

Beth Israel Lahey Health 
Anna Jaques Hospital

***MEDICAL STAFF
RULES and REGULATIONS***

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MEDICAL STAFF RULES AND REGULATIONS INDEX

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MEDICAL STAFF RULES AND REGULATIONS

I. Responsibilities of Medical Staff Members

Each member of the medical staff shall:

1. Abide by all applicable standards and requirements as stated in the Rules and Regulations, Policies and Bylaws of the medical staff and Hospital.
2. Sign a statement pledging to provide for continuous, optimal patient care without regard to race, color, religion, age, national origin, sex, sexual orientation, physical or mental handicap, veteran or financial status.
3. Pay Medical Staff dues (including Continuing Medical Education fees) and the biennial reappointment fee as determined by the Medical Staff Executive Committee, in accordance with the Bylaws of the Medical Staff.
4. Maintain a valid Massachusetts medical license, a Federal and State Drug Enforcement Agency Registration number (when applicable), malpractice insurance appropriate to specialty, certifications appropriate to specialty (as determined by Department and/or Medical Staff Bylaws), and valid NPI number. The member shall notify the Medical Staff Office of any change in status in the above or any changes of status that may affect patient care with the Hospital.
5. Shall participate in Continuing Medical Education in accordance with State law, professional society recommendations, The Joint Commission (TJC) standards and policies and requirements of the specific Department and Medical Staff.
6. Shall participate in the Medical Staff Orientation Program.
7. Be responsible to the Department Chief and Governing Body and fulfill department requirements of the on-call requirements and serve as proctor if appointed by the Department Chief in accordance with the Bylaws of the Medical Staff.
8. Serve on Medical Staff Committees as set forth in the Medical Staff Bylaws.
9. Follow the Code of conduct Policy
10. Follow the Physician Health Policy
11. Participate in Hospital wide Performance Improvement Activities.
12. Participate in the Hospital Disaster Plan

13. A physician may not treat including prescribing Controlled Substances; themselves, or members of their immediate families who are inpatients, observation status, or in the emergency department. In extreme emergency situations where there is no other qualified physician available to treat the patient, physicians may treat themselves or family members until another physician becomes available, (Reference AMA Ethics Guidelines E-8-19, June 1993).
14. ICU/Special Care Unit Privileges. All Physicians and qualified licensed practitioners who care for patients in the ICU and Special Care Units must have the training, experience and qualifications to care for those patients in accordance with the Policies and Procedures of the Special Unit. Any Physician or qualified licensed practitioner who does not meet the requirements, but desires these privileges would require special permission from the Medical Staff Executive Committee and the Governing Body, and a change in their scope of practice.
15. Members of the Clinical Associate Staff and Support Staff shall abide by the Rules and Regulations of the Medical Staff within the Guidelines and Job Descriptions of their respective specialty. The following include, but are not limited to, Members of the Associate Clinical Staff and Support Staff.

Associate Clinical staff that provide patient care without supervision.

- Dentists
- Optometrists
- Psychologists

Associate Clinical Staff and Support Staff who provide patient care with supervision of a Member of the Active Medical Staff (Sponsors):

- Certified Nurse Anesthetists
- Certified Nurse Practitioners
- Certified Nurse Midwives
- Psychiatric Nurse Mental Health Specialists
- Physician Assistants
- First Assist R.N.
- Healthcare Technicians (e.g. orthopedic)
- Audiologists
- Mental Health Consultants to the Emergency Department

II. **Physician Assignment**

1. **The Admitting Physician:** The Member of the Medical Staff who is responsible for the admission of the patient to the Hospital.
2. **Attending Physician:** The Member of the Medical Staff who is most responsible for patient care during the current Hospital stay. In Obstetrical admissions and

transfers, the Physician who delivered the patient is considered to be the Attending Physician. In surgical admissions or transfers, the Physician who operated on the patient is designated the Attending Physician. In multiple trauma cases, the General Surgeon will be considered the Attending Physician.

3. **Consultant:** The Member of the Medical Staff who sees a patient in consultation for specialty services.

III. **Coverage**

1. All Active and courtesy Staff physicians provide On – Call coverage as required by the department up to a maximum intended frequency of 1 in 4 days (not including increases in call frequency due to planned vacation periods, illness or other leave) as a responsibility of being part of the medical staff. This is to include a proportionate number of week-end and holidays per physician providing coverage. This On – Call coverage intended frequency only applies to coverage for unassigned patients. On – call coverage is defined as the obligation to maintain availability for timely (as defined elsewhere in the Medical Staff Rules and Regulation and/or Administrative Policies) evaluation and treatment of hospitalized patients and/or patients presenting to the Emergency Department as requested by the Attending Physician.
2. All patients admitted to the hospital shall have a designated Attending Physician. In the absence of the Attending Physician, a Covering Physician shall be designated by the Attending Physician and shall assume all responsibility for the care of the patient during the time of coverage. Attending Physicians assume the post-hospital coverage of recently discharged patients and for patients that have had recent surgical procedures. The Attending Physician will need to provide consultation or admissions, as needed for these patients either by themselves or by their designated Covering Physicians. The coverage for an Attending Physician’s inpatients and recent discharges and outpatient practice patients needs to be provided at any time, every day notwithstanding the frequency of call needed to provide that coverage.
3. In the event that the Nursing Staff is unable to contact the Attending Physician (per Medical Staff policy), the Chief, Acting Chief or Chief Medical Officer shall assume responsibility for finding appropriate medical coverage for the patient.
4. Any member of the Medical Staff may be required to provide emergency care for the patient.

The Anna Jaques Hospital defines “Essential Medical Services” as Anesthesiology, Cardiology, Emergency Medicine, General Surgery, Medicine, Obstetrics, Orthopedics, Neonatology and Radiology. Anna Jaques Hospital requires “Essential Medical Services” to have On – Call coverage 24hr per day,

365 days per year. For these “Essential Medical Services”, the hospital shall make arrangements for coverage as necessary if the per physician frequency of On-Call exceeds the goal delineated in the Medical Staff Rules and Regulations for a period in excess of sixty days (see number 1.).

IV. **Hospital Care of the Patient**

1. The Attending Physician or designee shall see the patient daily or more often as the patient’s condition warrants, and write Daily Progress Notes even if the patient is being seen regularly by a consultant.
 - 1-A Progress notes shall be recorded at least daily and shall include information on the patients’ current status, treatment and care plan. Each clinical event should be recorded as soon as possible after its occurrence.
 - 1-B Each entry into the patient’s chart shall be authenticated by appropriate signature, date and time of entry.
 - 1-C All documentation in the medical record must be legible.
 - 1-D Symbols and abbreviations listed on the Hospital’s Do Not Use Abbreviation List may not be used (see attached list of commonly confused Do Not Use Abbreviations located on page 22 of this document).
2. Pursuant to EMTALA requirements and hospital policy, patients who come to the hospital seeking an examination or treatment of a medical condition, will be given an “appropriate medical screening examination” by a qualified medical provider (QMP), which includes physicians and other qualified licensed practitioners including Obstetrical RNs following Obstetrics Nursing Protocols.
3. It is the Practitioner’s responsibility to be aware of and abide by the Administrative Policies and Procedures concerning various Aspects of Patient Care including but not limited to information disclosure to patients of adverse or unanticipated outcomes, universal precautions, advance directives, the smoking policy, restraints, pain management, informed consent, etc.
4. The attending physician shall anticipate the date of discharge and begin the interdisciplinary process for discharge planning with the assistance of Case Management.
5. Documentation for continued hospitalization shall conform with the criteria established by Case Management.
6. Diagnostic and therapeutic documentation of test results shall be completed promptly and filed in the medical record, either electronically or hard copy, within

twenty-four (24) hours of completion of the test including: pathology, laboratory, radiology, pulmonary, cardiology and nuclear medicine reports.

7. Patient may not be transferred to another physician's service without direct physician to physician communication and the consent of the accepting physician. If the transfer is acceptable, the transferring physician must document that in the Progress notes and write an order for the transfer.
8. In the event of a cardiac arrest in the hospital, the switchboard operator shall be asked to Page Code 99 naming the location. The Code 99 Team shall respond.
9. In the event of a Critical Condition, the switchboard operator will be asked to page Rapid Response naming the location; the Rapid Response Team shall respond.

V. **Emergency Care**

1. All Physicians and qualified licensed practitioners shall respond to an emergency request from all patient care areas in a timely fashion. If the Physician or qualified licensed practitioners cannot be contacted, the Chief of the Department will be contacted to either care for the patient or arrange for alternative care.

All Physicians and qualified licensed practitioners shall be available to assist in the care of patients during an unexpected disaster of any kind. (Disaster Plan)

VI. **Physician and Qualified Licensed individual Orders**

1. All medication and therapeutic orders shall be in accordance with the Policies and Procedures of the Hospital, Policies and Procedures of the Pharmacy and Therapeutics Committee.
2. Standing orders are those established by the Departments or Services to apply to all patients admitted to the respective Departments or Services.
 - Standing orders will be approved by the Departments and presented to the Medical Staff Executive Committee (MSEC) for review and approval.
 - Standing orders will be reviewed annually.
 - Standing orders must be entered upon the patient's record and signed by the staff member involved.
 - A file of all standing orders will be kept on file with the Director of Quality and Patient Safety.

3. All orders shall be legible (nursing and pharmacy must be able to interpret without any questions).
4. A verbal order from a qualified licensed individual is an order that is given in person to another healthcare provider, both the giver and the receiver of the order are physically present at the time; the verbal order will be limited to emergency situations only.
5. A verbal order must be authenticated by the time of completion of the medical record by a signature, date and time of the ordering qualified licensed individual.
6. A telephone order is an order given when the qualified licensed individual is not physically present. It must be authenticated by the time of completion of the medical record by a signature, date and time of the ordering qualified licensed individual.
7. All elective surgical admissions presenting to the Admitting Office must have Preoperative Orders at the time of admission.
8. All pre-printed orders must be signed by the Responsible Physician with date and time.
9. All new pre-printed orders must be approved by the Hospital Forms committee and the Medical Executive Committee.

VII. **Admissions**

1. The Admitting or Attending Physician must have privileges to admit, perform the History and Physical exam, and treat the patient as delineated in his/her Privilege Cards.
2. There should be a Member of the Medical Staff in attendance of a patient at all times, only members of the Active, Courtesy, Senior Active and those qualified Members of the Associate Clinical Staff with Admitting privileges may admit patients to the Hospital.
3. All patients shall be admitted and discharged according to Hospital Policy. The Hospital shall admit patients suffering from all types of illness insofar as satisfactory facilities exist.
4. The admitting/attending physician or designee shall assume care of patients admitted to the medical/surgical units of the hospital at the time of admission after discussion with the emergency physician, with the exception of direct-admissions. The admitting physician must give written or telephone orders generally within 4 hours or at the time specified by the emergency physician. After this time the

temporary holding orders written by the emergency physician will expire.

5. All patients admitted to the Intensive Care Unit shall be seen by the admitting/attending physician within two (2) hours of admission. All patients admitted to the Intensive Care Unit will be admitted by a physician with critical care specialist privileges, or co-managed with a consultation by a physician with critical care specialist privileges.
6. No patient shall be admitted or transferred to the service of a physician without the knowledge and consent of the patient and the physician.
7. All patients will be admitted to the Hospital with a documented Provisional Diagnosis.
8. Medicare and Medicaid patients must meet the Federal and State Admission Severity of Illness Criteria for admission to the Hospital.
9. Once all licensed beds have been filled, only emergency cases shall be accepted in the Emergency Department without prior notification by the admitting physician. Justification for this emergency must be documented in the medical record.
10. A complete history and physical shall be present in the chart within twenty-four (24) hours of admission and shall include the following pursuant to Hospital Policy:

Patient identification data, reason for admission (if admitted), assessment, medical history including the chief complaint, details of the present illness, past history (medical and surgical), social history and family histories, medications, review of systems, allergies, physical examination, impressions drawn from the physical examination, relevant laboratory data, diagnosis and treatment plan for the patient.
11. When a patient is readmitted within seven days for the same or related problem, an interval history and physical reflecting any subsequent changes may be used in the medical record provided the original information is available.
12. Qualified oral maxillofacial surgeons and podiatric surgeons with clinical privileges, who admit patients, may perform the history and physical examination on those patients and may assess the medical risks of the proposed surgical procedure.
13. Dentists may admit patients to the Hospital when an appropriate Physician Member of the Medical Staff assumes responsibility for the overall aspects of the patients care throughout the hospitalization including the Medical History and Physical (TJC-CMS). Dentists are responsible for that portion of their patients' history and physical exam related to dentistry.

14. Other qualified licensed individuals* permitted to perform the History & Physical exam may do so in accordance with hospital policy, pursuant to state law, if granted such clinical privileges and if the findings, conclusions and assessments of risk are confirmed or endorsed by a Qualified Physician on the Medical Staff prior to major diagnostic or therapy intervention, or within twenty-four (24) hours, whichever occurs first.
*The exception being Neonatal Nurse Practitioners (NNPs) who may examine evaluate and discharge healthy babies independently and without delay. NNPs may also examine, evaluate and transfer babies to a Level III service after a phone consultation with a covering neonatologist.
15. Admissions to and transfer from ICU, Telemetry and other special care areas shall follow the ICU Admission Policy, and other special care area policies.
16. The Admitting Practitioner shall not withhold information necessary to ensure the protection of a patient from self harm and to assure the protection of others whenever a patient might be a source of danger. This practice shall be consistent with the Confidentiality Policy of Anna Jaques Hospital.

VIII. Consults

1. The Medical Consultation is recommended when the specific skill of another practitioner could improve care of the patient. If the patient meets one or more of the following criteria, then the Attending Physician or other qualified licensed practitioner shall ensure the clinically appropriate consultation is obtained:
 - The Attending or Covering Physician feels that a patient's clinical condition warrants evaluation or treatment by another provider.
 - Patient requires clinical services for evaluation or treatment for which the Attending Physician does not have the privileges.
 - A patient or his/her family requests a clinical consultation or second opinion from another practitioner.
 - A patient for whom Hospital policy or Practitioner Privileges require a mandatory consultation from another clinician.
 - A patient for whom a third party payer requires a second opinion in order for the services provided to be eligible for insurance reimbursement.
 - A patient for whom a Medical Staff Department Chief or other elected or appointed Medical Staff Leader as identified by the Hospital, determines a consultation is warranted.
2. All consultation requests shall indicate the reason (s) for the consultation and the urgency for the completion.

3. Consultations must be completed within the following time frame as requested by the Attending Physician or other qualified licensed practitioners. Direct physician to physician communication regarding all consults is strongly suggested.
 - **Urgent/Emergent**: The Attending or Covering Physician must contact the consultant directly for this type of consult with response time being determined by the physicians. The consulting physician will contact the referring physician at the end of the consult to review the findings, unless both physicians agree it is not necessary.
 - **Non-Urgent** within twenty-four (24) hours.
4. The Consultation must be dictated or written at the time of the initial consult.
5. Unexplained failure to complete a requested consult will be reviewed by the Performance Improvement Committee and Recommendations of Further Action given to the Medical Staff Executive Committee.

IX. **Transfers**

1. **Transfer of an in-patient from another hospital**: In-patients transferred into Anna Jaques Hospital for admission from another acute care hospital, need approval by Case Management, Chief Medical Officer, or Administrative Nursing Supervisor.
2. **Transfer of an in-patient to another hospital**: Patients being transferred to another hospital shall be seen by the Attending Physician or Designee prior to the transfer. The Physician must document in the Medical Record the reason for the transfer, discussion with the patient regarding reason for transfer noting if the service is or is not available at Anna Jaques Hospital and the risks and benefits of the transfer. Prior to the transfer, the Physician or Designee must ensure that the Receiving Facility Physician will accept the patient in transfer and treatment. A patient may not be transferred until necessary stabilizing treatment has been rendered and the Authorization for Transfer Form has been completed.
3. **Transfer of a patient within Anna Jaques Hospital**: All transfers due to a patient's level of care will require a Physician's Order. The Physician will be notified if a patient is transferred for Administrative Reasons. A transfer with Change of Level of Care will require a new set of orders, medication reconciliation (active medication list).

The Medical Staff and Anna Jaques Hospital in Accordance with the Emergency Medical Treatment and Active Labor Act (**EMTALA**) will comply with the policies regarding patient transfers and shall comply with all applicable laws regarding patient transfers.

X. Discharges

1. Patients shall be discharged in accordance with the Medical Staff Policies, and involve Hospital Collaborative, interdisciplinary process.
2. Patients will be discharged only with a written or telephone order from the Attending Physician or Designee.
3. Physician or Designee shall consult Case Management to assist in any anticipated discharge needs, and assist in the interdisciplinary process to ensure the patient or the patient's family/representative will have adequate medical care and services available upon discharge.
4. The Physician or Designee is responsible for completing the Discharge Summary and the necessary forms when applicable. Per CMS regulations and payor requirements, **the Discharge Summary must be dictated, typed and available for discharge and must accompany the patient at the time of transfer to another facility, ie rehab hospital, SNF, acute hospital, visiting nursing care services.**
5. Discharge Summaries otherwise must be dictated within forty eight (48) hours after patient leaves the Hospital.
 - 5-A Discharge Summaries shall recapitulate concisely the reason for the hospitalization, significant findings, procedures performed and treatment rendered, the condition of the patient at discharge, medications, diet, follow-up care and any specific instructions given to the patient or family related to activity.
 - 5-B A Discharge Summary must be dictated, typed and completed for all patient stays.
6. The records of discharged patients shall be completed within fourteen (14) days following discharge, including signature, timing and dating.

XI. Deaths

1. In the event of a hospital death, the Deceased shall be pronounced **dead by a physician within a reasonable time**; if he/she is unable to do so, it shall be his/her responsibility to procure another physician for that task.
2. Upon pronouncement of death, the Physician will document time and date of the pronouncement in the Medical Record.

3. The Physician or coverage is responsible for notification of the appropriate individuals of the patient's death.
4. The Physician or coverage is responsible for completion of the Death Certificate in Accordance with Massachusetts General Law Chapter 46, Section 9.
5. Members of the Medical Staff are encouraged to secure autopsies on the patients whenever appropriate and as Mandated by State Regulations.

The Physician is responsible for reporting deaths to the Medical Examiner in Accordance with MGL Chapter 38, Section 3.

6. Physicians will participate with Anna Jaques Hospital in making referrals to the New England Organ Bank in compliance with State and Federal Regulations.

XII. Informed Consent

In accordance with the Regulations of the Massachusetts Board of Registration in Medicine 243 CMR 3.10, at TJC Standards and Good Medical Practice, the following applies to obtaining Informed Consent:

1. The Physician or qualified licensed practitioner shall obtain Informed Consent prior to any therapeutic or diagnostic procedures including use of blood and blood products that are invasive or can carry substantial risk to the patient.
2. Informed Consent is required for all surgical procedures, general or regional anesthesia including moderate to deep sedation, and human experimentation.
3. Informed Consent is required for emergency procedures if possible. If no consent is obtained under these circumstances, the physician must clearly document the performance of the procedure and the emergency indications in the patient's medical record.
4. The Physician performing the procedure has the responsibility for providing the information to the patient regarding the procedure or treatment and, if possible, is the individual obtaining the signed consent.
5. The Individual obtaining the patient's signature, if not the Physician performing the procedure or treatment must ascertain that the patient has discussed the proposed treatment with the Physician and that all questions have been answered.
6. Telephone consent may be obtained, by the physician, from the patient. The RN will confirm with the patient that he/she has been consented by the Physician. An RN can act as a witness to the patient's signature but holds no responsibility regarding informing the patient of risks/benefits.

7. For a patient who does not have the competency to consent, the hospital's standard consent policy for non-competent patients will be followed.

7-A Blood Consents

- Outpatient: Benefits, risks and complications explained by physician. Consent valid for 6 months.
 - Inpatient: Benefits, risks and complications explained by physician. New consent must be signed each admission.
 - Informing the patient of the risks, benefits, alternatives and potential complications of the transfusion is the responsibility of a physician and can not be delegated. It is not necessary to witness the physician informing the patient of risks/benefits.
8. Explanation of the proposed treatment should include:
 - Name of the patient's condition
 - Benefit and risks of the proposed treatment and possible alternatives including the alternative of no treatment at all.
 - If applicable, the Physician should discuss the possibility of adverse outcomes that may be irreversible.
 - All major risks should be disclosed, with the disclosure documented on the Consent Form.
 - The likelihood of the patient achieving his or her goals, and any well documented potential problems that might occur during recuperation.
 9. The process to obtain Informed Consent for minors and adults incompetent to give Informed Consent may be found in Anna Jaques Hospital Policy and Procedure Manual. (Policy #C-15).

XIII. Surgery and Anesthesia

1. A History and Physical Examination shall be performed by the Attending Physician or Designee and be present on the Medical Record before an operative or diagnostic procedure is performed.
2. The expectation for an elective surgical admission is a dictated History and Physical on the Hospital system or a typed History and Physical from an electronic medical record.
3. Urgent or Emergent Surgical Admissions at hours when transcription is not available may be handwritten on the Urgent or Emergent Form. If the patient remains in the hospital over forty-eight (48) hours, this form will be transcribed into a typed History and Physical.

4. Informed Consent: Except in an emergency, a surgical operation may be performed only after obtaining Informed Consent. In any instance where Informed Consent cannot be obtained prior to emergency surgery, the Attending Physician shall document in the Medical Record at the earliest opportunity the clinical and/or administrative circumstances which precluded obtaining an Informed Consent. An Informed Consent shall be obtained in accordance with the Administrative policies and procedures of the Hospital, confirmation that Informed Consent has been obtained shall be documented in the medical records.

5. Scheduling surgery. Patients who require surgery may be scheduled only after they have been approved for admission except in situations in which emergency surgery is necessary.
 - 5-A A preoperative diagnosis shall be recorded and signed by the surgeon prior to surgery on the OR booking sheet or in the preoperative History and Physical for in-patients going to the operating room.

6. Pre-procedure documentation: The following pre-procedure documentation is required for the following types of procedures:
 - Local anesthesia – Reason for procedure, allergies, medications, significant past medical history recorded on the booking form or in an attached history and physical.

 - Minimal sedation (E.G. IM pain medication) – Reason for procedure, allergies, medications, significant past medical history recorded on the booking form or in an attached history and physical.

 - Moderate sedation – History and physical for sedation and analgesia including ASA Classification and interval history.

 - Deep sedation/general anesthesia – Complete admission History and Physical in the medical record prior to the start of surgery; the History and Physical may be performed within thirty (30) days of the procedure (TJC), but an interim note must be completed 24 hours prior to the surgery documenting any changes since the History and Physical.

 - Pre-anesthesia evaluation: All patients receiving moderate sedation/anesthesia must have a pre-sedation/anesthesia evaluation performed including ASA Classification immediately prior to surgery. An H&P for sedation and analgesia may be used to document the evaluation. All physicians who prescribe moderate sedation must demonstrate competency as required by the Anna Jaques Hospital Administrative Policy (A-18) indicating greater than twenty-five (25) moderate sedation cases every two year cycle, or completion of the educational program and self test every two year cycle.

7. Brief operative note shall be written in the medical record immediately after surgery prior to the patient going to the PACU.
8. Dictated operative note containing a description of the findings, the technical procedures used, specimens removed, preoperative and post operative diagnoses, the names of the primary surgeon, surgical assistance and anesthesiologists, and the type of anesthesia must be dictated within twenty-four (24) hours post surgery.
9. Post anesthesia evaluation per Department of Public Health Interpretative Guidelines, Section 482.52 (B) (3). The post anesthesia follow-up report must be written within forty-eight (48) hours after the patient's surgery. The follow-up report must be written by the individual who administered the anesthesia or in accordance with State Law 482.12 (C) (1) (I), an MD/DO may delegate the post anesthesia assessment in writing of the post anesthesia follow-up report to practitioners qualified to administer anesthesia in accordance with State Law and Hospital Policy. (Anesthesia policy) When delegation of the post anesthesia follow-up report is permitted, the Anesthesia Staff must address its delegation requirements and methods in its current policies

XIV. Medical Records

1. All Patient Healthcare Information including but not limited to the Medical Record and the Electronic Health Information is the property of the Hospital and shall be removed from the Hospital only by the Director of Health Information Management and/or Risk Manager except upon receipt of a valid court order or subpoena. Medical records shall not be taken outside of the hospital without prior authorization from the HIM department.
2. All Patient Healthcare Information is confidential.
3. The Hospital prohibits the alteration of Medical Records when such alterations misrepresent any facts or circumstances described in the original documentation.
4. Medical Records shall meet the requirements set forth in the current Comprehensive Accreditation Manual for Hospitals published by the Joint Commission (TJC), Medicare Conditions of Participation (MCOP), and relevant Federal and State Legislation.
5. A physician, or maxillofacial surgeon or other qualified Licensed Practitioner shall complete the Admission History and Physical, Operative Note when applicable, Discharge Summary in accordance with hospital policy, the State and Federal Laws, TJC, and MCOP Standards.

XV. Medical Record Delinquency

1. Medical Records for both inpatients and outpatients are considered delinquent if the record is not complete within fifteen (15) days of the patient's discharge.
2. Delinquent Medical Record Notification shall be made according to the Medical Record Policy .
3. The Medical Staff Executive Committee shall be given information concerning those Physicians who have delinquent Medical Records.
4. Upon suspension of Privileges due to delinquent Medical Records, all patient care departments will be notified. The suspended Physician shall lose all patient care privileges and shall arrange for alternate coverage for his/her patients until all Medical Records are completed.
5. The Protocol shall be waived for Medical Records becoming delinquent during a Medical Leave of Absence, or planned vacation with prior notice to HIM. All records must be completed prior to a Non-Medical Leave of Absence.
6. **The expectation is that History and Physicals and Operative Notes be completed and signed within 24 hours and Discharge Summaries and Outpatient Notes be completed and signed within 48 hours.**

XVI. Performance Improvement

Medical Staff supports the process of measurement, assessment and improvement of patient care processes among individuals with clinical privileges and throughout Anna Jaques Hospital.

The following are the processes used to monitor issues surrounding Patient Care with the focus on an opportunity to improve.

1. The Peer Review Process:
 - Hospital wide processes coordinated through Quality Management/Risk Management and the Performance Improvement Committee, and the PCAC.
 - Occurs through case reviews, patient care studies initiated by the Medical Staff or the Quality Management/Risk Management Staff, and written referrals.
 - Identifies significant departures from established patterns of clinical practice.
2. Blood Usage Review:
 - Reviewed and evaluated by the pathologist.
 - Reported to the Quality Management/Risk Management Department.

3. Tissue Review:

- Reviewed and evaluated by the Pathologist.
- Reported to Quality Management/Risk Management Department.

XVII. Medical Staff Rules and Regulations Adoption/Amendment

1. Adoption and Amendment

The Medical Staff, by vote of the Medical Executive Committee, shall adopt, and may from time to time amend, such Rules and Regulations and Policies as are necessary or appropriate to implement the Medical Staff Bylaws, to define the general principles contained therein, or for patient care or the proper conduct and responsibilities of each practitioner in the Hospital. The Governing Body, the Medical Executive Committee, or any member of the Active Medical Staff may propose an amendment to the Medical Staff Rules and Regulations and to Medical Staff Policies. Any amendment to the Medical Staff Rules & Regulations requires the approval of the Governing Body. Neither the Medical Staff nor the Governing Body may unilaterally amend the Rules and Regulations.

2 Periodic Review

The Medical Staff shall review the Medical Staff Rules and Regulations at the Annual Medical Staff meeting. The Medical Executive Committee shall review the Medical Staff Rules and Regulations biennially and Medical Staff Policies periodically as needed.

3 Distribution

A copy of the Medical Staff Rules and Regulations shall be distributed with each appointment and reappointment package. Copies of Medical Staff Policies shall be disseminated as may be determined by the Medical Staff President or the Medical Executive Committee, and shall be made available to Medical Staff members and other practitioners in the Hospital upon request.

Addendum: The Physician is responsible for reporting deaths to the Medical Examiner in Accordance with MGL Chapter 38, Section 3:

- (1) death where criminal violence appears to have taken place, regardless of the time interval between the incident and death, and regardless of whether such violence appears to have been the immediate cause of death, or a contributory factor thereto;
- (2) death by accident or unintentional injury, regardless of time interval between the incident and death, and regardless of whether such injury appears to have been the immediate cause of death, or a contributory factor thereto;
- (3) suicide, regardless of the time interval between the incident and death;
- (4) death under suspicious or unusual circumstances;
- (5) death following an unlawful abortion;
- (6) death related to occupational illness or injury;
- (7) death in custody, in any jail or correctional facility, or in any mental health or mental retardation institution;
- (8) death where suspicion of abuse of a child, family or household member, elder person or disabled person exists;
- (9) death due to poison or acute or chronic use of drugs or alcohol;
- (10) skeletal remains;
- (11) death associated with diagnostic or therapeutic procedures;
- (12) sudden death when the decedent was in apparent good health;
- (13) death within twenty-four hours of admission to a hospital or nursing home;
- (14) death in any public or private conveyance;
- (15) fetal death, as defined by section two hundred and two of chapter one hundred and eleven, where the period of gestation has been twenty weeks or more, or where fetal weight is three hundred and fifty grams or more;
- (16) death of children under the age of 18 years from any cause;
- (17) any person found dead;

(18) death in any emergency treatment facility, medical walk-in center, child care center, or under foster care; or

(19) deaths occurring under such other circumstances as the chief medical examiner shall prescribe in regulations promulgated pursuant to the provisions of chapter thirty A. A physician, police officer, hospital administrator, licensed nurse, department of children and families' social worker, or licensed funeral director, within the commonwealth, who, having knowledge of such an unreported death, fails to notify the office of the chief medical examiner of such death shall be punished by a fine of not more than five hundred dollars. Such failure shall also be reported to the appropriate board of registration, where applicable.

APPENDIX TO THE
 MEDICAL STAFF RULES & REGULATIONS
 OF ANNA JAQUES HOSPITAL

ATTENTION

The following is a list of abbreviations that are commonly confused and result in medication errors. **Please do not use any of these abbreviations.**

(This list has been approved by the Pharmacy and Therapeutics Committee)

qd, Q.D., or Q.O.D	Often mistaken for one another or Q.I.D.	Write daily, every other day Or q day
µg (For microgram)	Often mistaken for milligram	Write “mcg”
.1	Always include a zero before a decimal	Write “ 0.1 ”
1.0	Never include a trailing zero	Write “ 1 ”
I.U.	Often mistaken for IV	Write “ international units ”
U	Often mistaken for zero, four or cc.	Write “ unit ”
MS	Often confused for one another Could be Morphine Sulfate of Magnesium Sulfate	Write “ Morphine or Magnesium ”
MSO₄	As above	As above
MgSO₄	As above	As above
A.S., A.D., A.U O.S., O.D., O.U.	Often mistaken for each other, or od vs. qd	Write full instructions: “right ear, left ear” / “right eye, left eye” etc

***NOT A PART OF THE PERMANENT RECORD
 PLEASE LEAVE IN CHART***

APPENDIX TO THE MEDICAL STAFF RULES & REGULATIONS OF ANNA JAQUES HOSPITAL

Medical Staff Policies

Policy Title	Policy No.
Appointment Policy	MS-1
Reappointment Policy	MS-2
Temp. Priv. Policy	MS-3
Leave of Absence Policy	MS-4
Resignation Policy	MS-5
Additional Privilege Policy	MS-6
Proctoring Protocol Policy	MS-7
Low Volume Practitioner Policy	MS-8
Streamline Credentialing	MS-9
Proctoring/Case Reimbursement Policy	MS-10
Student Clinical (sponsored by a physician) Rotations Policy	MS-11
Disaster/Emergency Privileges Policy	MS-12
Cardiac Catheter Privileges Policy	MS-13
Physician Activity Profile	MS-14
Provider Health Policy (Allied Health)	MS-15
Criminal Background Check Policy	MS-16
Limited Privilege Policy	MS-17
Tele-Radiology Credentialing Policy	MS-18
Medical Staff Focused Professional Practice Evaluation Policy	MS-19
Medical Staff Ongoing Professional Practice Evaluation Policy	MS-20
Medical Staff Visitor Policy	MS-21
Medical Staff Policy verification of renewals and adverse action reporting	MS-22
Medical Staff Policy on Evaluation Malpractice Claims for Credentialing & Privileging	MS-23
Credentialing requirements for stress test performance	MS-24
Confidentiality & Access to Medical Staff Records	MS-25
Discharge Summary Policy	MS-26
Medical Staff Credentialing APNs and PAs	MS-27
Medical Staff For Cause Drug and ETOH	MS-28
Medical Staff History and Physical Documentation	MS-29
Medical Staff information Disclosure to Patients	MS-30
Medical Staff On-Call	MS-31
Medical Staff Physician Health	MS-32
Medical Staff Credentialing for Fluoroscopy Equipment	MS-33
Medical Staff Credentialing of Persons Providing Patient Care	MS-34
Medical Staff Ordering Outpatient Services	MS-35
Medical Staff Physician Performed Testing	MS-36
Medical Staff Pneumococcal and Influenza Vaccine Policy	MS-37
Medical Staff Research & Evaluation Process	MS-38

APPENDIX TO THE
MEDICAL STAFF RULES & REGULATIONS
OF ANNA JAQUES HOSPITAL

Anna Jaques Hospital
Policy and Procedure Index and Location
Administrative, **Emergency**, **Nursing Policies** & **Nursing Procedures**
<http://annaonline.ajh.org/policies/policies.html>