

CONNECTICUT CHILDREN'S MEDICAL CENTER
MEDICAL STAFF RULES & REGULATIONS

GENERAL RULES & REGULATIONS APPLICABLE TO ALL DEPARTMENTS & DIVISIONS

I.CARE OF PATIENTS

- A.All patients admitted to Connecticut Children's shall have an attending practitioner of record who is actively and continuously involved in their care and management. The practitioner of record may be a member of the Department of Pediatrics or the Department of Surgery and must be a member of the Medical Staff who has been granted such privileges.
- B.There shall be one standard of care for all patients at Connecticut Children's.
- C.As a site for resident training, all patients admitted to any inpatient unit may be assigned to the care of one or more resident physicians in addition to the attending physician, except in extra-ordinary circumstances which will be approved by the Physician-in-Chief or the Surgeon-in-Chief.
- D.All resident physicians shall function under the supervision of a practitioner on the Active or Associate Active Medical Staff.
- E.All patients admitted shall have documented evidence of daily evaluation by a practitioner, or by or such practitioner's covering physician or a Professional Staff member supervised by or collaborating with the practitioner, as well as documentation of continuing supervision by the attending practitioner of record. Such documentation shall include an admitting note written by the attending practitioner of record (or such practitioner's covering physician or a Professional Staff member supervised by or collaborating with the practitioner) and daily notes as specified in the Medical Staff Rules and Regulations. All medical records shall meet the requirements of the Medical Staff Rules and Regulations.
- F.An attending practitioner unable to meet these requirements shall be responsible for arranging alternate coverage.
- G.Attending practitioners admitting normal newborns to Hartford Hospital shall follow the Rules and Regulations and Standards of Care for the Hartford Hospital Department of Pediatrics.
- H.Whenever possible, there should be notification of the attending practitioner of record or their designee (a) related to a decline in patient status, (b) potential patient transfer to another unit, or (c) upon performance of a consultative service on the patient.
- I.Practitioners caring for patients in Connecticut Children's are responsible for the appropriate use of consultations on their patients. The consulting practitioner and attending practitioner are responsible for communication regarding a patient's care as a result of the consultation. If there is any recommendation for significant changes in the care plan, it should be documented in the record and communicated personally between practitioners to insure appropriate and timely initiation of the new plan whenever possible.
- J.Consultations – See Medical Staff Bylaws, Article 3.5.11 and 3.5.12.

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II.MEDICAL RECORDS

A.Preparation of the Hospital-Based Medical Record

1.Operative Notes

- a)At the completion of surgery, a brief operative progress report on the patient is entered into the medical record. A complete operative report including the names of the surgeons, findings, procedures, specimens removed, estimated blood loss, any blood transfused and post-operative diagnosis shall be dictated by the resident physician, attending practitioner, or the attending before the patient is transferred to another level of care.
- b)The attending practitioner of record shall sign/authenticate all operative notes as soon as possible following the procedure.

2.Informed Consent(s)

- a)When discussing a proposed procedure or course of treatment, the practitioner has a duty to provide information that a patient or the parent/legal guardian would find helpful in deciding whether to agree to the proposed course of treatment. The information must include all reasonable treatment options, including no treatment or treatments considered more risky by the practitioner, nature and probability of risks and benefits, likely recuperative time, and the likelihood of achieving the care or treatment goals of the proposed surgical/invasive procedure or treatment.
- b)If informed consent is not obtained, treatment may not proceed, except in case of emergency.
- c)The consent form must be signed, dated and timed in ink. A signed Informed Consent form is valid for a particular treatment or procedure for 90 days unless significant changes occur within the 90 days, at which time a reassessment should occur and the form updated and resigned or a new form signed.

3.Progress Notes

- a)Progress notes are intended to be a chronological report of the patient's hospital treatment and course.
- b)Pertinent progress notes sufficient to permit continuity of care shall be written daily and dated and timed at the time of observation, except for Rehabilitation Medicine, where weekly notes are acceptable
- c)Daily progress notes shall document continuing supervision by the attending practitioner or such practitioner's covering practitioner.

4. Student Notes

- a)All student notes shall be countersigned by the supervising licensed professional within 24 hours.
- b)In the case of medical students, the supervising resident physician may countersign notes.

5.Orders

- a)All inpatient care orders shall be entered into the record by means of Computer Provider Order Entry (CPOE). Only in the event that CPOE is unavailable, should these orders be entered on paper forms, and then only on forms provided by Connecticut Children's Medical Center. Orders entered on paper forms shall be signed by the practitioner privileged to write orders and shall include the date and time of the order.

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- b) Resident physicians or fellows and Professional Staff member may write orders in accordance with their individual privileges.
- c) In an emergency, verbal orders may be accepted by a registered nurse, respiratory therapist, radiologic technologist or pharmacist, as appropriate, who shall transcribe such orders in the proper place in the medical record or CPOE of the patient. Verbal orders given and accepted under other circumstances must conform to the Medical Center policy titled "Verbal Orders."
- d) Verbal orders shall be signed, dated and timed by the ordering practitioner, his/her covering practitioner or the practitioner described in Section II.A.14 of these Rules & Regulations within 24 hours for medications and nutritionals, and within 30 days for all other orders.

6. Patient Discharge

- a) Patients shall be discharged from the Hospital only on the written order of the attending practitioner, or his/her covering practitioner (including APRN or resident) in accordance with established discharged criteria specific to said patient.
- b) At the time of discharge, the discharging practitioner shall complete the discharge instructions form detailing the final diagnosis, outpatient medications or treatment, and arrangements for follow-up care.
- c) If a patient signs out of the hospital against the advice of the attending practitioner, the reasons and circumstances concerning this shall be recorded in the discharge note.

7. Patient Transfer

- a) Patients may be transferred to other facilities if the medical or surgical services they require are not available at Connecticut Children's and in accordance with Connecticut Children's EMTALA policy. The attending practitioner or his/her covering practitioner will contact an attending practitioner at the proposed referral facility and obtain acceptance from that practitioner.
- b) The attending practitioner or his/her covering practitioner will obtain parent/legal guardian consent to transfer.
- c) The attending practitioner will document patient transfer information in the medical record including: reason for transfer, current status of patient, accepting practitioner, and name of practitioner responsible for the patient during transfer.

8. Discharge Summary

- a) A discharge summary shall be written or dictated within 30 days of discharge for all patients admitted for inpatient care by the attending practitioner of record, his/her covering practitioner or the practitioner described in Section II.A.14 of these Rules & Regulations.
- b) The attending practitioner of record shall sign all dictated discharge summaries within 30 days of discharge from the Medical Center.

9. Practitioner of Record

- a) The practitioner of record for a given patient shall be defined as the practitioner who is a Medical Staff member and who is legally responsible for the care of that patient.
- b) A practitioner of record must be established prior to or at the time of admission.
- c) Any transfer of a patient from one practitioner's service to another must be with the knowledge and consent of the patient and/or his/her guardian, and both practitioners, and documented as an order.

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10. Authentication of Written Entries

All written entries in the patient's medical record shall be accurately dated and timed and authenticated by means of the legible written signature of the individual making the entry. If the signature is not legible, the individual must print his/her name and professional title beneath the signature.

11. Authentication of Dictated Notes

- a) Every attempt should be made to have the practitioner who dictates a note for the medical record, such as an operative note or discharge summary, be the one to sign the note. In the event the dictating practitioner is not physically available within the timeframe for completion of the medical record, certain other practitioners are authorized to sign for a colleague. In order for another practitioner to sign in the place of the dictating practitioner, the following criteria must be met:
- (1) The signing practitioner must be in the same profession and specialty and must be legally associated with the dictating practitioner, i.e., in the same corporation or partnership.
 - (2) The signing practitioner must be on the list of those authorized to sign for the dictating practitioner. The Director of the Health Information Department shall maintain such a list for each practitioner.
 - (3) The signing practitioner must have sufficient knowledge of the specific patient about whom the note is dictated in order to authenticate the content of the note. In the case of operative notes, the signing practitioner must have been present at the procedure. The practitioner of record must sign a discharge summary or operative note on his/her patient by a resident physician or fellow.
- b) The authentication, or signing, of dictated notes shall be any means of Electronic Signature (E-sig) program.

12. Completion of Medical Records

The practitioner of record at the time of discharge shall see that the patient's medical record is complete within 30 days of discharge. To ensure such timely completion of the record, Section 10.5.5 of the Medical Staff bylaws and procedures developed by the Medical Records Committee and approved by the Medical Staff Executive Committee shall apply. Such Bylaws provisions and procedures shall specify sanctions to be applied to Medical Staff members who fail to abide by the procedures for timely completion of the medical record.

B. Access to and Storage of Hospital-Based Medical Records

1. Custody of Medical Records

All medical records are the property of the Medical Center and may not be removed from the Medical Center's jurisdiction and safekeeping except by court order or in accordance with Connecticut General Statute and Regulations. Medical Records shall also include any information regarding a patient's clinical status stored on electronic media. Unauthorized removal of medical records from the Medical Center is grounds for suspension of the Medical Staff Member for a period of time to be determined by the Medical Staff Executive Committee.

2. Medical Record Filing

A medical record shall not be permanently filed until it is completed by the practitioner of record or is ordered filed by the Medical Records Committee. Records that are the

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responsibility of practitioners, who are deceased or permanently unavailable, may be declared complete for filing purposes by the Medical Records Committee. A note indicating such a record's incomplete status and the reason therefore shall be filed in the record.

3. Authorization for Release of Information

Written authorization of the patient or his/her parent or legal guardian is required for the release of medical information to persons not otherwise authorized to receive this information.

4. Access to Medical Records: Staff

Access to the medical records of patients shall be afforded to members of the Medical Staff for bona fide study and research to the extent permitted by law, consistent with preserving the confidentiality of protected health information, concerning individual patients. The Institutional Review Board shall approve all such projects before the records are reviewed. Subject to the discretion of the General Counsel or Risk Management of the Medical Center, former Medical Staff members shall be permitted access to information from the medical records of their patients covering periods during which they attended such patients in the Medical Center. In cases of readmission of a patient, all previous records of that patient shall be made available for the use by the responsible practitioner whether or not the same practitioner attended the patient.

5. Access to Medical Records: Patient

All requests for information contained in the medical record made by a patient or his/her parent or guardian should be directed to the Health Information Department. The Director of the Health Information Department shall be responsible for devising guidelines for the safe and legal review of records by the patient or his/her legal representative.

6. Alteration of the Medical Record

- a) Following review of the medical record, an attending practitioner or consulting practitioner has the right to request that alterations be made to the medical record in the form of corrections or addenda in accordance with the following guidelines:
 - (1) No statement previously written or recorded in the medical record shall be deleted or otherwise physically damaged or altered.
 - (2) Any addendum to be entered while the patient is still in the Medical Center shall be made after consultation with the practitioner of record. The addendum shall appear in the record in writing, including notation that the addendum was made at the request of the attending practitioner or consulting practitioner. The dates and specifics of the original entries shall be cross-referenced.
 - (3) Alterations requested after the patient has been discharged shall be approved by the Director of the Health Information Department and made in the manner described above. The practitioner of record shall be notified by the Health Information Department of any alterations made.
 - (4) Any correction of an error made at the time of writing a note in the medical record shall be made by drawing a line through the error, labeling the error as such, dating and initialing the label. Corrections shall not be made by using "white-out" or by otherwise attempting to obliterate the erroneous entry.
- b) If patient or his/her parent or legal guardian requests changes or alterations to his/her medical record, Medical Center HIPAA policy shall be followed.

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III. OTHER RULES AND REGULATIONS

A. Neonatal Intensive Care

1. All infants admitted to the Neonatal Intensive Care Unit (NICU) must be assigned to an appropriately credentialed pediatrician or neonatologist. Patients admitted by pediatric surgery or neurosurgery shall be followed by an appropriately credentialed pediatrician or neonatologist in addition to their attending pediatric surgeon or neurosurgeon.
2. Infants must be seen daily by their attending practitioner, who shall discuss management issues with the house staff and primary nurse.
3. Newborns with any of the following problems must be under the care of a certified neonatologist who shall evaluate the infant on a daily basis:
 - a) Birth weight less than 1500 grams
 - b) Gestational age less than 32 weeks
 - c) Progressive respiratory distress ($FiO_2 > 40\%$ for 12-24 hours, frequent apnea, etc.)
 - d) Ventilator assistance or CPAP
 - e) Chest tube or needle aspiration of pneumothorax
 - f) Bronchopulmonary dysplasia (unstable) requiring adjustment in oxygen, diuretics, steroids, bronchodilators
 - g) Intra-arterial pressure monitoring
 - h) Vasopressor support
 - i) Intravenous alimentation as the predominant source of nutrition
4. Newborns not meeting the above criteria may be on the service of a primary care pediatrician or pediatric surgeon. All such infants will have an initial consultation by the attending neonatologist with ongoing follow-up.
5. Newborns remaining or anticipated to be unstable should be under the care of the full-time neonatology attending staff.
6. Infants on the neonatology service no longer meeting the above criteria may be transferred back to the primary care pediatrician's service.
7. Decisions regarding transfer of care should be made with the mutual approval of the two pertinent practitioners and documented by an order on the patient's chart.
8. The full-time attending neonatologist shall have final authority over the appropriateness of such decisions.

B. Privileges in Pediatric Intensive Care

1. All patients admitted to the Pediatric Intensive Care Unit (PICU) shall have a multi-disciplinary, collaborative management approach. It is, therefore, a requirement that all

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Critical Care Division patients have their care supervised by an attending practitioner who is board eligible or board certified in Pediatric Critical Care and is a member of the Active Staff with privileges in Critical Care.

2. All patients admitted by a pediatric sub-specialist or surgeon may be cared for solely by that service if the admitting diagnosis or reason for admission is directly related to the sub-specialist's area of expertise. However, any patients having multi-system disease and/or significant instability will be co-managed in collaboration with the PICU service.
3. All patients will be seen and examined, and have their progress documented, at least daily, by their attending practitioner of record or a practitioner designated by the attending practitioner of record.
4. Primary care physicians are encouraged to maintain regular communications with the attending practitioner of record, and vice versa. Situations may arise where the direct input of the primary care physician would be valuable, at which time a consultation would be made by the attending practitioner of record.
5. The decision to transfer a patient from one service to another in the PICU must be agreed upon by the two attending practitioners involved and must be documented in the chart as an order which is timed and dated.
6. Any practitioner wishing to admit or transfer a patient to the PICU, regardless of the admitting service, will notify the attending physician for the PICU or the PICU nursing staff on duty at such time of the impending admission and confirm that bed space and staffing are available prior to initiating the process.

IV. AMENDMENTS

Rules & Regulations may be adopted, amended, repealed or added by vote of the Medical Staff Executive Committee at any regular or special meeting. Following approval by the Medical Staff Executive Committee, adoption of and changes to the Rules & Regulations shall become effective only when approved by the voting members of the Active Staff and the Board of Directors. Rules and Regulations may also be adopted, amended, repealed or added by the Medical Staff at a regular meeting or special meeting called for that purpose provided that the procedure used in amending the Medical Staff Bylaws is followed. All such changes shall become effective only when approved by the Board of Directors.

V. DEPARTMENTAL RULES AND REGULATIONS

A. Department of Pediatrics: All Divisions

1. The name of this organization shall be the "Department of Pediatrics at Connecticut Children's Medical Center.
2. Membership:
 - a) The Department of Pediatrics consists of pediatricians, family practitioners and other physicians practicing general pediatrics, sub-specialty pediatrics and adolescent medicine who are members of the Connecticut Children's Medical Staff. They are

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entitled to practice at Connecticut Children's only within the scope of their approved privileges.

- b) Applicants shall be interviewed by the Physician-in-Chief and the applicable Division Director.

3. Organization:

- a) The Department shall be directed by the Physician-in-Chief who is selected by the process outlined in the Medical Staff Bylaws.
- b) The duties and responsibilities of the Physician-in-Chief are as outlined in the Connecticut Children's Medical Staff Bylaws Article VII. Section 3, Paragraph 3.2.
- c) Department committees may be constituted as needed.
- d) The Physician-in-Chief shall notify the Department members of the time and place of the meetings.
- e) Special meetings may be called at any time by the Physician-in-Chief or by written request of 25% (twenty-five percent) of the Active Staff members of the Department.
- f) Twenty percent (20%) of the Active Staff membership of the Department shall constitute a quorum.
- g) Roberts Rules of Order (Revised), unless otherwise specified, shall govern all meetings of this Department.

4. Responsibilities:

- a) Documented CME activity of 50 AMA PRA Category I credit(s)TM over 24 months, of which a portion should support the privileges and mandatory CME courses as stated in the Connecticut General Statutes and Regulations.
- b) Attendance at meetings for Active Staff. Fifty percent (50%) of Department of Pediatrics/Division meetings unless formally excused.

5. General:

- a) The educational activities of the Department will adhere to state and federal guidelines and the policies as established by the Department.

B. Department of Pediatrics: Division of Community Pediatrics

1. The name of this organization shall be the "Division of Community Pediatrics in the Department of Pediatrics at Connecticut Children's Medical Center."

2. Membership:

- a) The Division of Community Pediatrics consists of pediatricians and family practitioners practicing general pediatrics and adolescent medicine in a community office setting providing complete well and sick child health care.
- b) Applicants shall be interviewed by the Director of the Division.
- c) Physicians in other sub-specialties who may request membership in the Division of Community Pediatrics shall be subject to the same procedure as applies to physicians for whom the Division of Community Pediatrics is their primary appointment.

3. Organization:

- a) The Division shall be led by a Director selected by the Physician-in-Chief.

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- b) Divisional meetings shall be held monthly; except for those months in which Department of Pediatrics meetings are scheduled. The Division Director shall notify the Division members of the time and place of the meetings.
- c) Special meetings may be called at any time by the Director or by written request of 25% (twenty-five percent) of the Active Staff of the Division.
- d) Thirty percent (30%) of the total voting membership of the Division shall constitute a quorum.

4. Responsibilities:

- a) Documented CME activity of 50 AMA PRA Category I credit(s)TM over 24 months, of which a portion should support the privileges and mandatory CME courses as stated in Connecticut General Statutes and Regulations.
- b) Attendance at meetings – 50% (fifty percent) of Division of Community Pediatrics meetings and 50% (fifty percent) of the Department of Pediatrics meetings.

C. Department of Surgery

1. The name of this organization shall be the "Department of Surgery of the Connecticut Children's Medical Center."

2. Officers:

- a) The Surgeon-in-Chief shall be selected according to Medical Staff Bylaws Article 7.3.3.
- b) There shall be an Associate Director-in-Chief.
- c) The Associate Director-in-Chief shall be appointed by the Surgeon-in-Chief.
- d) The duties and responsibilities of the Associate Director-in-Chief shall be assigned by the Surgeon-in-Chief at Connecticut Children's.

3. Organization:

- a) The Surgeon-in-Chief shall assign the members of the Active Staff to their various duties, including special assignments.
- b) The Surgeon-in-Chief shall preside over the Executive Committee of the Department of Surgery and Operating Room Committee.
- c) There shall be an annual Department meeting of all Active Staff members.
- d) The regular meetings of each Division shall be scheduled each month, except in the event of a holiday.
- e) A Morbidity & Mortality conference of each Division shall be held on a regular schedule, at which time all deaths and complications shall be reviewed and recorded. The minutes of each meeting will be forwarded to the Surgeon-in-Chief in each quarterly Department report.
- f) Special meetings of the Department of Surgery may be called at any time by the Surgeon-in-Chief.
- g) One-half of the total voting membership of the Department shall constitute a quorum. Five of the members of the Executive Committee shall constitute a quorum. If only four are present, the Surgeon-in-Chief may appoint a pro tem member of the Executive Committee.
- h) The place of each meeting is to be specified by the Surgeon-in-Chief, and it shall be the duty of the Executive Associate to the Surgeon-in-Chief to notify each member of the time and place of each meeting at least one week before the meeting is scheduled.
- i) An annual report of the Research activities shall be included in the annual report of the Department of Surgery.
- j) The Surgeon-in-Chief may, subject to approval of the Executive Committee of the Department of Surgery, establish or reverse policies for the operation of the

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Department. These changes shall be presented at the monthly Department meeting for approval.

- k) Should any elected office of the Department become vacant, it shall be filled at the next meeting of the Department by the same procedure as at the Annual Meeting.
- l) Vacancy in the position of Surgeon-in-Chief shall be filled according to the Medical Staff Bylaws, Article 7.3.3.
- m) Roberts Rules of Order (Revised), unless otherwise specified, shall govern all locations of this Department.

4. Executive Committee:

- a) The Surgeon-in-Chief and Associate Director-in-Chief shall be members of the Department of Surgery Executive Committee. The Surgeon-in-Chief shall act as Chairman of the Executive Committee. The Surgeon-in-Chief may appoint the Associate Director-in-Chief to serve as Chairman of the Department of Surgery Executive Committee.
- b) Each specialty Division in the Department shall appoint a representative to participate and attend each meeting.
- c) The Executive Committee shall be empowered to transact all business of the Divisions of the Department of Surgery and shall report to the Divisions for information and ratification
- d) The Executive Committee shall meet monthly.

5. Responsibilities:

- a) Documented CME activity of 50 AMA PRA Category I credit(s)TM over 24 months, of which a portion should support the privileges and mandatory CME courses as stated in Connecticut General Statutes and Regulations.
- b) Active Staff must attend 50% of the Morbidity & Mortality conferences conducted by the specialist Divisions.
- c) Staff members must attend any Morbidity & Mortality conference in which their patient is to be discussed (unless previously excused).

6. Resident Supervision:

- a) Residents enrolled in training programs in the Department of Surgery will assist in the care of patients admitted to the hospital under the supervision of the attending staff.
- b) Patients may enter the hospital with a pre-established practitioner who is a member of the attending staff of the Department of Surgery, and that practitioner will be responsible for the supervision of resident and student participation in the care of his/her patients.
- c) Patients who enter the Medical Center without a pre-established attending practitioner of record will have assigned a member of the attending staff of the Department of Surgery as the responsible supervising practitioner according to the call system published monthly. The responsible attending practitioner for these patients will be notified immediately of the admission of a patient to Connecticut Children's. The responsible attending surgeon will provide initial consultative guidance and assistance and will enter an "attending" admission note on the chart of all patients within 24 hours of admission. The attending surgeon will remain the responsible attending throughout the hospital stay of that patient unless this responsibility is transferred to another, and appropriately noted in the chart. The responsible attending surgeon will be informed and concur in advance and will be present and available in the hospital for all operative surgery.

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- d) For inpatients, the "bedside" supervision of residents in the care of patients is the responsibility of either the attending practitioner of record or the assigned attending practitioner, the overall responsibility for policies and lines of communication with regard to supervision rests with the Program Director of University of Connecticut School of Medicine.
- e) For Emergency Department patients, the attending physician in the Emergency Department is responsible for the overall care of the patient. When the Emergency Department attending requests a consultation, the supervision of the consultant resident or responding APRN or PA-C is the responsibility of the on-call specialty/subspecialty attending physician for the purpose of the requested consult.
- f) The practitioner of record shall provide written daily documentation of treatment plans and objectives on all hospitalized patients.

7. General:

- a) Physician Assistants and Nurse Practitioners shall be involved with the care of the patient in any role the supervising physician deems proper, provided that it is in accordance with the following: applicable State and Federal regulations, the Connecticut Nurse Practice Act; Connecticut Children's Medical Staff Bylaws; Peri-Operative Policies & Procedures. In all instances, Physician Assistants and Nurse Practitioners will work in accordance with their delineated privileges.
- b) Patients admitted by a member of the Courtesy Staff may be required to have a written pre-operative consultation by the Surgeon-in-Chief or his designee to determine the necessity and appropriateness of the proposed care or operation or both.

D. Residents:

All residents training at Connecticut Children's Medical Center will be supervised by faculty in all settings in such a way that the residents assume progressively increasing responsibility for patient care according to their level of training, experience, and ability. The faculty members responsible for the care in which the residents are involved determine the level of responsibility accorded to each resident. The on-call schedules for the faculty are structured to ensure that supervision is readily available to residents on duty at all times. Residents will perform procedures under supervision until they have been qualified by the faculty to perform the procedure without direct supervisory observation.

Faculty are responsible for the care of all patients and in each area of resident training have determined the timing and manner in which supervisory responsibility will be accomplished, by providing explicit guidelines for resident reporting and for the determination of resident level of involvement. This information is presented at orientation for each rotation for each resident, and it represents a specific set of expectations for each level of training in each setting of resident participation. It includes the order and timing of reporting to supervisory faculty.