RULES AND REGULATIONS
MEDICAL STAFF OF
TORRINGTON COMMUNITY HOSPITAL

TABLE OF CONTENTS

RULES AND REGULATIONS
MEDICAL STAFF OF
TORRINGTON COMMUNITY HOSPITAL

1. No patient is to be sent to the hospital except in case of emergency without a provisional diagnosis by the attending practitioner. In case of emergency, the provisional diagnosis shall be given as soon after admission as possible. Practitioners shall be responsible for giving the hospital such information as will enable the hospital to protect the other patients from those who are a source of danger from any cause whatever.

2. Standing orders shall be formulated by conference between the Medical Staff and the NS administrator. They may be changed only by the administrator after conference with the Medical Staff. These orders shall be signed by the attending practitioner.

3. All orders shall be in writing. An order shall be considered to be in writing if dictated to a registered professional nurse, a licensed practical nurse, a Dietician, or a Pharmacist or to personnel representing certain departments, including, but not limited to, Radiology, Physical Therapy, Laboratory and Respiratory Therapy, provided that acceptance of such dictation is within such person's scope of practice and license. The orders shall be signed by the person to whom dictated with the name of the physician, per such person's own name. All orders shall be countersigned by the physician within fifteen (15) days of discharge of the patient. Medication verbal orders must be signed by a physician within forty-eight (48) hours.
Revised 06/20/02; 03/15/07

4. Dangerous drugs shall be given properly with reasonable Medical Staff control. This control shall prevent indiscriminate and harmful usage of dangerous drugs. Therefore, all orders for antibiotics, sedatives, and hypnotics, anticoagulants, and narcotics, regardless whether administered orally or parenterally, shall be automatically discontinued after a period of five (5) days. The exceptions to this will only be when the practitioner reorders the medication, when the practitioner has ordered an exact number of doses, or when an exact period of time has been specified for medication. Drugs in common usage that would fall into the above-mentioned categories are:

    a. **Antibiotics:** Penicillins, tetracyclines, neomycin, streptomycins, chloramphenicol erythromycin, etc.

    b. **Sedatives and hypnotics:** Barbiturates, non-barbiturates, chloral hydrate, paraldehyde, etc.

    c. **Anticoagulants:** Dicumarol, heparin, etc.

    d. **Narcotics:** Demerol, codeine, morphine, codeine compounds, dilaudid or dihydromorphionone HCL, nisentil, or alphaprodine HCL, etc.

    e. The use of antibiotics in the presence of infection is based on necessary culture and sensitivity tests and clinical judgment.

5. **Oxytocic Drugs:** By protocol, okay by Medical Staff.

6. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. Except in emergency, the physician will be notified if the patient prefers to sign the form prior to treatment in the hospital.

7. A complete history and physical examination shall, in all cases, be written, or dictated, within 24 hours after admission of the patient.

8. Surgery is performed only after an H&P, preoperative diagnosis, and diagnostic tests have been completed and are in the record, except in emergencies.

9. Written, signed, informed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to condition of the patient. In emergencies involving a minor or unconscious patient, in which consent for surgery cannot be immediately obtained from parents, guardian, or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.

10. Should a second operation be required during the patient's stay in the hospital, a second consent, specifically worded, shall be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to on the same form.

11. Anesthesia will be administered by a qualified practitioner who is credentialed and privileged according to the Medical Staff Bylaws. The anesthesia practitioner shall maintain a complete anesthesia record, which will include evidence of both the pre-anesthetic evaluation and the post-anesthetic assessment of the patient. The surgeon of record is responsible for the overall care of the patient during any procedure.

12. In any surgical procedure as defined by the surgeon in charge, there must be a qualified assistant present and scrubbed. A qualified assistant is defined as a physician designated by the executive committee to assist. "Qualified," in this instance, means physicians acknowledged by the executive committee as having sufficient training to properly and adequately assist.

13. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on critically ill patients, and those where there is difficulty in diagnosis or management of the clinical problem.

14. Operative reports shall include a detailed account of the findings at surgery, as well as the details of the surgical technique. Operative reports shall be prepared (or dictated) immediately following surgery for outpatients, as well as inpatients, and the report promptly signed by the surgeon and made a part of the patient's current medical record. All specimens removed at operation shall be sent to pathology for evaluation at the discretion of the surgeon in charge.

15. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. It is understood that the intellectual judgment and moral conscience of the attending physician related to the patient's welfare is the best stimulus for acquiring consultation. The ordering practitioner shall order the

consultation on the physician order sheet and shall include the reason for the consult and the name of the requested consulting physician. The ordering practitioner and/or nursing staff will notify the consultant physician of the request. The date of the consultant notification should be recorded on the order. The consultant should, in most cases, examine the patient and record within 24 hours, a consultation note to include pertinent findings, opinions and recommendations.
Revised 06/20/02

16. The therapeutic termination or interruption of a pregnancy in its first trimester may be performed within the hospital. When such therapeutic terminations or interruptions of pregnancy are performed, the prior written consent of the patient shall be obtained and if the patient is married, the consent of the husband shall also be obtained. If it is determined that the husband is deceased, disabled, or otherwise unavailable to give his consent, then it shall not be necessary to obtain the same. When the patient is not married and is a minor as defined by the laws of the State, it will be necessary to obtain the written consent of both parents of the patient, if living, or of the patient's legal guardian.

    Any physician on the Medical Staff of the hospital or a person employed by the hospital may refuse to participate directly in any termination or interruption of pregnancy. A written statement to that effect from such physician or employee of the hospital shall be filed with the administrator.

    Attention shall be given to special requirements pertaining to consents affecting minors who are pregnant, married, or are parents.

    The therapeutic termination or interruption of a pregnancy after the first trimester shall only be performed within the hospital when:

    a. There has been consultation as provided in Rule 15 above, with at least one other physician not related nor associated with the attending physician in the practice of medicine. The consultation report of such physician shall be in writing, shall be recorded as provided in Rule 15, and shall reflect that the continued pregnancy threatens the life or the health of the mother.

    b. The consent referred to in Rule 9 has been obtained.

17. A patient admitted for dental care is a dual responsibility involving the dentist and physician member of the Medical Staff.

    a. **Dentists' Responsibilities:**

        (1) A detailed dental history justifying hospital admission.

        (2) A detailed description of the examination of the oral cavity and a preoperative diagnosis.

        (3) A complete operative report, describing the finding and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.

        (4) Progress notes as are pertinent to the oral condition.

        (5) Discharge summary.

b. **Physicians' Responsibilities:**

(1) Medical history pertinent to the patient's general health.

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

c. The discharge of the patient shall be on written order of the dentist member of the Medical Staff.

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

19. If a nurse has any reason to doubt or question the care provided to any patient, and no action has been taken by the attending practitioner or the chief of staff, he/she shall call this to the attention of her superior, who, in turn, shall refer the matter to the NSA. If warranted, the NSA shall bring the matter to the attention of the chief of staff or administrator.

20. In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or by a staff physician designated by him/her, within a reasonable time frame.

21. The attending practitioner shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical, laboratory, x-ray, and other; provisional diagnosis; medical or surgical treatment; pathological findings; progress notes; final diagnosis; condition on discharge; followup and autopsy report when available; and discharge summary. No medical record shall be filed until it is complete, except on order of the Executive Committee.

22. The patient's medical record shall be complete at time of discharge, including progress notes, final diagnosis, and (dictated) discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available for the practitioner to complete.

23. All records are the property of the hospital and original records shall not be removed from the hospital without a court order, subpoena, or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether or not the patient be attended by the same practitioner or another practitioner.

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

25. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee of the Medical Staff before

records can be studied. Subject to the discretion of the administrator, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

26. Each member of the courtesy Medical Staff not resident in the city or immediate vicinity shall name a member of the active Medical Staff who is resident in the city who may be called to attend patients in emergency. Any member of the staff leaving the city must make satisfactory arrangements for care of his/her hospital patients while absent. In case of failure to name association, the administrator of the hospital shall have the authority to call any member of the active Medical Staff, if available, and if not, he/she shall have the authority to make such other arrangements for medical care to protect the patients, should he/she consider it necessary.

27. Patients shall be discharged only on written order or verbal order utilizing discharge criteria of the attending practitioner. At the time of discharge, the attending practitioner shall see that the record is complete, state his/her final diagnosis, and sign the record. Should a patient leave the hospital against the advice of the attending practitioner, a notation of the incident shall be made on the patient's record. The patient, or his/her authorized representative, shall sign a "Statement of Patient Leaving Hospital Against Advice" form.

28. Except in cases ordered or performed by a coroner or other authorized official, postmortem examination shall not be performed by the hospital pathologist or other authorized physician without obtaining prior written consent from the nearest living kin of the deceased. The signed consent and identity of the person giving the consent shall be filed and kept with the patient's medical record. The person performing the autopsy shall prepare a written report of the procedures and findings which shall also be filed and kept in the patient's medical record.

    In cases where a person has made an anatomical gift of all or part of his/her body, for one or more purposes, such gift shall authorize a postmortem examination to assure the medical acceptability of the gift for the purposes intended. As in the case of other autopsies or postmortem examinations, the physician performing the same shall keep a complete record of the procedures and findings and such records shall become a part of the medical record of the patient along with evidence of the anatomical gift.

29. The annual meeting of the Medical Staff shall take place at the first regular meeting in January. Notice regarding time and place shall be given to each member of the staff at least one week in advance.
    Revised 12/11/00

30. The Medical Staff shall meet monthly but at least four (4) times per year. Notice regarding time and place shall be given to each member of the medical staff at least one (1) week in advance of the meeting.
    Revised 12/11/00

31. No physician on the hospital Medical Staff, or person employed by the hospital, shall be required to participate directly in the sterilization of either a male or a female patient. A written statement by the physician or employee of refusal to participate shall be filed with the administrator. Surgical procedures for the purpose of sterilization of either a male or a female patient shall be in accordance with any applicable State law and subject to the following conditions:

a. When, in the opinion of the attending physician, a sterilization is justified because of the prior medical history of the patient or because of other justifiable medical or psychiatric reasons.

b. When sterilizations are performed, the prior written consent of the patient shall be obtained. When the patient is unmarried and is a minor, as defined by the laws of the State, or is otherwise incapable of giving consent, it shall be necessary to obtain written consent of both parents, if living, or the patient's legal guardian.

c. Special attention shall be given to special requirements pertaining to consents affecting minors who are pregnant, married, or are parents.

32. Except as hereafter noted, every active Medical Staff member in accordance with his clinical competence and privileges, shall serve on emergency room call at the hospital. Emergency room call shall commence at 8:00 a.m. and continue for a 24-hour period. The call will be rotated on a staggered basis, so no practitioner will have the same day on call each week. The practitioner on call will be responsible for seeing all patients entering the emergency room requiring the attention of a physician, except when the patient or a member of his family should specifically request that a different member of the Medical Staff be called.

Any practitioner who refuses to comply with this rule shall be subject to summary suspension as specified in Article VII, Section 2, of the Medical Staff By-Laws.

Any member of the Community Hospital active Medical Staff who had served for 20 years or more in the Goshen County may be excused from taking further emergency call and maintain staff privileges.
(Rule 32: Revised 03/10/80)

33. That as a condition of obtaining staff privileges initially and by April 15, 1981, all members of the Medical Staff shall, as a condition precedent to obtaining or retaining staff privileges, satisfy the Medical Staff and hospital administrator that the practitioner has medical malpractice insurance minimum amount of $100,000.00 - $300,000.00
(Rule 33: Addition 04/15/81)

34. DNR – withholding CPR including chest compression, artificial respiration, and/or cardioactive medication in the event of cardiac or respiratory arrest.

A "do not resuscitate" order may be written in the medical record by the attending physician.

a. Requested by patient or patient's family or legal guardian if patient is unable to express his/her wishes or desires.

b. Directed by signed and documented copy of advanced directive or living will.

c. Deemed appropriate by attending physician based on his knowledge and evaluation of the patient and the patient's condition in concert with the patient's family (or legal guardian) and their wishes and desires.

d. If patients/families are having a difficult time making a DNR decision, the nursing ethics plan will be implemented which includes contacting the ministerial service of their choice.

e. If needed, further physician consults may be obtained and used to help the decision process continue.

Rule 34: Revised 4-19-94

35. **Resident Physicians**

a. Residents are those individuals who are serving assignments, as part of their formal training, with Medical Staff members who are a part of their teaching programs. Termination of their affiliation with a Residency Program for any reason or failure of the Program itself to be accredited will result in termination of all privileges. Residents shall not be required to seek allied health of Medical Staff status (membership).

b. Supervision: Residents will be under the general supervision or direction of a member of the Medical Staff. Active participation in and supervision of the patient's care by the supervising physician must be documented by the supervising physician.

c. Responsibilities: Residents in formal training program may make entries in the patient's medical record under the following conditions:

- history and physical examinations, operative notes, Emergency Room encounter forms and discharge summaries must be countersigned by the supervising physician.
- consultation reports must be countersigned by the supervising consultant.
- progress notes need not be countersigned.
- orders written by the resident physician need to be countersigned by the supervising physician according to Medical Staff Bylaws, Rules and Regulations.
- ultimate responsibility for the medical record shall lie with the attending physician.

Addition 3/20/03

36. **Students –** Students will be under the direct supervision of a member of the Medical Staff. All entries made by a student in the medical record must be countersigned.
Addition 8/21/03

37. **Authentication:** All authenticating signatures entered into a patient's medical record shall be by signature, initials, electronic signature, or authorized rubber stamp. Members of the Medical Staff desiring to employ the use of rubber stamp signatures must first notify the hospital in writing of their intent to use other than original signatures. Each member of the Medical Staff also must certify that such member of the Medical Staff will be the only person authorized to use the rubber stamp and that it will not be delegated to any other person, as more particularly described in the "Electronic Signature Authentication of Dictated Reports" policy.
Addition 1/18/07

ADDITION TO THE MEDICAL STAFF RULES AND REGULATIONS 7-6-94

Restraints: Physician's order will be obtained prior to placing patient in restraints. The order for restraints shall be reviewed and renewed every 24 hours.