h) Review all cases of suspected untoward medication reactions or side-effects;
  - (i) Review antibiotic usage in the Hospital; and
  - (j) Ensure optimal use of electronic means of prescribing and dispensing medications to patients.
  - (k) Designation of and supervision of the Antibiotic Stewardship Committee, as provided within these Rules and Regulations.
- (3) **Meetings, Reports and Recommendations.** The Pharmacy and Therapeutics Committee shall meet as often as necessary to transact its business (but at least six times per year), shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the MEC.
- (4) **Antibiotics Stewardship Committee.** There shall be a single, common, Antibiotic Stewardship Committee of the Medical Staff, and it shall be a subcommittee of the Pharmacy and Therapeutics Committee. The composition and duties of the Antibiotics Stewardship Committee shall be established by the Pharmacy and Therapeutics Committee but there shall be at least one representative from each of Samaritan Hospital, St. Mary's Hospital, Albany Memorial Hospital and St. Peter's Hospital. To the extent practical at all times in which this committee is functioning, at least two Infectious Disease Specialists holding privileges at one or more the Hospitals shall serve as members of the committee. All decisions of the committee shall be subject to the approval of the Pharmacy and Therapeutics Committee before being presented to the Medical Executive Committee and/or Staff and/or Board in conformity with these Rules and Regulations.

- c. ***Transfusion/Blood Products Committee.*** There shall be a single, common Transfusion/Blood Products Committee of the Staffs of St. Peter's Hospital, Albany Memorial Hospital, Samaritan Hospital, and St. Mary's Hospital. The composition and duties of the Transfusion/Blood Products Committee shall be set forth in a common policy or resolution adopted by the Medical Executive Committees of the four Hospitals.
  
- d. ***Patient Safety/Quality Improvement Committee.*** There shall be a Patient Safety/Quality Improvement Committee organized for the purpose of reviewing, monitoring, and assuring the quality of patient care and services offered at the Hospital.
  - (1) **Composition.** The composition of the Patient Safety/Quality Improvement Committee shall be set forth in a policy or resolution adopted by the Medical Executive Committee. The Chair of the Patient Safety/Quality Improvement Committee shall be the Vice President of the Staff, as elected or appointed in conformity with the Bylaws.
  
  - (2) **Duties.** The Patient Safety/Quality Improvement Committee shall:
    - (a) Assure a key leadership role in quality improvement and patient safety activities that are dependent upon the performance of Staff members;
    - (b) Evaluate the effectiveness of quality improvement and patient safety activities for major patient populations and identify areas of excellence and opportunities for improving the clinical outcomes and cost of, satisfaction with, and access to care and service;
    - (c) Review findings of investigations/root cause analyses of significant and sentinel events and ensure the dissemination of lessons learned from these reviews;
    - (d) Monitor and evaluate the effectiveness of quality improvement and patient safety activities for key Staff functions such as assessment and treatment of patients; medication use, infection control, use of blood and blood components, restraint use, resuscitation outcomes, Staff effectiveness and significant departures from expected patterns of clinical practice;
    - (e) Develop and oversee the implementation of a process that defines the circumstances requiring a focused review of the performance of a member of the Staff or Allied Health Professional Staff and the evaluation of such practitioner's performance by peers;
    - (f) Review periodic quality improvement summary and quality improvement and patient safety priority initiatives; and
    - (g) Recommend to the MEC and Hospital administration actions that will improve the effectiveness of quality improvement and patient safety activities.

In order to carry out its duties, the Patient Safety/Quality Improvement Committee may utilize its own specific policies and procedures, which shall be approved by the Patient Safety/Quality Improvement Committee and the MEC.

- (3) The Hospital will designate in a medical staff policy the committees and departments reporting to the Patient Safety/Quality Improvement Committee. The Medical Executive Committee should review this policy annually. The Patient Safety/Quality Improvement Committee also may designate subcommittees to carry out all or part of its responsibilities.
  
- (4) **Meetings, Reports and Recommendations.**



- (a) The Patient Safety/Quality Improvement Committee shall meet as often as necessary to transact its business (but at least ten times per year), shall maintain a permanent record of its findings, proceedings, and actions and shall make a report thereof to the MEC and to the Board (or the Board's designated committee).
  - (b) The Patient Safety/Quality Improvement Committee shall report (with or without recommendation) to the Credentials Committee for its consideration and appropriate action any situation within the jurisdiction of the Patient Safety/Quality Improvement Committee involving questions of clinical competency of, or patient care and treatment or case management by, any member of the Staff or Allied Health Professional Staff, including any focused review of the performance of a practitioner.
  - (c) The Patient Safety/Quality Improvement Committee shall report (with or without recommendation) to the MEC for its consideration and appropriate action any situation within the jurisdiction of the Patient Safety/Quality Improvement Committee involving a question of professional ethics, infraction of the bylaws, rules and regulations or policies of the Staff or the Hospital or unacceptable conduct on the part of any member of the Staff or Allied Health Professional Staff.
- e. **Health Information Committee.** There shall be a single, common Health Information Committee of the Staffs of St. Peter's Hospital, Albany Memorial Hospital, Samaritan Hospital, and St. Mary's Hospital.
- (1) **Composition.** The Health Information Committee shall consist of two or three members of the Attending, Courtesy and/or Community-Based Staff of each Hospital, appointed by the President of the Staff of such Hospital; the Chief Medical Information Officer (CMIO) of St. Peter's Health Partners; the Director of Health Information Technology for St. Peter's Health Partners; the Director of Health Information Management for St. Peter's Health Partners; and up to three representatives of nursing appointed by the chair of the committee with the approval of the Presidents of the Staff of each Hospital. The CMIO shall serve as chair of the Health Information Committee.
  - (2) **Duties.** The duties of the Health Information Committee shall be set forth in a common policy or resolution adopted by the Medical Executive Committees of the four Hospitals.
- f. **Breast Cancer Committee.** The overall purpose of the Breast Cancer Committee will be to ensure adherence of the Hospital's Breast Center to the guidelines and requirements of The National Accreditation Program for Breast Centers (NAPBC).
- (1) **Composition.** The Breast Cancer Committee will consist of the Surgical Director of the Breast Program, the Medical Imaging Director of the Breast Program and the chief of Surgery (in each case, *ex officio* with vote), a medical oncologist and a radiation oncologist (each of whom is an active participant in the Breast Program), quality improvement staff, and additional members of the Attending or Courtesy Staff as may be appointed by the President of the Staff. The administrative director of the Breast Center will also be a voting member of the Committee. Physician members of the Committee must be board certified in their respective fields of practice.

- (2) Duties. The Breast Cancer Committee will be given responsibility and accountability for the services provided by the Breast Center. The Committee will meet at least quarterly to review data and outcomes related to the care of patients with benign and malignant diseases of the breast. The Committee shall also review the practice patterns of physicians and surgeons who treat and manage breast diseases, in the form of Ongoing Professional Practice Evaluations (OPPEs) and will forward this data to the respective department and division chiefs for use in the credentialing and recredentialing processes. The Committee will review published guidelines and protocols for evaluation and treatment of breast diseases and will distribute this information to caregivers. The Committee will be responsible for goal setting, and for planning and implementing breast-related activities. The Committee will periodically assess the performance of the Hospital and the Staff in terms of adherence to and compliance with accreditation requirements of NAPBC and will recommend either individual or systemic changes in practice patterns to achieve and maintain such accreditation. Annual outcome auditing and reporting will be performed according to NAPBC requirements.
- (3) Meetings, Reports and Recommendations. The Breast Cancer Committee shall meet as often as necessary to transact its business (but at least quarterly). The Committee shall maintain a permanent record of its findings, proceedings and actions, and shall make reports to the Hospital's Cancer Committee with respect to all matters concerning the Breast Center and maintenance of NAPBC accreditation and to the MEC with respect to matters concerning the clinical competency and credentials, or patient care and treatment or case management by, any member of the Staff or Allied Health Professional Staff.

## **2. EXAMINATION, ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS**

2.1. *Medical screening examination.* When a patient comes to the Hospital and a request is made by or on the patient's behalf for examination or treatment of a medical condition, the Hospital must provide an appropriate medical screening examination to determine whether emergency medical condition exists, meaning either (a) the patient suffers from a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention would place the patient's health in jeopardy, or (b) in the case of a pregnant woman, she is experiencing contractions. The medical screening examination shall be performed on the Hospital's grounds, either in the emergency department or a specialized service area where an appropriate diagnosis of the patient's condition can be made. Subject to the supervisory responsibilities of members of the Staff, the medical screening examination may be performed by the following members of the Staff and the Allied Health Professional Staff:

- physicians;
- physician assistants;

- nurse practitioners;
- certified nurse midwives;
- specialist assistants (within their area of specialty practice);
- dentists/oral surgeons; and
- registered nurses (limited to performance of initial pelvic examination to evaluate labor status and imminence of delivery, provided there are no complications/contraindications to the pelvic exam).

Hospital personnel designated to perform medical screening examinations may consult with on-call practitioners from other clinical departments (“Specialists”) to determine whether an emergency medical condition exists. The emergency department physician shall also be available at all times for consultation regarding treatment in the emergency department.

2.2. ***Emergency cases.*** If a patient has an emergency medical condition, then he or she shall receive appropriate treatment to stabilize the medical condition. If the Hospital is unable to stabilize the condition, an appropriate transfer to a medical facility with available space and qualified personnel for the treatment of the patient may be effected. A physician member of the Staff or a designated member of the Allied Health Professional Staff (i.e., physician assistants, nurse practitioners, certified nurse midwives, and specialist assistants) shall advise the patient of the risks and benefits to the patient of transfer. The physician shall certify that the patient has been advised of the risks and benefits of transfer. If an Allied Health Professional must advise the patient of the risks and benefits of transfer because the physician is not physically present in the emergency department at the time of transfer, then the physician must countersign the Hospital’s Certificate of Transfer form within 24 hours of the transfer. If transfer is needed, Hospital staff shall contact the receiving facility to confirm that space is available and that qualified personnel are present to treat the patient. Hospital staff shall arrange to effect the transfer through qualified personnel and transportation equipment, as required by the patient’s needs. A copy of the patient’s medical records shall accompany him or her to the receiving facility.

2.3. ***Admissions.*** Patients may be admitted as an inpatient to the Hospital only by members of the Attending or Courtesy Staff, by members of the Adjunct Staff who have been granted admitting privileges, or by physician assistants or nurse practitioners who are members of the Allied Health Professional Staff after consultation

with their respective supervising or collaborating physician. No patient shall be admitted to the Hospital until after a provisional diagnosis has been stated, and all required prior approvals and authorizations for the contemplated treatment or procedures are obtained. In an emergent situation, the foregoing requirements shall be waived. Members of the Staff admitting patients shall be held responsible for giving information necessary to assure the protection of other patients from those who are a source of danger. All patients admitted to the Hospital must be seen by the responsible Staff member on a timely basis appropriate to the patient's condition. It is expected that the Hospitalist Service will admit and manage the care of dental and podiatric patients who have medical co-morbidities or conditions requiring on-going medical care and attention.

#### 2.4. *Consultations.*

- a. Any practitioner who admits, treats or discharges a patient for a condition outside the scope of the member's training, practice, experience or expertise shall arrange for an appropriate consultation. The Hospital shall maintain a list of on-call Specialists who are available for consultation. If the patient's condition warrants it, an on-call Specialist may be required to report to the Hospital to examine and provide treatment. In the event that the on-call Specialist is unable to be reached for an urgent or emergent problem, the Hospital staff person attempting to reach the on-call Specialist should first contact the attending or requesting practitioner for further orders. no event shall a member of the Staff who is not currently on the Emergency Department on-call list maintained by the Hospital be compelled to provide care or consultation to any patient. If necessary, the Hospital staff person attempting to reach the on-call Specialist may attempt to secure the consultation from another member of the Specialist's practice, another practitioner of a similar specialty who is presently on the on-call list,, the appropriate division chief or department chief, or, finally, the CMO in that order to resolve the problem. The same order of contacts should be used for a practitioner who declines to respond appropriately to a request for urgent or emergent consultation.
- b. Before accepting a transfer from another hospital, the accepting Emergency Department or Hospitalist physician will consult with a treating Specialist to ensure that the treating Specialist is able to provide needed services to the patient once transferred (in those circumstances where the Emergency Department or Hospitalist physician determines the patient will require such specialty services).
- c. It is the expectation of the Staff that when requesting a consultation the referring practitioner will provide for adequate communication with the consultant, supplemented with practitioner to consultant verbal communication if appropriate, to allow optimal response to the requested consultation. Consultant practitioners shall respond to requests for consultation in a timely manner by seeing the patient and discussing the findings and recommendations with the referring practitioner (or covering practitioner) within 24 hours of the consultation request or within such other time period as requested, or sooner if clinically appropriate.
- d. Without relieving a practitioner of the obligation to arrange for a consultation in other situations where required under paragraph a of this Section, the following clinical situations require a consultation with the indicated specialty:

- (1) Dental and podiatric patients: Generalist for history and physical examination if the dentist or podiatrist does not have privileges to perform a full history and physical; Specialist for specialty medical care
- (2) Acute psychiatric conditions such as suicide attempt or acute non drug-related psychosis: psychiatry liaison service or psychiatrist
- (3) Patients requiring a capacity evaluation: psychiatry liaison service or psychiatrist
- (4) Patients requiring substance withdrawal treatment or admission to the detox/withdrawal unit: specialist in withdrawal treatment or physician with privileges in addiction medicine
- (5) Obstetrical patients admitted to any critical care unit: appropriate intensivist, cardiologist or other specialist with critical care privileges
- (6) High risk deliveries, as defined by the department of Obstetrics and Gynecology: neonatologist
- (7) Newborns requiring admission to the Neonatal Intensive Care Unit: neonatologist

2.5. ***Responsibility for care.*** Patients who require hospitalization and who have no preference regarding a private physician will be assigned to an Attending Staff member according to a schedule submitted by the chief of the department, and such patients will thereafter be cared for by the assigned Attending Staff member or his or her designee during the patient's hospitalization. Each member of the Staff is responsible for the medical activities of medical students, House Staff, and Allied Health Professional Staff who participate in the care of his or her patients. Each patient's medical record must contain evidence of active supervision by the responsible Staff member. References in these Rules and Regulations to the "responsible Staff member" mean the admitting or assigned Staff member, unless the context clearly suggests otherwise.

2.6. ***Informed Consent.***

- a. ***Disclosure.*** The responsible Staff member should educate the patient and/or the family regarding the nature of the patient's illness(es) and any proposed treatment or diagnostic procedure recommended, together with any potential consequences of the treatment or procedure and any other available options. Consistent with the best interest of the patient, the patient and/or the family should be informed of the expected course of the illness, the anticipated extent of recovery and the treatment and follow-up reassessment advised following discharge. No patient may be treated or operated upon in the Hospital until the appropriate consent and authorization form has been properly signed by the patient or on his or her behalf.
- b. ***Refusal of treatment.*** Whenever a patient refuses consent to treatment (or transfer) recommended by a Staff member or designee of a responsible Staff member, that refusal should be documented and all reasonable efforts shall be made to have the patient sign the Hospital's informed consent to refuse treatment form.

2.7. **Daily Visits.** All inpatients (including those receiving hospice inpatient services), with the exception of those who have been approved for discharge by the responsible Staff member or who have been placed on Alternate Level of Care (ALC) status or who are receiving non-acute rehabilitation services, shall be seen at least daily by the responsible Staff member or his or her designee. Patients on ALC status or receiving non-acute rehabilitation services shall be seen as warranted by their medical condition.

2.8. **Testing and examination.** Sickle cell testing will be performed upon admission for all susceptible patients unless previously performed, in which case the results of the prior testing shall be documented in the medical chart. Palpation of the breasts and pap tests, unless medically contraindicated or refused by the patient, will be included in the medical examination of all women over 21 years of age as part of the physical examination of such patients upon their admission to the Hospital.

2.9. **Palliative Care Consultations.** If a Hospital patient is diagnosed with a terminal illness or condition, the responsible Staff member shall offer to provide the patient with information and counseling regarding palliative care and end-of-life options appropriate to the patient, including prognosis, risks and benefits of the various options, and the patient's rights to comprehensive pain and symptom management.

2.10. **Discharge.** Patients shall be discharged only on order of the responsible Staff member, or of the member of the Staff or the Allied Health Professional Staff designated by the responsible Staff member, or upon the patient's signing a release in a form approved by the Hospital. Prior to discharge, the responsible Staff member shall be responsible for ensuring that appropriate medication reconciliation has occurred, discharge instructions have been provided, the patient has been referred to appropriate and timely post-hospital care, ensuring the continuity of care through appropriate communication, and assuming responsibility for care until appropriate transfer to another practitioner is accomplished.

2.11. **Patient Death.** In the event of the death of a patient in the Hospital, the deceased shall be pronounced dead by the responsible Staff member, a registered nurse, or another designee in accordance with Hospital policy, within a reasonable time. The responsible Staff member or his or her designee must complete the death certificate within the New York State designated timeframe.

### 3. **MEDICAL RECORDS, CHARTS AND COMMUNICATION**

3.1. ***Content of Record.***

- a. Medical records shall contain information to justify admission and continued hospitalization, support the diagnosis and describe the patient's progress and response to medications and services. The following information, when applicable to a patient's treatment, shall be included: identification data; chief complaint; history of present illness; past history; family history; physical examination; provisional diagnosis; medications; allergies; clinical laboratory reports; x-ray reports; consultations; treatment (medical and surgical); tissue report; progress notes; final diagnosis; discharge summary; and autopsy findings.
- b. All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Hospital's policies and procedures. By authenticating an entry a person verifies that the entry is complete, accurate, and final.

3.2. ***Operative and Invasive Procedures.***

- a. If a patient is to undergo an operative/invasive procedure, the preoperative diagnosis, indications for the contemplated procedure, including any pertinent laboratory studies and other indicated diagnostic tests, and if moderate or deep sedation or anesthesia is contemplated, evidence of the performance of a pre-sedation or pre-anesthesia assessment, must be included within the patient's medical record.
- b. Operative reports must be dictated immediately following surgery. If an operative report is not dictated within 24 hours, the responsible attending surgeon's name will be included in a count of undictated operative reports which will be posted daily.
- c. Immediately following the completion of a procedure or operation, the surgeon or a designee must complete a form in the patient's medical record that contains the following elements: the preoperative and postoperative diagnosis; the procedure performed; the name of the primary surgeon and any assistants; the type of anesthesia used, the amount of fluids the patient received during the procedure, estimated blood loss, and urine output during the procedure (all if applicable); findings at surgery; specimens removed (if any); drains placed (where and what types); complications; and disposition.

3.3. ***Delinquent Medical Records.*** It is the duty of each member of the Staff and the Allied Health Professional Staff to complete those portions of the medical records for which he or she is responsible and to sign, date and time each such entry. Discharge summaries for patients awaiting transfer should be prepared in a timely fashion so as to facilitate the transfer. Medical records must be completed within 30 days of discharge. Each week the Medical Records Department shall compile a list of those members who have delinquent records and shall give written notice to those members of the Staff and the Allied Health Professional Staff who have delinquent records of such fact and the aggregate number of delinquent days that the member has accumulated. A copy of such notice shall also be provided to the member's department chief and to the CMO. Each day on which a member is delinquent in completing or signing one or more medical records, when the medical record has been made available

by the Medical Records Department, shall count as one delinquent day. A member shall bring any error in the calculation of the number of his or her delinquent days to the attention to the Director of the Medical Records Department so that it may be corrected. Records that are not completed within 30 days of discharge will be considered delinquent. Except in emergency situations, members who accumulate 30 consecutive delinquent days on one or more individual patient medical records are subject to automatic suspension of all clinical privileges upon receipt of written notice thereof from the CMO or his/her designee. The automatic suspension shall be lifted upon the member's completion of the delinquent medical records.

3.4. ***Hospital Property.*** All records are and shall remain the property of the Hospital. In case of readmission of a patient, all previous records shall be available for the use of the Staff member responsible for the patient's care.

3.5. ***Removal of Hospital Records.*** Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. Copies of medical records may be provided in accordance with procedures set forth in the Medical Records policy.

3.6. ***Daily Progress Notes and Communication.***

- a. There shall be at least daily progress notes written by the Staff member responsible for the patient's care or his or her designate, for all inpatients except those who have been approved for discharge by the responsible Staff member or who have been placed on Alternate Level of Care or who are receiving non-acute rehabilitation services. Progress notes shall give a chronological picture of the patient's progress and be sufficient in content and detail to delineate the course and results of treatment. The condition of the patient shall determine the frequency of progress notes otherwise. Nevertheless, in instances when the clinical status of the patient or the treatment plan has changed significantly, a progress note should be written.
- b. Pertinent progress notes also shall be made by other practitioners who have been granted clinical privileges to do so. All clinical entries made by House Staff or Allied Health Professional Staff members prior to major diagnostic or therapeutic intervention or when a significant change in the clinical status of the patient has occurred shall be countersigned or expressly acknowledged in a subsequent note written by the Staff member responsible for the care of the patient. All clinical entries made by medical students shall be countersigned or expressly acknowledged in a subsequent note written by the Staff member responsible for the supervision of the student.
- c. If verbal communication between or among practitioners about a patient's status is in the best interest of efficient patient management and patient safety, it is the expectation of the Staff that this communication will occur, especially at times of transition of patient care responsibility from one practitioner to another.



3.7. ***Dictated Discharge Summary.*** All inpatients whose length of stay exceeds 48 hours shall have a dictated discharge summary signed by the responsible Staff member. A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a 48-hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. An interim discharge summary shall be signed by the responsible Staff member within 72 hours after an inpatient is placed on Alternative Level of Care (ALC) status and an addendum note(s) should be added when appropriate.

3.8. ***Countersignature.***

- a. All countersignatures must be legible, dated, timed and in written or electronic form, consistent with the Hospital's policies and procedures. By countersigning an entry in a medical record a person attests to its adequacy and appropriateness.
- b. Wherever the Bylaws, rules and regulations or the policies of the Staff or Hospital require that an order, H&P, progress note or other entry in a medical record be countersigned or be acknowledged in a subsequent note by the responsible Staff member, the responsible Staff member shall do so by the next day; provided, however, that all orders and all medical student entries shall be countersigned by the responsible Staff member within 24 hours.
- c. Medical orders of physician assistants need not be countersigned by the physician assistant's supervising physician unless required by the supervising physician. The supervising physician shall be responsible for notifying the physician assistant, the department chief, and the Medical Records Department when countersignature is required. In no event shall countersignature be required prior to execution of the order.

3.9. ***Legibility.*** All entries that are handwritten in the medical record must be legible.

3.10. ***Use of Electronic Medical Records Systems.*** All members of the Staff and Allied Health Professional Staff who provide patient care are expected to use currently-available electronic medical record systems and programs at the Hospital. This requirement extends to participation in education and training in the use of such systems and programs. The Hospital and St. Peter's Health Partners are expected to provide sufficient technology, computers and human/manpower resources (including, as needed, additional administrative support) training and facilitation of implementation of systems.

#### **4. SURGERY**

4.1. A surgical operation shall be performed only upon consent, in writing, of the patient or the patient's legal representative, except in emergency. In emergency cases, in which the patient's consent cannot be obtained, the nature of the emergency shall be documented in the medical record.

4.2. All operations performed shall be fully described by the attending surgeon in the operative note.

Specimens removed at the operation shall be sent to the Hospital pathologist, who shall make such examination as he may consider necessary to arrive at a pathological diagnosis. The Hospital shall establish and maintain an exempt specimen list in consultation with the Staff and annually approved by the MEC, which allows the surgeon the option of appropriately disposing of specimens on the exempt list at his or her discretion. Any specimen that is submitted will continue to be evaluated in the customary fashion.

## **5. ORDERS**

5.1. ***In General.*** All orders must be recorded in writing in the patient's chart and dated, timed and authenticated by the ordering practitioner. Only those abbreviations approved for use in the Hospital may be used on order sheets.

5.2. ***Verbal Orders.*** The use of verbal orders (which include telephone orders) shall be infrequent and limited to those situations in which it is impossible or impractical for the ordering practitioner to write the order on paper or electronically. Verbal orders must be authenticated by the ordering practitioner or by another Staff member covering for the ordering practitioner within 24 hours, with the date and time of authentication recorded. Verbal orders may be received and transcribed upon the order sheet by the following persons, provided that the order is within the recipient's scope of practice: R.N., L.P.N, CT technologist, Ultrasound technologist, MRI technologist, Sonography Technologist, Mammography Technologist, Radiological Technologist, Nuclear Medicine Technologist, Physical Therapist, Occupational Therapist, Speech-Language Pathologist, registered pharmacist, respiratory therapist, and dietitian. The recipient must write down or record the entire verbal order, repeat the entire verbal order back to the ordering practitioner, receive confirmation of the accuracy of the read-back from the ordering practitioner, and then immediately enter the verbal order into the patient's medical record in writing and include the following information: date, time, verbal order, name of ordering practitioner, read-back verification, and signature of the recipient of the order. Verbal orders for controlled substances are not accepted or carried out except in an emergency situation, which for this purpose means that the immediate administration of the controlled substance is necessary for proper treatment, no alternative treatment is available and it is not possible for the ordering practitioner to provide a written prescription at the time. Verbal orders for antineoplastic agents and investigational drugs are not accepted.

**6. PHARMACEUTICALS**

6.1. Pharmaceuticals shall be prescribed, dispensed and administered in accordance with the Pharmacy Department's policies and procedures. The metric system of weights and liquid measure is used when ordering pharmaceuticals. Medication dosage orders (excluding fixed combination pharmaceuticals) will include the metric dosage designation.

6.2. Under THE FORMULARY SYSTEM the prescribing practitioner agrees that, when prescribing a drug by its proprietary name, the practitioner is, unless otherwise stated, authorizing the Hospital pharmacist to dispense, and the nurse to administer, the therapeutically equivalent drug provided the Pharmacy and Therapeutics and Medical Executive Committees have approved the substitution and the new, equivalent drug is on the Hospital formulary. The Hospital Formulary is adopted for all patients in the Hospital. A patient may receive a non-formulary drug provided that the responsible Staff member first received approval from the chair of the Pharmacy and Therapeutics Committee or the chair's designee and personally signs the medication order.

6.3. Medications brought to the Hospital by a patient should be given to a member of the family to take home. Medications brought by the patient may be administered based on the specific written and signed order of the responsible Staff member. The Staff member shall write the order and the pharmacist shall be responsible for identification and labeling of the medication.

6.4. Stop orders on certain drugs shall be established by the Pharmacy and Therapeutics Committee and shall be brought to the attention of the Staff.

**7. REFERRAL TO OUTSIDE LABORATORIES**

Laboratories are provided by the Hospital to insure as complete a service as possible, but procedures which cannot be done in the Hospital Laboratory shall be referred to an approved outside laboratory.

**8. AUTOPSIES**

Every member of the Staff shall be actively interested in securing autopsies whenever possible. No autopsy shall be performed without proper legal consent and authorization. All autopsies shall be performed by the Hospital pathologist, a physician to whom he or she may delegate the duty, or a Coroner's physician when the law so

requires. Autopsies should be performed in the following cases:

- a. unexpected or obscure cause of death
- b. death occurring while patient is being treated under an experimental regimen
- c. death occurring within 48 hours after surgery or an invasive diagnostic procedure
- d. death incident to pregnancy/delivery
- e. all infant/children deaths
- f. intraoperative or intraprocedural death.

## **9. EMERGENCY CARE INVOLVING INPATIENTS**

Nurses who have had previous instructions may institute appropriate therapy in emergencies, as detailed in the nursing manual. The responsible Staff member still remains responsible for the patient's management.

## **10. PRACTITIONER HEALTH**

- 10.1. The MEC shall approve a policy regarding practitioner health which outlines the following elements:
  - a. The Staff and other practitioners, as well as appropriate employees of the Hospital shall be educated on a regular basis about health issues specific to practitioners;
  - b. The ability of a practitioner with an impairing health problem to self-refer to an appropriate person or committee within or outside of the Hospital and the ability of others to refer a practitioner with a suspected health problem;
  - c. The ability of a practitioner to be referred to the most appropriate professional resources for confidential assistance;
  - d. The maintenance of confidentiality regarding practitioner health issues, unless federal or state law or ethical or safety obligations override such confidentiality;
  - e. The monitoring of the recovery of the practitioner in order to assure the safety of patients; and
  - f. The ability to take disciplinary action under the Bylaws or the Allied Health Professional Policy, as applicable, if the practitioner is rendering unsafe care or refuses to undergo recommended treatment.
- 10.2. The policy will ensure that matters of individual practitioner health are dealt with in a manner that is separate from the Staff and Allied Health Professional Staff disciplinary functions.

## **11. HOUSE STAFF**

- 11.1. No person may serve as a member of the House Staff until he has been certified by the graduate medical education program in which he participated as (1) exempt from licensure under Section 6526 of the Education Law or the holder of a limited permit under Section 6525 of the Education Law; (2) a participant in good standing of such graduate medical education program; and (3) having received an adequate and appropriate medical education that satisfies the requirements of Section 405.4(f)(1) of the Commissioner's regulations.
- 11.2. No member of the House Staff may work in excess of the maximum hours permitted under Section 405.4(b) of the Commissioner's regulations. All members of the House Staff shall be

required to fully disclose to the Hospital any hours worked by them outside the Hospital and the hours devoted to such other employment.

- 11.3. Members of the House Staff may write patient care orders, make other medical record entries and engage in such other patient care activities as are specified in the appropriate departmental or sponsoring residency program policies. Such policies shall be kept in the office of the CMO, updated on an annual basis and made available to the Staff for their information. Counter-signature of House Staff medical record entries by the supervising member of the Staff is required for histories and physicals, discharge summaries, significant interventions or when a major change in the condition of the patient has occurred.
- 11.4. The residency program directors from the sponsoring institutions(s), or their designees, and those members of the Staff who are responsible for House Staff supervision will communicate on a regular basis regarding the progressive involvement and independence of each member of the House Staff in specific patient care activities. Such communication may include written evaluations prepared by the supervising Staff member submitted to the residency program, meetings, telephone contacts, correspondence or indirect communication through Staff representatives on the graduate education committee(s) of the sponsoring institutions. Any restriction of the progressive independence of a House Staff member will be noted and reported to the House Staff member's department chief.
- 11.5. Members of the Staff who are responsible for overseeing the supervision of House Staff will make a regular report (no less frequently than semiannually) to the Medical Executive Committee regarding the safety and quality of patient care provided by, and the related educational and supervisory needs of, the House Staff under their oversight. The President of the Medical/Dental Staff or the CMO will make a periodic report on behalf of the MEC to the Board (no less frequently than semiannually) regarding the status of all residency programs, including the performance and educational needs of the House Staff.

## **12. STAFF DUES**

- 12.1. All Attending Staff, Courtesy Staff, Telemedicine Staff, Community-Based Staff, and Allied Health Professional Staff are required to pay annual Staff dues, with the following exceptions:
  - a. Attending Staff, Courtesy Staff, Community-Based Staff and Allied Health Professional Staff who are at least 70 years of age and were members of the Attending, Courtesy, Community-Based Staff or Allied Health Professional Staff for at least ten years prior to reaching age 70;
  - b. General practice dentists who have been appointed to the Staff for the purpose of teaching and supervising dental residents; and
  - c. Staff and Allied Health Professional Staff who have been granted an authorized leave of absence (in which case, the annual dues payable shall be prorated for the portion of the year the member was not on leave of absence).
- 12.2. The amount of annual dues shall be established by the Medical Executive Committee.
- 12.3. Dues are due and payable on or before April 1 of each year. Any person who fails to pay the required dues by April 1 shall be notified by mail of the delinquency, as a courtesy. Any person who fails to pay the required dues by May 1 of such year will be deemed to have voluntarily resigned from the Staff or Allied Health Professional Staff, without regard to whether such notice of delinquency was sent or received.

**13. ETHICS AND ETHICAL RELATIONSHIPS**

- 13.1. The Code of Ethics and Rules of Professional Conduct and Guidelines as adopted by the American Medical Association and other recognized national specialty colleges and organizations, including, in the case of dentists, the American Dental Association, or in the case of podiatrists, the American Podiatric Association, shall govern the professional conduct of the members of the Staff. Among other things, members of the Staff shall pledge themselves neither to receive from, nor to pay to, another physician, directly or indirectly, any part of a fee received for professional services. All fees shall be collected and retained by the individual physician in accordance with the value of services rendered.
- 13.2. The Staff recognizes that all practitioners granted clinical privileges in accordance with these Bylaws or the Allied Health Professional Staff Policy must adhere to the Ethical and Religious Directives for Catholic Health Care Services, as promulgated by the United Conference of Catholic Bishops (the "Directives"), within the Hospital. This shall not be construed to require any practitioner to comply with the Directives with respect to health care services rendered outside the facilities controlled by St. Peter's Health Partners, nor shall it be construed to prevent practitioners from discussing or recommending medically appropriate treatment options, including those whose implementation within a St. Peter's Health Partners controlled facility may be prohibited by the Directives or from making appropriate referrals to outside facilities if such interventions are deemed necessary. The Directives recognized herein are those in publication as the latest version in September 2014. Future versions of the Directives may be incorporated by the procedures set forth for the amendment of these Rules and Regulations.