

# **BYLAWS OF THE MEDICAL STAFF**

# **RULES AND REGULATIONS**

*August 2024*

**MEDICAL STAFF**  
**RULES AND REGULATIONS**  
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## **MEDICAL STAFF RULES AND REGULATIONS**

### **A. ADMISSION AND DISCHARGE OF INPATIENTS**

1. A patient may be admitted to the Hospital only by order of a member of the Medical Staff with admitting privileges.
2. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis and valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as practical. The patient shall be seen by the attending physician, a covering member of the Medical Staff or the Allied Health Professional Staff, within a timeframe appropriate to the admitting diagnosis, or as appropriately defined by the specific department and/or clinical service, but not to exceed a twelve (12) hour period.
3. A member of the Medical Staff may admit a patient to his service only, and is responsible for that patient until he formally transfers the patient to another physician and the responsibility is accepted. The physician to whom the patient is transferred to must be available to attend to the patient at the time of transfer.
4. Members of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring physician and to relatives of the patient. Whenever these responsibilities are transferred to another Medical Staff member, both an order covering the transfer of responsibility and an order accepting transfer of responsibility shall be entered on the order sheet of the medical record.
5. A patient to be admitted on an emergency basis who does not have a private physician, or for whom the requested physician is not available, may request any physician in the applicable Department or Section to attend him if agreed to by that physician. Where no such selection is made, a member of the Active Medical Staff on duty in the appropriate Department or Section will be assigned to the patient.
6. The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical Department and approved by the Medical Staff Council.

Patients are admitted to specialty areas within the Hospital based on established criteria, which have been approved by the Medical Staff, and a patient's condition consistent with those criteria.

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7. If any question as to the validity of admission to or discharge from either the Intermediate Care Unit or the Critical Care Unit should arise, that decision is to be made in consultation with the Director of Critical Care Services, or designee.
8. Patients shall be discharged only on an order of the attending physician or covering physician. Should a patient leave the Hospital against the advice of the attending physician, or without proper discharge, documentation of this occurrence shall be made in the patient's medical record.

**B. DEATHS / AUTOPSY**

1. In the event of the death of a patient, the deceased shall be pronounced by a physician, an advanced practice registered nurse, or, in the event of an anticipated death, a physician assistant for those patients with an Allow Natural Death order. The body shall not be released until an entry has been made and signed in the medical record by a member of the Medical Staff. The attending physician, advanced practice registered nurse or physician assistant caring for the patient, must sign the death certificate and return it to the funeral director within twenty-four (24) hours. In the event of an anticipated death, an authorized registered nurse may make the actual determination and pronouncement of death of a patient in accordance with applicable law and Hospital policy provided that (1) the death is anticipated, (2) the RN must attest to the pronouncement on the death certificate, and (3) a physician must certify the death and sign the death certificate within 24-hours of the nurse's pronouncement. It is the responsibility of the attending physician to notify the family.
2. If an autopsy is deemed appropriate, it shall be the duty of all Medical Staff members to secure consent to autopsy. An autopsy may be performed only with proper consent, except as authorized by the State of Connecticut Chief Medical Examiner, in accordance with State law and Hospital policy. Consent for an autopsy shall be effective only by inclusion of such notation on the appropriate Hospital form signed by the appropriate legal representative of the patient. A copy of the autopsy report shall be forwarded to the patient's attending physician and included in the patient's medical record. A Provisional anatomic diagnosis shall be recorded on the medical record within forty-eight (48) hours. Complete autopsy protocol shall be included in the medical record within thirty (30) working days if uncomplicated; if complicated, within three (3) months.

**C. MEDICAL RECORDS**

1. A medical record will be maintained for each patient who is evaluated or treated as an inpatient, outpatient, or emergency patient. The medical record for each patient shall be complete and legible and its contents shall be pertinent and current. Each record shall contain documentation of all care provided to the patient including: identification data, complaint, history of present illness, past medical history, medications, allergies, personal history, family history, physical examination, medical treatment, condition on discharge,

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provisional and/or final diagnosis; and any relevant consultation, laboratory and radiology reports, , surgical treatment, operative report, pathological findings, progress notes, discharge summary, and autopsy report when performed within the Middlesex Health System.

2. All entries in the medical record will be dated, timed, and authenticated promptly by the person making the entry. Authentication means to verify that an entry is complete, accurate and final and to establish authorship by written signatures or computer entry using electronic signatures.
3. A complete medical history and physical examination (H & P) shall be recorded on the patient's chart at the time of admission to the inpatient service, or within thirty (30) days before the admission provided the patient's condition has not significantly changed since the H & P was performed. All H & P reports must be included in the medical record within twenty-four (24) hours of the admission, but prior to any surgery except in cases of emergency. If the initial H & P is handwritten, it is the attending physician's responsibility to ensure a dictated H & P is completed.

A medical history and appropriate physical examination is required for outpatients when an outpatient procedure is to be performed with the use of sedation. Sedation is defined to include procedural sedation and analgesia and monitored anesthesia care. The H & P must be completed within thirty (30) days prior to the procedure provided the patient's condition has not significantly changed since the H & P was performed.

When the H & P is conducted within thirty (30) days before admission or registration, an update must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or any procedure requiring anesthesia services. The examination must be conducted by a licensed practitioner who is credentialed and privileged to perform an H & P. The update note must document an examination for any changes in the patient's condition since the patient's H & P was performed that might be significant for the planned course of treatment.

The required H & P content shall always include sufficient information necessary to provide the care and services required to address the patient's conditions and needs and thus may vary with the setting and type of care delivered. The H & P report shall include reason for admission, pertinent past history, pertinent physical findings, diagnosis, and plan of treatment or operative procedure. For appropriate non-sedated, invasive procedures performed outside the operating room, the H & P shall indicate significant medical history, other significant physical findings, and diagnosis.

The H & P must be completed and documented by a physician, an oral maxillofacial surgeon, or a podiatrist, with specific privileges in accordance with state law and hospital policy. Members of the Allied Health Professional Staff may perform H & Ps if granted the appropriate privileges; the H & P must then be validated and countersigned, timed and dated, by the attending physician.

The attending physician shall countersign all H & Ps and discharge summaries recorded by a member of the House Staff.

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4. Pertinent and legible progress notes shall be recorded at the time of observation/ evaluation and shall be sufficient to permit continuity of care. Each of the patient's clinical problems and treatment plan should be clearly identified in the progress notes. Progress notes may be entered by the attending physician, a covering member of the Medical Staff or the Allied Health Professional Staff, physicians who have been asked and who have agreed to serve as consultants, and other members of the Medical Staff who have a previously established relationship with the patient and who have relevant information regarding that patient. Progress notes must be written at least daily on all patients by the attending physician, or designee.

5. Surgical Care

A legible, handwritten operative note must be entered in the patient's medical record immediately following surgery. This handwritten operative note will include pre-operative diagnosis, procedure, name of surgeon and assistant(s), findings, post-operative condition, specimen(s) removed, and post-operative diagnosis. A comprehensive operative report shall be dictated within one working day of the surgery. Dictated operative reports will be promptly reviewed and signed by the surgeon.

Except in severe emergencies, the medical history and physical examination, preoperative diagnosis and required laboratory and radiology tests must be recorded on the patient's medical record prior to any surgical or other invasive procedure. If not recorded, the procedure shall be delayed until appropriate data is recorded. In an emergency, the physician shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

Surgeons are expected to provide appropriate surgical assistants dependent on the complexity of the surgery and the medical condition of the patient.

Tissues removed at the operation shall be sent to the Hospital pathologist in accordance with Hospital policy who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. The pathologist's authenticated report shall be made a part of the patient's medical record.

6. Obstetrical records shall include the patient's complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital prior to the patient's admission. If the patient's prenatal record is provided prior to admission and contains an H & P that was performed no more than thirty (30) days prior to admission, a detailed admission H & P does not have to be dictated by the responsible physician. However, an interval admission note that includes pertinent additions to the patient's medical history and any subsequent changes in the physical findings shall be entered in the record by the attending physician at the time of admission.

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7. The psychiatry attending physician is responsible for the provision of psychiatric care for patients presenting to the Crisis Intervention Service; including the oversight of patient care and disposition provided by crisis clinicians.
8. Only those symbols and abbreviations that have been approved by the Medical Staff may be used in medical record entries. The Director of Health Information Management will maintain an official record of approved abbreviations.
9. Written consent of the patient is required for release of medical information to persons not otherwise authorized or permitted by law to receive this information, in accordance with the Hospital's privacy policies.
10. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order or upon the approval of Hospital Risk Management or other appropriate Hospital Administrator in accordance with applicable law. All medical records are the property of the Hospital and, except in the foregoing, shall not be removed from the Hospital without permission of the President of the Hospital. In case of readmission of a patient, all previous medical records shall be available for reference by the attending physician. This shall apply whether the patient is attended by the same physician or by another.
11. Access to patient medical records for the purpose of conducting medical research or other study projects shall be approved in advance by the Medical Staff Council, if requested by the Internal Review Board (IRB). Any approved research will be conducted in a manner consistent with preserving the confidentiality of any information that may in any manner identify individual patients.
12. The patient's medical record shall be completed at the time of discharge. The discharge summary shall be dictated at the time of discharge and shall include a concise statement of the reason for hospitalization; significant findings; procedures performed and treatment rendered; the patient's condition on discharge; and instructions regarding diet, medication, activity, follow-up care and other specific instructions given to the patient and/or families. If laboratory or other reports essential to preparing the discharge summary are not available at the time of discharge, a note in the dictated discharge summary should indicate that reports are pending, and an addendum may be dictated. A dictated Discharge Summary shall be completed for all patients hospitalized, except for normal obstetrical deliveries, normal newborn infants, and patients with selected problems of a minor nature. The Medical Staff Council shall approve these exceptions. For all exceptions, a final summation Discharge Summary will be entered in the patient's medical record by the responsible physician. A summation Discharge Summary shall be sufficiently comprehensive to justify the diagnosis, selected course of treatment, and end result, and shall be signed by the responsible physician.
13. The Discharge Plan shall be developed in collaboration with the patient or such patient's family or legal representative, and shall include physical activity, medications, diet, and follow-up care, and will be approved on the order sheet. The Discharge Plan shall be

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provided to, and signed by, the patient, the patient's family or the patient's legal representative prior to discharge.

14. Following the patient's discharge, all inpatient and designated outpatient medical records shall be forwarded to the Health Information Management Department for processing. Upon completion of the medical record analysis function and identification of incomplete sections of the medical record, deficient medical records will be identified and each physician shall be required to complete those sections of the record for which he is responsible within fifteen (15) days of the date of discharge or date of service (outpatient).
15. A medical record shall not be filed until it has been completed by the responsible physician(s) or has been ordered filed by the Executive Committee on the recommendation of the Director of Health Information Management.
16. An Incomplete Record Plan and Penalty Fee System may be established and implemented by the Medical Staff Council and/or Medical Staff Executive Committee to facilitate the timely completion of inpatient and outpatient medical records.

Persistent failure by a practitioner to promptly complete medical records shall constitute grounds for corrective action, including, but not limited to, suspension or termination of Medical Staff membership and clinical privileges in accordance with the Bylaws of the Medical Staff.

**D. INFORMED CONSENT**

1. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending physician whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the physician's obligation to obtain proper consent before the patient is treated in the Hospital. Adults and emancipated minors should sign their own consent form. When unable to sign, signature should be obtained from a responsible next of kin. When such patient is alert and able, he/she should sign a second consent form.
2. A special consent form signed by or on behalf of every patient shall be obtained prior to an operative procedure and anesthesia except in those situations wherein the patient's life or limb is in jeopardy and documented in the medical record. An opportunity will be provided for a verbal repeat back of what was told during informed consent. In emergencies involving a minor or unconscious patient when 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. The treating practitioner, when possible, must consult one other physician regarding the recommended treatment. The consulting practitioner must attest to the immediate need for the admission or treatment by signing the patient's medical record.



**E. PATIENT CARE ORDERS**

1. Within a reasonable amount of time following appointment to the Medical Staff or Allied Health Professional Staff, all members will be trained in the use of the Hospital's computerized provider order entry (CPOE) system. All orders for patient care and treatment shall be placed in the CPOE or be in writing on designated order forms. Diagnostic and treatment orders may be written by any member of the Medical Staff or Allied Health Professional Staff with appropriate privileges. Orders shall be written only with the approval or under the supervision of the physician in charge of the patient. Orders not written by the attending physician shall be regularly reviewed by the attending physician.
2. In an emergency, an order may be dictated by a member of the Medical Staff or Allied Health Professional Staff. Verbal orders taken by a Registered Nurse must include the date, time, and legal signature of the Registered Nurse taking the order. Verbal orders for Schedule II controlled substances must be signed by the prescriber within twenty-four (24) hours. All other orders taken by a Registered Nurse must be signed by the prescriber within forty-eight (48) hours.
3. Verbal orders may also be taken by licensed respiratory care practitioners, registered dietitians, licensed physical medicine and rehabilitation therapists, pharmacists, and licensed radiologic technologists when the order is for discipline specific treatment as defined in patient care policies. These orders must include the date, time, and legal signature of the person taking the order. The prescriber must sign these verbal orders within forty-eight (48) hours.
4. All patient care orders are suspended when patients go to surgery.

**F. MEDICATION ORDERS**

1. All medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration. Medications used shall be on the formulary unless a medical necessity is otherwise appropriately documented in accordance with the Pharmacy and Therapeutics Committee's recommendations. Only medications purchased through or approved by Pharmacy will be administered to patients of the Hospital and its outpatient facilities.
2. It shall be considered acceptable routine practice to dispense generic equivalents when trade name products are ordered by the Medical Staff. Physicians may reserve the right to insist on trade name products.

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3. All medication orders shall be placed in the CPOE system or in writing on designated order forms, and signed, timed and dated by the prescribing practitioner. Practitioners prescribing controlled drugs in the Hospital must have a Federal DEA number and proper registration with the State of Connecticut Department of Consumer Protection (DCP). The number must be on file with the Medical Staff Services office and in the Pharmacy Department. Physicians who have their DCP numbers but are waiting for their Federal DEA numbers may use the hospital DEA number, but must write out their name, the hospital DEA number and the two letter suffix attached to them (the first and last letter of the physician's name).
4. Prescriptive authority for members of the Allied Health Professional Staff (i) shall be subject to the appropriate registration by such Allied Health Professional Staff member with the Federal DEA and the DCP, (ii) shall be in accordance with the scope of practice of the individual practitioner's licensure, and (iii) shall be outlined in the physician supervisory or collaborative practice agreements and specialty-specific privilege delineation.
5. All Schedules II through V medications, antibiotics, and respiratory medications shall automatically be discontinued after seven (7) days. All other drugs and biologicals shall automatically be discontinued after thirty (30) days unless:
  - a. The order indicates an exact number of doses to be administered.
  - b. Exact period of time for medication is specified.
  - c. The physician reorders the medication.
  - d. An order may be written "until discharge."
  - e. Any other exceptions will be noted in hospital policy.
6. Orders and reorders shall be specific as to name of medications, dose, strength, route of administration. If the order expires during the night, it should be called to the physician's attention the following morning. All medications should be automatically discontinued when a patient is transferred to a delivery room, operating room, or intensive care unit. No medications shall be discontinued without notifying a physician. No medications shall be given without a specific continuing order.

**G. CONSULTATIONS**

1. Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his area of expertise.
2. Except in an emergency, consultation is recommended in the following situations:
  - a. When the patient is not a good risk for operation or treatment.

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- b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.
  - c. Where there is doubt as to the choice of therapeutic measures to be utilized.
  - d. In unusually complicated situations where specific skills of other practitioners may be needed.
  - e. In instances in which the patient exhibits severe psychiatric symptoms.
  - f. When requested by the patient or his family.
  - g. When surgery is a potential therapeutic option.
3. The attending physician is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit another physician to attend or examine his patient, which requirement may be waived in cases of emergency. All consultants shall report to the attending physician within twenty-four (24) hours after evaluating the patient.
  4. Consultations shall show evidence of a review of the patient's medical record and, as appropriate, examination of the patient by the consultant and document the consultant's pertinent findings, opinion, and recommendations. The consultant's report shall be made a part of the patient's medical record. If the initial consultation note is handwritten, it is the consultant's responsibility to ensure that a dictated consult note is completed within twenty-four (24) hours of the consultation. If an operative procedure is to be performed, the consultation report shall, except in emergency situations, be recorded prior to the operation. The consulting physician shall authenticate all consultation reports.

**H. EMERGENCY SERVICES**

1. Each Hospital emergency facility will have on duty, during all hours of the facility operation, at least one physician who is a member of the Hospital Medical Staff with privileges in the Department of Emergency Medicine.
2. In addition, the Medical Staff shall adopt a method for providing twenty-four (24) hour daily coverage of the Hospital emergency facilities by appropriate Departments and Sections. Each Department and Section, except for those exempted by the Medical Staff Executive Committee (MSEC), shall have an emergency on-call coverage schedule providing continuous coverage to the Hospital, and participation in Emergency Department call will be defined by each Department and approved by MSEC. The purpose of the on-call schedule will be to designate the physician in the Department responsible for patients who require either admission or specialist coverage for emergencies and acute follow-up. Each Department's on-call schedule and policy will be determined by the respective Department Chair in consultation with Department members; provided, however, if the Department members cannot agree, the Department Chair shall

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make the necessary assignments to assure continuous Emergency Department coverage. If a Department does not comply with developing such a call coverage schedule, the call coverage schedule for that Department will be developed by the President of the Medical Staff and approved by MSEC. If a Medical Staff member believes that the call schedule is unfair or inappropriate, the member's complaint should be made to the President of the Medical Staff who will bring the issue to MSEC. In such cases, MSEC will have the final decision for determining the on-call coverage for the Department. The on-call coverage schedule for Sections shall be determined by the respective Section Chief in the same manner as Departments. The on-call physician shall not consider the patient's financial circumstances or the patient's insurance or means of payment in the decision to respond to, treat, or transfer the patient. Coverage requirements may be further delineated in Medical Staff policy or Department specific Bylaws.

**I. GENERAL RULES**

1. If a member of the Nursing Staff has any reason to doubt or question the care provided to any patient, the nurse should contact the physician involved for clarification. If the nurse is still doubtful, he shall call this to the attention of his superior, who in turn may refer the matter to the Director of Nursing. If warranted, the Director of Nursing may bring the matter to the attention of the Chair of the Department wherein the physician has clinical privileges. Where circumstances are such as to justify such action, the Chair of the Department may request a consultation. If the physician involved is the Department Chair, the matter shall be addressed by the President of the Medical Staff.
2. No physician shall absent himself from duty without procuring some other Hospital Medical Staff member who is qualified to cover his specialty as determined by the Medical Staff Council to serve as his substitute; and he shall inform the President of the Hospital prior to the prolonged absence, giving the name of any substitute.
3. In an emergency, if the physician or his coverage cannot be reached, the Department Chair/designee will be called and, if he cannot be reached, the President of the Medical Staff will be called, and if needed the Vice President of the Medical Staff.
4. In accordance with the Code of Medical Ethics of the American Medical Association, it is the policy of the Medical Staff that, because of the possible lack of objectivity in decision making, the clinical privileges of a member of the Medical or Allied Health Professional Staff shall under no circumstances be interpreted as permitting the member to provide medical care in the Hospital to any individual in the member's immediate family including parents, siblings, children, and spouse.

**J. HOUSE STAFF**

1. The House Staff will be under Medical Staff supervision as outlined by the Family Medicine Residency Program policy. Their cases will be reviewed by the Residency

Program as per the Residency Program's policies and according to the Quality Improvement Plan of their Department.

**K. MEDICAL STUDENTS**

1. Medical students will be under direct supervision of a Hospital Medical Staff member. No orders written by a medical student will be taken before being countersigned by a member of the House Staff or the attending physician. All notations in the medical record by a student will be countersigned by the attending physician and the content is adopted by the attending physician as his own.

**L. CONTINUING EDUCATION REQUIREMENTS**

1. Members of the Medical Staff are required to obtain a minimum of one-hundred (100) hours of postgraduate medical education in their specialty over a two (2) year period during the reappointment period, at least forty (40) of which are Category I credits, but shall in all cases be at least what is required by applicable state or federal law.
2. Continuing educational requirements for the members of the Allied Health Professional Staff are determined by the respective Department, and approved by the Medical Staff Council, but shall in all cases be at least what is required by applicable state or federal law.

Approved by the Medical Staff on July 31, 2024



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Nancy J. Rini, M.D.  
Medical Staff President

Approved by the Board of Directors on August 5, 2024



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Jonathan D. Levine, M.D.  
For the Board of Directors

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4/22/93	Bylaws Committee / Medical Staff Council
5/12/93	Approved by Medical Staff
5/26/93	Approved by Board of Directors
11/9/94	Approved by Medical Staff
11/9/94	Approved by Board of Directors
9/13/95	Approved by Medical Staff
9/27/95	Approved by Board of Directors
5/15/96	Approved by Medical Staff
5/22/96	Approved by Board of Directors
4/22/99	Approved by Medical Staff Council
5/12/99	Approved by Medical Staff
6/21/99	Approved by Board of Directors
1/12/00	Approved by Medical Staff
2/3/00	Approved by Board of Directors
11/8/00	Approved by Medical Staff
11/16/00	Approved by Board of Directors
11/14/01	Approved by Medical Staff
11/15/01	Approved by Board of Directors
5/14/03	Approved by Medical Staff
7/11/03	Approved by Board of Directors
1/9/08	Approved by the Medical Staff
1/25/08	Approved by the Board of Directors
9/10/08	Approved by the Medical Staff
11/14/08	Approved by the Board of Directors
11/11/09	Approved by the Medical Staff
11/20/09	Approved by the Board of Directors
1/14/2011	Approved by the Medical Staff
2/18/2011	Approved by the Board of Directors
3/14/2012	Approved by the Medical Staff
4/13/2012	Approved by the Board of Directors
1/11/2017	Approved by the Medical Staff
2/3/2017	Approved by the Board of Directors
5/18/2017	Provisionally adopted by the Medical Staff Council
6/23/2017	Provisionally approved by the Board of Directors
9/13/2017	Approved by the Medical Staff
9/11/2019	Approved by the Medical Staff
9/27/2019	Approved by the Board of Directors
1/8/2020	Approved by the Medical Staff
2/7/2020	Approved by the Board of Directors
7/31/2024	Approved by the Medical Staff
8/5/2024	Approved by the Board of Directors