THESE RULES AND REGULATIONS HAVE BEEN ADOPTED BY
THE MEDICAL EXECUTIVE COMMITTEE AND THE MEDICAL STAFF
FRANKLIN HOSPITAL

Signed

Chairman of the Medical Executive Committee

Signed

President of Medical Staff

As Amended through August, 2009
# INDEX

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. GENERAL POLICIES</td>
<td>3</td>
</tr>
<tr>
<td>B. ADMISSION AND DISCHARGE OF PATIENTS, INCLUDING</td>
<td>3</td>
</tr>
<tr>
<td>EMERGENCY PATIENTS</td>
<td></td>
</tr>
<tr>
<td>C. INFORMED CONSENT</td>
<td>6</td>
</tr>
<tr>
<td>D. HISTORY AND PHYSICAL EXAMINATION</td>
<td>8</td>
</tr>
<tr>
<td>E. MEDICAL RECORDS</td>
<td>10</td>
</tr>
<tr>
<td>F. GENERAL CONDUCT OF CARE</td>
<td>14</td>
</tr>
<tr>
<td>G. REGULATORY REQUIREMENTS</td>
<td>20</td>
</tr>
<tr>
<td>H. MISCELLANEOUS HOSPITAL AND PATIENT CARE REGULATIONS</td>
<td>22</td>
</tr>
<tr>
<td>I. HOME CARE PROGRAM</td>
<td>23</td>
</tr>
<tr>
<td>J. SUPERVISION OF RESIDENTS ROTATING THROUGH THE HOSPITAL</td>
<td>24</td>
</tr>
<tr>
<td>K. ADDITIONAL REFERENCE MATERIALS</td>
<td>26</td>
</tr>
</tbody>
</table>

As Amended through: August 2009
A. GENERAL POLICIES

1. In addition to the Rules and Regulations, hereinafter set forth, the New York State Hospital Code, and all federal, state and local statutory and administrative law pertaining to Hospitals, and Departmental policies and procedures, the practice of medicine, dentistry, podiatry and allied health professions shall also govern the actions of the Medical Staff.

2. It is incumbent upon every practitioner to comply with and participate in the quality management/performance improvement program which has been established to maintain quality patient care and ensure optimum utilization of hospital beds and medical services.

3. After a finding, in accordance with the procedures of Articles VIII of the Bylaws of the Medical Staff, that a Staff member has violated the following Rules and Regulations, the Staff member shall be subject to discipline, which may include restriction or withdrawal of privileges, and/or the possibility of non-reappointment.

4. In order to promote the advancement of better medical education and thereby increased quality of care, Medical Staff members are urged, although not required, to participate in the Hospital’s teaching programs.

B. ADMISSION AND DISCHARGE OF PATIENTS, INCLUDING EMERGENCY PATIENTS

1. FRANKLIN HOSPITAL (“Hospital”) shall accept patients for care and treatment appropriate to an acute care and rehabilitation hospital, irrespective of their race, color, creed, sex, national origin, sexual orientation, marital status, age, veteran’s status, disability, or the source of payment for their care, except that it may, in non-emergency situations, elect to exclude the prospective patient if:

   (a) the capacity of the Hospital has been reached as determined by the Medical Director, the Executive Director or designee, or his designee; or
   (b) such patient requires a type of medical service not authorized by the Hospital’s Operating Certificate; or
   (c) the admission of such patient would, in the opinion of the examining practitioner, and concurred in by the Director of the Department or the Director’s designee, endanger other patients.

2. Categories of medical conditions and criteria to be used to implement patient admission priorities shall be developed by each Clinical Department.

3. All patients may be included in the teaching program. A practitioner may exclude a patient from the teaching program when he or she considers such participation to be detrimental to the welfare of the patient or at the request of the patient.

4. (a) A patient shall be admitted to the Hospital only by a member of the Medical Staff with admitting privileges. The admitting practitioner must provide a provisional diagnosis and plan of care and adhere to the admitting policies and
procedures of the Hospital. In the case of an emergency admission, the medical record must clearly justify the patient’s emergency medical condition and such findings shall be recorded on the patient’s medical record as soon as possible after admission. All admissions are subject to review by the respective Department Director or Chief of Division or Service.

(b) The Hospital shall effectively meet the needs of the ambulatory care patient including providing for care in a continuous manner through the goal of assigning the same primary health care practitioner whenever possible. This health care practitioner shall be responsible for managing the care of the patient including the development of a written plan of treatment. Medical record documentation for patients receiving continuing ambulatory care services shall include a list of known significant diagnoses, conditions, procedures, drug allergies and medications.

5. Each member of the Medical Staff with admitting privileges must sign the New York State required “Notice to Physicians” acknowledgment pursuant to Sec. 405.3 of NYCRR Title 10.

6. Every patient of the Hospital shall have an attending physician who is responsible for the patient’s medical care and treatment while the patient is in the Hospital, for seeing the patient on a daily basis, for the prompt completion and accuracy of the medical record, for any necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Staff member, a note covering the transfer of responsibility shall be entered in the progress notes of the medical record.

7. All patients, regardless of source of payment, shall be treated by members of the Medical Staff who are assigned to such patient. As per the Director of the appropriate Clinical Department Director.

8. Practitioners admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm as well as protection of other patients, Hospital personnel and visitors from those who are a source of danger from any cause whatsoever.

9. Each practitioner must assure timely, adequate, professional care for his or her patients in the Hospital by being available or having available to his or her office an eligible alternate practitioner with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of the attending practitioner to meet these requirements may result in corrective action. In case of failure to make such arrangements, the Medical Director of the Hospital in consultation with the Director/Chief of the Department/Division shall have the authority to call upon a member of the staff to provide continuing medical care.
10. No person who presents for medical care to the Hospital shall be removed, transferred, or discharged for the purpose of effecting a transfer from the Hospital unless such removal or transfer is carried out after a written order made by the attending practitioner that in his judgment such removal or transfer will not create a medical hazard to the person, and that such removal or transfer is considered in the person’s best interest, despite the potential hazard of movement. Such removal or transfer shall be made only after prior notification to an appropriate medical facility and only with the consent of the patient or other individual authorized to consent on behalf of the patient.

11. The decision to discharge a patient must be made by the attending practitioner. A resident rotating through the Hospital or a physician’s assistant or physician coordinator may write a discharge order after discussion with the attending practitioner. The discharge note must be written on the day of discharge and shall include the condition of the patient on discharge and instructions given to the patient. Except when special circumstances exist, notice of discharge must be given to the patient at least one (1) day prior to the patient’s discharge. Within 24 hours prior to discharge the practitioner shall record the final diagnosis, and complete and sign the patient’s medical record. Residents rotating through the Hospital may complete the applicable final notes or discharge summaries, provided any such completed note or discharge summary is appropriately countersigned by the attending physician.

12. An unemancipated minor under eighteen (18) years of age shall be discharged only in the custody of his/her parent(s) or his/her legal guardian unless the parent(s), or guardian, shall otherwise direct in writing on a form approved by Hospital Administration.

13. No patient shall be detained in the Hospital against his/her will, nor shall a minor under eighteen (18) years of age be detained against the will of his/her parent or legal guardian, except as authorized by law. In no event shall a patient be detained solely for non-payment of the hospital bill or physicians statement for medical services. However, it is acceptable to attempt to persuade a patient to remain in the Hospital in the patient’s own interest. If there is a concern that the patient lacks capacity or that there is a concern that the patient may be a danger to himself/herself or others, the patient may be temporarily detained pending a prompt psychiatric evaluation and determination of the patient’s legal rights. If an adult patient lacks capacity for any other reason, and there is no legal guardian or properly designated health care agent, Administration shall be consulted. If a patient who has capacity insists upon being discharged against the advice of a member of the Medical Staff, the patient shall be requested to sign in the appropriate section on the Emergency Department and inpatient face sheet of the medical record (“Release When Patient Leaves Against Medical Advice”). The physician involved is responsible for documenting the facts and circumstances surrounding the act of the patient leaving the against medical advice. In the event the patient refuses to sign the form, the physician will document in the patient’s chart that the patient is leaving against medical advice.
and that the physician has explained the consequences of this action to the patient.

C. INFORMED CONSENT

These Rules and Regulations are a summary of the Administration Policy and Procedure regarding informed consent. Refer to this Policy or any other applicable Administration Policy and Procedure that may be promulgated for more specific details on informed consent policies.

I. General Requirements

(a) Upon admission the patient shall be requested to sign a general admission consent form. If the patient lacks capacity to provide the general admission consent, then the patient’s health care agent (if any), relative, parent (if the patient is a minor) or legal guardian should be requested to sign the general admission consent form.

(b) A properly designated health care agent may make any decision that a patient could make if the patient were capable of giving consent. Refer to the Administration Policy and Procedure regarding Advance Directives. Any questions concerning a health care proxy document shall be referred to Hospital Administration.

(c) Specific informed consent must be obtained by the member of the Medical Staff credentialed to perform a procedure, for all invasive procedures and/or procedures which bear risk to life or health or which involve anesthesia, analgesia or sedation, or which include the use of blood or blood products or which involve research. Also informed consent is required prior to administering an H.I.V. antibody test. The member of the Medical Staff shall document the informed consent discussion in the patient’s medical record.

(d) The informed consent discussion should include but not be limited to the following:

1. The procedure to be performed, which should be explained in simple language, understandable by a layperson.

2. A description of the attendant discomforts and risks, and the possible consequences.

3. A description of the benefits to be expected.

4. A description of the risks, benefits and the alternatives to the administration of blood and blood products, if applicable.
5. A description of the risks, benefits and alternatives to the use of anesthetics, analgesia or sedation which may be utilized in the performance of the procedure.

6. A disclosure of any appropriate alternative procedure(s) and attendant risks of each alternative.

7. A disclosure of the risks attendant to the refusal to agree to the performance of the procedure or the use of anesthesia, analgesia, or sedation and the administration of blood or blood products as the case may be.

(e) The Medical Staff member will be responsible for completing any required hospital forms in effect at the time the procedure is contemplated.

(f) The informed consent requirement may be waived or modified under the following circumstances:

1. In the case of a medical emergency, where in the judgment of the responsible Medical Staff member, the risk of delay is greater than the risk of proceeding, unless the Medical Staff member has knowledge that the patient would have refused the procedure or treatment in question.

2. When the Medical Staff member has reason to believe that the patient would suffer immediate and severe harm from a discussion of the patient’s condition and need for treatment.

II. Persons Qualified to Consent to Treatment

1. Persons with the capacity to make health care decisions who are eighteen (18) years of age or older may consent to their own treatment. If the responsible Medical Staff member is uncertain about a patient’s ability to consent to treatment, a psychiatric evaluation should be obtained.

2. A person with the capacity to make health care decisions who is under eighteen (18) years of age may consent to his/her own medical treatment if that person is a parent, is pregnant, has been married or is married or qualifies as an “emancipated minor”. An emancipated minor is a person who has not yet reached the age of eighteen (18), but who has assumed all of the responsibilities of adulthood, e.g., is self supporting, lives apart from parents or pays own living expenses in their parent’s home. The “emancipated minor” must be sufficiently mature and intelligent to give informed consent and the Medical Staff member must document the minor’s ability to consent to the treatment. A minor may consent to his/her own treatment which involves birth control, abortion, sexually transmitted disease or substance abuse treatment and the parents should not be notified of such treatment, unless the Medical Staff member is requested to do so by the patient.
3. Legal consent to treatment may only be given by a patient, a parent (if the patient is a minor), a properly designated health care agent, a legal guardian or a court appointed guardian.

III. Right to Refuse Treatment

1. An adult with the capacity to make health care decisions and an emancipated minor has the right to refuse treatment. This right includes the ability to refuse or request the withdrawal of life-saving treatment. A psychiatric consultation should be obtained if there is any doubt about a patient’s capacity to consent to or refuse treatment.

2. The Medical Staff member must fully document a patient’s refusal of treatment in the medical record. At a minimum, the member of the Medical Staff must document that he has explained the consequences of such refusal to the patient as well as an assessment by the Medical Staff member that the patient had the capacity to understand the nature and consequences of the refusal.

3. A Medical Staff member cannot deny lifesaving treatment to a minor even if a parent refuses to consent to the treatment.

D. HISTORY AND PHYSICAL EXAMINATION

1. The complete medical history and physical examination must be completed within twenty-four (24) hours of admission. If a complete history and physical examination has been obtained within thirty (30) days prior to admission, the requirement of the preceding sentence may be satisfied if a durable, legible copy of this report is placed in the patient’s hospital medical record at the time of, or prior to, any anticipated procedure provided that an update to the patient’s condition or a notation of no change has been recorded at the time of the admission or procedure. The admission history and physical examination, if recorded by a member of the graduate staff, physician’s assistant, or nurse practitioner shall be reviewed with and countersigned by the attending physician within twenty-four (24) hours of admission and prior to any major diagnostic or therapeutic intervention, but no later than twenty-four (24) hours of admission.

2. If the admission history and physical for an operative or invasive procedure is performed by a physician who is not a member of the Hospital’s Medical Staff, the Hospital shall independently confirm that the physician has a New York State license and is currently registered to practice medicine in the State of New York. The Hospital shall maintain documentation of such confirmation. The attending physician shall review and countersign the history and physical examination before the operation or procedure.
3. The physical examination shall include examination of the breasts and a screening cervical cytology smear on women 21 years and older unless the patient refuses or the examination is medically contraindicated. The cervical cytology smear may be deferred if one has been performed in the last three (3) years. Insofar as it is possible to identify patients who may be at risk for sickle cell anemia, all potentially susceptible patients including infants over six (6) months of age shall be examined for the presence of sickle cell hemoglobin unless testing has been previously performed. Results or refusal of these tests and examinations shall be recorded in the medical record.

4. When obtaining the admission history, the admitting physician shall inquire about the patient’s recent exposure to communicable diseases. Whenever there are positive findings, the physician shall take appropriate measures relative to the care of the patient and the protection of other patients and staff, which may include isolation of the patient.

5. When the history and physical examination, appropriate diagnostic tests, or informed consent are not completed before a surgical procedure, or any potentially hazardous diagnostic procedure for if the history and physical examination is required to be countersigned and such requirement has not been met, such procedure shall be canceled, unless, in the judgment of the surgeon or attending physician, it is determined that the risk of delay is greater than the risk of proceeding in the absence of conformity to such requirements and such determination is recorded on the patient’s chart and signed by such surgeon or attending physician.

6. (a) Attending physicians, dentists or podiatrists admitting patients for treatment based upon pathology reports prepared by pathologists not on the Medical Staff of this Hospital shall submit the pathology data (including slides of tissue sections) on which the results were based to the Hospital’s Department of Laboratories-Pathology for review by the Hospital’s pathologists prior to elective surgery or other major intervention (e.g., chemotherapy, radiation therapy). Exceptions to this rule must be justified in the chart by the responsible attending physician, dentist or podiatrist.

   (b) Attending physicians, dentists or podiatrists admitting patients for treatment based upon radiology tests conducted and reports prepared by physicians who are not on the Medical Staff of this Hospital or another Health System Hospital should provide a copy of the written report which accompanies such radiologic tests which will be included as part of the patient’s medical record. In lieu of the written report, the attending physician, dentist or podiatrist shall be required to document in the patient’s medical record prior to elective surgery or other major intervention a description of the report, including the test which was performed, the name of the party who performed the test and who issued the report, the date the test was performed and the findings and recommendations. Exceptions to this rule must be justified in the chart by the responsible attending physician, dentist or podiatrist and noted in the patient’s chart.
(c) All physicians, dentists and podiatrists admitting patients must include in
the record a summary of the indications for elective surgery or other major
intervention.

7. A New York licensed independent practitioner shall perform a medical history
and physical examination on a non-inpatient in accordance with the Hospital’s
Pre-surgical Testing Department’s History and Physical Policy and Procedure.

E. MEDICAL RECORDS

1. The practitioner of record shall be responsible for ensuring that the medical
record accurately reflects the patient’s medical condition (whether inpatient,
outpatient, emergency or home care). The contents of the record shall be
pertinent and current.

2. The attending physician shall be held responsible for the preparation of the
complete medical record for each patient. The medical record shall contain in
addition to the demographic data, an appropriate history (chief complaint, present
illness, past history, review of systems, allergies, current medications, family
history) and physical examination, provisional diagnosis, plan of treatment,
clinical laboratory reports, x-ray reports, consultations, medical and surgical
treatment, pathological findings, tissue report, progress notes, final diagnoses,
condition on discharge, discharge instructions, discharge summary and autopsy
findings, if performed.

3. The attending physician, dentist or podiatrist of record is responsible for
ensuring that the entries in the medical record reflect that the physician, dentist
or podiatrist of record is directly involved in the overall care of the patient.
Pertinent progress notes shall be recorded at the time of observation, sufficient to
permit continuity and transferability of care. 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 all patients.

4. Entries in the medical record must demonstrate that the physician, dentist or
podiatrist of record was directly involved in the overall care of the patient. All
clinical entries in the patient’s medical record shall be accurately dated, signed
and timed (signatures shall consist of the full last name and first initial of the
recording person) and be legible. If the entry reflects a prior encounter with the
patient, the date of such encounter should be reflected in the medical record.

5. Symbols and abbreviations may be used only when they have been approved
by the Medical Board. An official record of approved abbreviations shall be kept
on file in the Health Information Management Department, and on each nursing
unit.
6. A practitioner’s routine orders, when applied to a given patient, shall be reproduced in detail on the order sheet of the patient’s record, dated, timed and signed by the practitioner.

7. Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and shall be dated, and signed by the responsible physician at the time of discharge of all patients.

8. Any entries made in the medical record by medical, dental or podiatric students, shall be countersigned within twenty-four (24) hours by the attending physician, dentist or podiatrist of record (as applicable) or by a supervising resident who shall be at least at the level of a PGY-3 and shall be a licensed physician, dentist or podiatrist in accordance with New York State law.

9. Members of the Allied Health Professional Staff (who are appropriately credentialed and privileged: physician’s assistants, nurse practitioners and nurse midwives) and residents rotating through the Hospital may dictate discharge summaries, provided that such summaries are reviewed and countersigned by the appropriate attending physician of record. Nurse midwives may dictate a labor and delivery report, provided that such report is reviewed and countersigned by the appropriate attending physician of record. Nothing contained in this Section shall be interpreted to in any way change the attending physician’s ultimate responsibility for the patient’s care and the contents of the patient’s medical record.

10. Residents must be supervised by the attending physician, dentist or podiatrist of record or a designee. The attending physician or dentist is responsible for countersigning the history and physical written by a resident within twenty-four (24) hours. Further documentation in the medical record must evidence the level of involvement by the attending physician or dentist of record.

11. Notwithstanding the fact that a member of the Medical Staff may employ or otherwise supervise, in accordance with law, an individual who is a member of an allied health profession, such individual allied health professional may not have any patient care responsibilities for any Hospital patient nor make any entries in the medical record with respect to any Hospital patient unless such individual is separately and appropriately credentialed and privileged as a member of the Allied Health Professions Staff. Members of the Allied Health Professions Staff shall not act outside of the scope of their delineated clinical privileges, which shall be consistent with the legal authority governing their scope of practice. Physicians, dentists or podiatrists who supervise or collaborate with members of the Allied Health Professions Staff shall not delegate to these individuals responsibility for activities which are not consistent with their delineated clinical privileges as approved by the Medical Board and the Hospital’s Board of Trustees.

12. The following types of cases do not require a dictated final summary to complete the medical record:
- Ambulatory Surgery Cases
- Endoscopy cases
- Chemotherapy – less than 72-hour stay
- Hospital stays – less than 72-hour stay
- All behavioral health cases that have a written summary

Patients receiving hospice care and any patient who expires must have a dictated final summary.

Nonetheless, the medical record for such cases shall not be deemed complete unless it includes an appropriate entry by the responsible practitioner containing a discharge note with outcome of hospitalization, the disposition of the case, the condition at discharge, care, treatment and services provided, procedures performed and any provisions for follow-up care, and a final diagnosis.

12. All practitioners shall comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Hospital's policies and procedures governing patient confidentiality and the release of patient information.

13. Medical records may be removed from the Hospital's jurisdiction and safekeeping only as required or authorized by law. All records are the property of the Hospital and shall not be removed from the Hospital without permission of the Executive Director, or designee. In case of readmission of a patient, all previous records shall be available for the use by the practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of medical records from the Hospital by Staff members shall be grounds for disciplinary action.

14. Nothing contained in a patient’s medical record shall be removed from it. If an alteration needs to be made to an entry in a patient’s medical record, the practitioner who made the entry shall strike through, but not obliterate the erroneous notation, initial the error, a new entry shall be made to correct or alter a previous entry. If a physician wishes to revise a note previously written by a resident or a member of the Allied Health Professional Staff who is under his or her supervision, then the physician should enter a separate note, which outlines his or her own findings.

15. Medical records must accompany the patient at all times while the patient is in the Hospital.

16. All members of the Medical Staff and Allied Health Professional Staff shall maintain the confidentiality of their patients’ records and respect the confidentiality of the records of all patients of the Hospital.

17. Each member of the Medical Staff and Allied Health Professional Staff shall be given a password or other means of user identification ("Password"), which will allow the practitioner access to the Hospital’s information systems. No
practitioner shall give or disclose to another person, or allow another person to use the practitioner’s password(s), whether or not such other person is an authorized user on the Hospital’s information system in order to access protected health information. The assigned personal password constitutes the practitioner’s legal signature and the practitioner accepts full responsibility for all actions taken as a result of the use of the practitioner’s password. In the event that any practitioner reasonably suspects or becomes aware of any unauthorized disclosure or use of the practitioner’s password, the practitioner shall immediately report such unauthorized use or disclosure to the Medical Staff Office of the Hospital or Compliance Officer who shall take appropriate action. Each member of the Medical Staff and Allied Health Professional Staff shall log-off after use.

20. (a) Records of discharged patients shall be completed within thirty (30) days of such discharge.

(b) A medical record shall ordinarily be considered complete when the required contents are assembled and authenticated, including any required clinical resume or final progress note, and the recording, without use of symbols or abbreviations, of all final diagnoses and any complications. Completeness implies the transcription of any dictated record content and its insertion into the medical record.

(c) Suspension of privileges for incomplete medical records shall be imposed when:

(i) a Medical Staff Member has any incomplete medical records thirty (30) days after discharge of the patient, and he or she has been notified of the delinquent record(s).

(ii) a Member of the Graduate Staff has not completed a medical record within thirty (30) days after the patient’s discharge. Members of the Graduate Staff with incomplete medical records will be assigned to the Health Information Management Department until all of their incomplete records are completed, and shall be subject to such other sanction(s) as may be approved by the Medical Board and set forth in Medical Staff Bylaws.

(d) Repeated Suspensions: The Director of the Health Information Management Department shall report to the relevant Clinical Department Chair a physician’s pattern of repeated suspension for delinquent medical records. Such reports shall be included in the physician’s credentials profile and shall be considered as part of the recredentialing process, at the time that the physician applies for reappointment to the Medical Staff.

(e) Any suspension or other corrective action taken pursuant to this Section shall not give rise to the due process right granted to Medical Staff Members under Article VIII of the Bylaws of the Medical Staff.
F. GENERAL CONDUCT OF CARE

I. Orders

1. All orders for treatment shall be legible, and signed on the Order Sheet by an appropriately credentialed practitioner. Medication orders shall include the name of the drug, the strength expressed in the metric system, the dosage frequency, the route of administration and when indicated, the duration of therapy or number of doses to be administered. Written orders may be issued by a Medical Staff member, a resident, as well as a physician’s assistant, nurse practitioner, certified registered nurse anesthetist, and nurse midwife.

2. Telephone orders shall be used sparingly when the practitioner who is authorized to issue an order is not readily available on-site and shall not replace an appropriate medical assessment. Practitioners who are authorized to issue telephone orders shall include Medical Staff members, residents, nurse practitioners, certified registered nurse anesthetists (CRNA), physician’s assistants, and nurse midwives. A registered professional nurse (RN), a pharmacist, a member of the Allied Health Professional Staff can transcribe a telephone order when the order is within the scope of their practice or their clinical privileges, whichever the case may be. Telephone orders must be countersigned within forty-eight (48) hours by the ordering/supervising physician.

3. Verbal orders shall be issued primarily during an emergency by a member of the Medical Staff, a resident, Allied Health Professional Staff. Verbal orders can be accepted by a member of the Allied Health Professional Staff, a pharmacist, an RN, a respiratory therapist when the order is within the scope of their practice or their clinical privileges, whichever the case may be.

4. Telephone/verbal orders must be authenticated by the prescribing practitioner within forty-eight (48) hours of issuing the order.

5. When a medication ordered by a physician is unavailable in the Pharmacy, but a substitution is possible, the Pharmacist will contact the physician as to the use of the substitute medication. If the physician approves the use of a substitution, the pharmacist will transcribe the order from the physician to the order sheet to be countersigned by the attending physician within twenty-four (24) hours.

6. All drugs used shall meet the standards of the United State Pharmacopoeia, National Formulary, of new and non-official drugs, with the exception of drugs used in clinical investigation approved by the IRB and the Medical Board. When a practitioner prescribes a medication by trade name, he does so with the clear understanding and agreement that the Hospital Pharmacist may dispense a generically equivalent drug. Physicians are not limited to the Formulary where, in their judgment a specific medication is indicated.
7. The Anesthesiology Department alone is responsible for ordering preanesthetic medication for surgical patients; including, but not limited to, narcotics, barbiturates, benzodiazepines, belladonna drugs and other related preanesthetic drugs. The Anesthesiology Department is not responsible for preoperative orders, which are unrelated to the anesthetic management of the patient.

8. (a) Orders for antibiotics must be renewed every seven (7) days.

(b) All narcotics, sedatives and tranquilizers on the controlled substances list must be renewed every forty-eight (48) hours.

9. Requisitions for blood and blood products for transfusion shall include the indications for transfusion and the ordering physician.

10. Adequate provision for coverage during absences must be made by the attending physician, dentist or podiatrist in order to provide the patient with continuing care.

If the attending physician, dentist or podiatrist fails to make such arrangements to provide for coverage of his or her patients during an absence, the Medical Director in consultation with the Department Director or Division Chief shall have the authority to call upon a member of the staff to provide continuing medical care. This shall be done with the consent of the involved patient. The attending physician shall be so notified of such a coverage decision by either the Medical Director, the Department Director or Division Chief.

II. Surgical Services

1. The surgeon shall ascertain that a record of the following appears in the patient’s medical record.

(a) A medical history and physical examination, including the indication(s) for the procedure, are recorded within seven (7) days prior to the procedure.

(b) A preoperative diagnosis and appropriate diagnostic tests.

(c) A written, signed informed consent consistent with the requirements of Section C (2) of these Rules and Regulations. Written consent shall be obtained prior to the operative procedure except in those situations where the patient’s life is in jeopardy and suitable signature cannot be obtained. In emergencies involving a minor or unconscious patient, in which consent for surgery cannot be immediately obtained from a parent or guardian or next of kin, the circumstances shall be fully explained in the patient’s medical record.

2. A preanesthesia assessment shall be made to include medical history, prior anesthetics, allergies, medications, pertinent laboratory tests, physical findings
and baseline vital signs. The admitting history and physical will provide information for this assessment.

A determination shall be made whether or not the patient is a suitable candidate for the proposed procedure and anesthesia. It is understood that all laboratory data may not be available at the time of initial assessment and that the patient will be reassessed on the day of the procedure by the care team for completeness of preparation and any change in patient status. The patient will be reevaluated immediately before anesthetic induction.

3. The surgeon, anesthesia provider and nurses in the OR shall, prior to commencing surgery, verify the patient’s identity and the site and side of the body to be operated on in accordance with the site verification policy.

4. The Hospital’s separate specific regulations for preoperative prep and scrub techniques shall be strictly observed.

5. All preoperative orders are automatically canceled upon operation and new post-operative orders must be written immediately.

6. The anesthesiologist shall maintain a complete anesthesia record to include evidence of preanesthetic evaluation, intra-operative management, and post anesthetic follow-up of the patient’s condition.

7. All operations performed shall be fully described in the medical record in a dictated or written operative report by the operating surgeon immediately following surgery. The operative report shall include, at a minimum, the name of the primary surgeon and assistants, finding, technical procedures used, complications (if any), specimens removed, the general condition of the patient and the postoperative diagnosis. A completed medical record must include both the dictated operative report and post-op report found in the progress notes.

8. All anatomical parts, tissues, and devices removed at operation shall be delivered to the Hospital Pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. A report of the Pathologist’s findings shall be filed in the patient’s chart and a copy of such report shall be available to the Tissue Committee.

9. The anesthesiologist shall have overall responsibility for patient supervision in the Post Anesthesia Care Unit. Care related to the surgical procedure shall be taken care of by the surgeon and shall be available for such. All other care shall be coordinated by the anesthesia care team. The anesthesiologist is responsible for determining when a patient is sufficiently recovered to permit the patient’s transfer to the next level of care, e.g., ICU, step down unit, or floor bed.

10. The post procedure anesthesia note should be completed immediately at the end of the procedure.
III. Emergency Department Patients

1. A physician on call in the Emergency Department or a physician in response to his own private patient must respond by phone within ten (10) minutes and by physical presence in the Emergency Department within thirty (30) minutes. The physician in attendance may establish the urgency and recommend other time parameters for the physical presence of the on call physician or the physician referring a private patient to the Emergency Department.

2. Each attending physician shall be held responsible for the preparation of a complete medical record of each patient’s treatment.

3. The Emergency Department record is organized into three parts:

   • Section 1. Registration data, nursing notes, medications ordered and supplies utilized during the Emergency Department visit;

   • Section 2. Vital signs, physician history and physical, diagnosis, condition of the patient and physician signature;

   • Section 3. Aftercare instruction sheet.

IV. Dental Patients

1. Patients admitted to the Hospital by a member of the Dental Staff, except for oral surgeons, must have a physician on the Professional Staff attend the patient during his hospitalization.

2. The dentist’s responsibilities shall include, but shall not be limited to:

   (a) A detailed dental history;

   (b) A detailed description of the examination of the oral cavity and preoperative diagnosis;

   (c) A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the Hospital Pathologist for examination;

   (d) Progress notes as are pertinent;

   (e) Clinical resume or summary statement.
3. The responsibilities of the physician shall include, but shall not be limited to:

(a) Admission note and medical history pertinent to the patient’s general health;

(b) A physical examination to determine the patient’s condition prior to anesthesia and surgery;

(c) Supervision of the patient’s general health status while hospitalized;

(d) Medication orders;

(e) Discharge summary.

V. Podiatric Patients

(a) All podiatric patients shall be admitted by and under the supervision of a physician member of the Medical Staff, but the discharge of the patient shall be on the written concurrence of both the podiatrist and the physician involved.

(b) The responsibilities of the podiatrist shall include, but shall not be limited to:

(i) A detailed podiatric history and physical examination to justify hospital admission; and

(ii) Completion of all appropriate elements of the patient’s medical record, including any orders for medication and treatment consistent with regulatory requirement and the policies of the Medical Staff and the recording of such progress notes as are pertinent to the podiatric condition.

(c) The responsibilities of the physician shall include, but shall not be limited to:

(i) Medical history pertinent to the patient’s general health.

(ii) A physical examination to determine the patient’s condition prior to the podiatric procedure or treatment.

(iii) Supervision of the patient’s general health status while hospitalized.
VI. Consultants

1. Except as otherwise provided for by the Medical Board, any qualified practitioner with appropriate clinical privileges in this Hospital may be called for consultation within his or her area of expertise.

2. The attending practitioner is primarily responsible for requesting the consultation when indicated and for calling in a qualified consultant. The request for consultation and the consultation report itself shall be made upon the Hospital’s form for this purpose, which is available at each Nurse’s Station and shall then be incorporated into the patient’s medical record.

3. Except in an emergency, consultation is indicated in the following situations, but shall not be limited thereto:

   (a) In cases where the scope of care needed by the patient is beyond the delineated clinical privileges of the practitioner;

   (b) In unusually complicated situations where specific skills of other practitioners may be needed;

   (c) In instances in which patients on non-psychiatric units exhibit suicidal tendencies or other severe psychiatric symptoms;

   (d) For conditions recommended by the Bureau of Maternal and Child Health of the State Department of Health;

   (e) When a patient is a poor surgical risk and the patient requires medical clearance prior to the performance of the surgical procedure;

   (f) When the diagnosis is obscure;

   (g) When there is doubt as to the best therapeutic measures to be utilized;

   (h) When the proposed treatment may involve significant hazard to the patient;

   (i) When requested by the patient or the patient’s family; or

   (j) Those situations specifically designated elsewhere in these Rules and Regulations, or in the Regulations of the various Clinical Departments or Special Care Units.

4. Consultations by physicians, dentists or podiatrists not on the Medical Staff must be consistent with the requirements of Article IV of the Medical Staff Bylaws regarding Visiting Pro Tem physicians.
5. A satisfactory consultation shall require that the consultant review the patient’s medical record and conduct a physical examination of the patient. A written opinion, signed by the consultant must be entered legibly in the patient’s medical record. Except in an emergency, when operative or invasive procedures are involved the consultation shall be recorded in the patient’s medical record prior to the performance of the surgical or invasive procedure.

G. REGULATORY REQUIREMENTS

1. Medical Examiner. The physician of record is responsible for reporting to the Medical Examiner’s Office all deaths that might fall under the purview of the Nassau County Medical Examiner. The following cases must be reported to the Medical Examiner: (a) deaths by homicide or suspicion of homicide, including automobile homicide in cases possible criminal negligence; (b) deaths by suicide or the suspicion of suicide; (c) deaths due wholly or in part by accidents, including industrial accidents; (d) maternal deaths involving abortion except for therapeutic abortions; (e) deaths due to poisoning or suspicion of poisoning, including chemical and bacterial food poisoning and industrial poisoning; (f) deaths which occurred in any unusual, peculiar or suspicious manner or deaths which were not attended by a physician; or (g) deaths during the performance of a surgical procedure. The Nassau County Medical Examiner shall be contacted if there is any question as to whether a case is reportable. It is the responsibility of the attending physician, dentist or podiatrist to notify the family that the patient’s death was reported to the Medical Examiner. Permission for autopsy should not be sought until it is determined that the death is not reportable to the Medical Examiner.

2. Infection Control. Members of the Medical Staff, the residents, and the Allied Health Professional Staff shall comply with all infection control regulations to prevent the transmission of infection. Additionally, members of the Medical Staff, residents and the Allied Health Professional Staff shall report any infections to the Department of Pathology-Laboratories and the Division of Infectious Diseases so that appropriate action may be taken.

3. Safe Medical Device Reporting. The members of the Medical Staff, the residents, and the Allied Health Professional Staff will comply with the Medical Center’s Medical Device Reporting Program, which was established to identify medical device related incidents in order to initiate corrective action and comply with the reporting requirements of the Safe Medical Devices Act of 1990. The members of the Medical Staff, the residents, and the Allied Health Professional Staff shall report any such potentially reportable incident to the Department of Risk Management.

4. Department of Health Incident Reporting. The members of the Medical Staff, the residents, and the Allied Health Professional Staff will assist the Department of Risk Management to ensure compliance with the New York State (NYS)
Health Code requirement that certain types of incidents be reported to the NYS Department of Health under NYPORTS.

5. **Child Abuse and Neglect.** Members of the Medical Staff and residents and the Allied Health Professional Staff shall be responsible for reporting suspected abuse and/or neglect of children as soon as possible to the Child Protective Services, Central Registry for Mandated Reporters. The Hospital Department of Social Work should be contacted to facilitate this reporting.

6. **EMTALA.** The Emergency Treatment and Active Labor Act (EMTALA) (along with corresponding regulations) is a Federal statute, which applies to all Medicare participating hospitals. The Hospital shall comply with EMTALA in accordance with the Hospital’s EMTALA Policy and Procedures.

7. **Mass Casualty and Disaster Planning.** Physicians shall be assigned to all posts, either in the Hospital or in the auxiliary hospital, or in mobile casualty stations and it is their responsibility to report to their assigned stations. No physician shall perform any duties other than those assigned. The Directors of Emergency Medicine and Surgery in the Hospital and the President/CEO of the Hospital will work as a team in coordinating activities and directions. In case of evacuation from Hospital premises, the Directors of the Medicine and Surgical Services during the disaster will authorize such movement of patients as directed by the President/CEO. All policies concerning patient care will be the joint responsibility of the Chiefs of Medical and Surgical Services and the President/CEO of the Hospital. In their absences, the Deputy Directors of the aforementioned medical staff departments and the designee of the President/CEO shall function in their stead. All professional staff of the Hospital, in cases involving mass casualties and disasters, shall relinquish the direction of the professional care of their patients, service and private, to the Director of Emergency Medicine, Medicine and Surgical Services.

8. **Do Not Resuscitate Orders (DNR).** With the exception of minors, any patient, if capable of making medical decisions, can request a DNR order. This should be done in writing and the patient’s signature shall be obtained. If a patient does not have capacity to make medical decisions, NYS law allows a surrogate to make the decision. Please consult Administration Policy and Procedure for further information on surrogate decision-making. If the attending physician does not agree with the patient’s or surrogate’s decision, the physician shall arrange for the patient to be transferred to the care of another physician. Any disputes shall be referred to the Medical Ethics Committee. When a patient or surrogate consents to the issuance of a DNR order, said order shall be entered on the order sheet by the physician. When any intervening procedure, either medical or surgical is being considered by the patient or surrogate (if applicable), a previously valid DNR is superseded by the informed consent for the procedure signed by the patient or surrogate. The informed consent shall include a definitive statement, signed by the patient or surrogate (if applicable) stating whether resuscitative measures should be performed during the performance of the procedure. After the procedure is performed, the physician will re-discuss the
issue of DNR with the patient or surrogate and enter an appropriate order. NYS law also makes provisions for patients to orally enter a DNR order. The NYS law also recognized out of hospital DNR orders. For additional details refer to Hospital Administration Policy and Procedure. DNR orders shall be reviewed every seven (7) days and re-ordered in accordance with the wishes of the patient or surrogate.

H. MISCELLANEOUS HOSPITAL MEDICAL CENTER AND PATIENT CARE REGULATIONS

1. Transfer of the care of a patient from one member of the Medical Staff to another must be indicated in the medical record by a signed note certifying the consent of the involved members of the Medical Staff. The Admitting Office shall be notified of such transfers.

2. The use of restraints, or the placement of a patient in seclusion, may only be accomplished by physician order. The order must be written to comply with Patient Care policies and procedures, where applicable, and the policies and procedures promulgated by the Department of Psychiatry.

3. Medical Staff members are expected to refer their patients who may need social service assistance, alternate level of care placement, or home care assistance to: Social Work Department.

4. When a patient dies, the patient shall be pronounced dead by the attending practitioner or designee. The attending practitioner, or physician designee, is responsible for making the appropriate entry in the patient’s medical record, for completing the death certificate and for notifying the next of kin. If the attending practitioner, or designee, is unable to contact the next of kin within eight (8) hours of the patient’s death, the attending shall notify Hospital Administration.

5. In cases which an autopsy is indicated for diagnostic purposes, quality monitoring, or education, Medical Staff members must attempt to secure consent for autopsy from the legal next of kin. Whenever autopsy consent is refused by the next of kin, the responsible medical staff member must document that a request for autopsy was made. All autopsies shall be performed at a system teaching hospital and records are maintained at Franklin Hospital Pathology Department. While an autopsy should be contemplated in every death, the following criteria define those cases where an autopsy is specifically indicated:

(a) Cases in which the cause of death is obscure;

(b) Cases involving possible infection where there may be implications concerning hospital staff of family members of the patient;

(c) Case involving rare or unusual disease providing considerable educational value.
6. Members of the professional Staff shall conform to the rules of the departments of Laboratories and Radiology as approved by the Medical Board.

7. Hospital supplies and equipment are exclusively for the use of registered patients and are not to be removed from the Hospital without the approval of Hospital Administration.

8. Members of the Medical Staff, residents, and the Allied Health Professional Staff are expected to cooperate as defined in the Hospital's Disaster Plan in any emergency or local disaster requiring the presence of the Medical Staff, residents, and the Allied Health Professional Staff.

9. Diagnosis or other clinical data shall not be discussed in elevators, corridors, or any other public place where such conversations may be overheard.

10. The Hospital has been designated as a “Smoke Free” hospital. The rules of the Hospital in regard to “No Smoking” shall be observed by all members of the Medical Staff.

11. Patients shall be discharged by written order by the attending physician. In unusual circumstances, the discharge order can be issued over the telephone subject to the countersignature requirements addressed previously.

12. Consistent with the Hospital’s policy of respect for the individuality and dignity of its patients, the Medical Staff endorses those “Patient’s Bill of Rights” as promulgated by the New York State Department of Health, and the New York State Office of Mental Health.

13. No physician shall be required to give advice regarding termination of pregnancy nor shall the physician be required to participate in the performance of this procedure. However, the physician shall be required to assist in transferring the patient to another physician who will provide the requested services.

14. The primary mechanism to address patients’ and staff needs for resolution of issues relating to the ethical and caring treatment of the patient shall be the responsibility of the Medical Staff member in consultation with the patient and/or family and, if necessary, with his or her Department Director/Division Chief. Additional counsel of the Medical Ethics Committee may be sought.

I. HOME CARE PROGRAM

1. A written plan of care shall be developed for each patient who is a candidate to receive home care services after hospital discharge. This plan will be based upon assessment of the patient’s post hospital home care needs by the appropriate staff and the physician who has primary responsibility for the patient.
2. During the patient’s hospital stay, this plan shall be periodically re-evaluated by staff in collaboration with the patient’s primary physician. The essentials of the written plan of care shall be made part of the patient’s medical record.

3. Patients may choose to receive home care services from any provider for reasons of preference, insurance coverage, or residence outside of the home care department’s catchment area. Notwithstanding section I.(1) and I.(2), the assigned clinical care coordinator shall make the necessary home care arrangements to reflect the patient’s choice.

4. After the patient is discharged from the Hospital into a home care program, a visiting nurse shall maintain regular contact with the primary physician to report on the patient’s progress. The primary physician, in consultation with the home care staff shall be responsible for the home care services plan and for the decision to discharge the patient from home care. Additionally, the primary physician will collaborate with the visiting nurse to develop a post home care plan when home care services are terminated.

J. SUPERVISION OF THE RESIDENTS ROTATING THROUGH THE HOSPITAL

1. Residents are given patient care responsibilities commensurate with their individual level of training, credentialing, experience and capability as determined by the chiefs of the respective clinical departments but they function under the direct supervision of a member of the Medical Staff. Resident may not admit patients to the Hospital. In all matters of an individual patient’s care, the attending physician is always responsible for the performance of the residents. Physical examinations, daily visits, orders, progress notes, recording of histories or other assigned medical care responsibilities performed by resident does not preempt the attending physician’s ultimate responsibility for the care of each patient.

2. The attending physician, podiatrist, or dentist is responsible to ensure that all decisions and determinations as to patient care are reflected in the treatment plan as written in the progress notes of the patient’s medical record. The treatment plan is the written vehicle through which communications among those attending physician(s), dentist(s), podiatrist(s) and residents involved in the patient’s care is enabled. Therefore, all relevant information must be clearly and thoroughly documented. The following requirements apply to treatment plans:

   (a) The treatment plans and any significant modifications must be addressed with the resident responsible for the patient’s care and approved by the attending physician(s), podiatrist(s), and dentist(s).

   (b) The treatment plan must be reviewed in accordance with the patient’s condition and can only be amended by the written authorization of the attending physician, dentist or podiatrist. A resident may only amend the treatment plan without consulting with the responsible attending when he or
she determines that an emergency exists. The amendment must be documented in the medical record, and the attending physician, dentist, podiatrist is notified within twenty-four (24) hours.

3. Supervision by the attending surgeon of the care provided to surgery patients by residents must be documented and include at least the following:

   (a) personal supervision of all surgical procedures requiring general anesthesia or which are performed in an operating room;
   (b) preoperative examination and assessment;
   (c) postoperative examination and assessment at least daily.

4. On-Call procedure:

   (a) Emergency Department – patients who present to the Emergency Department have to be evaluated by the Emergency Department attending physician.

      (i) Orthopedic Patients – the on-call orthopedic resident shall be called to evaluate the patient and then the on-call orthopedic attending physician shall be called.

      (ii) Surgical Patients – the on-call surgical resident shall be called to evaluate the patient and then the on-call surgical attending physician shall be called.

   (b) Inpatient Services

      (i) Orthopedic – when an inpatient requires orthopedic intervention, the orthopedic on-call resident shall be called to evaluate the patient. All non-orthopedic problems for orthopedic patients shall be referred to the house physician.

      (ii) Surgical – for surgical inpatients for whom the attending surgeon has authorized the residents to follow the patient, the on-call surgical resident shall be called and then the attending physician. For surgical patients of those attending surgeons who do not want their patients followed by the residents as part of the teaching program, the attending surgeon shall be contacted. All non-surgical problems shall be directed to the appropriate specialist on the case.

   Involved Department Directors/Division Chiefs are responsible for monitoring patient care services provided by residents to assure provision of quality patient care services within the scope of privileges granted to such trainees and responsibility for assuring corrective measures and/or disciplinary action when such services provided exceed the scope of privileges granted.
5. Within the context of the residency-training program, documentation in the patient’s medical record shall reflect the following requirements:

(a) When complex surgery or high risk procedures are performed by residents, documentation by the attending surgeon in the medical record must reflect that the attending surgeon was physically present during the key portion of the performance of the surgery or high risk procedures. Documentation must also reflect that the attending surgeon was immediately available to furnish services during the entire surgery or procedure.

(b) When endoscopic procedures are performed by residents in a teaching setting the attending physician must be present during the entire viewing. The entire viewing includes insertion and removal of the device, and the documentation in the medical record by the attending physician must reflect this fact.

(c) When radiologic procedures are performed by residents, documentation must reflect that the physician personally performed the interpretation of the test or reviewed the resident’s interpretation with the resident. Countersignature is not adequate documentation of attending physician supervision.

6. The Program Directors of the Hospital’s Graduate Medical education programs are responsible for ensuring compliance by Medical Staff Members with the supervision requirements of these Rules and Regulations and with the regulations applicable to supervision of residents.

K. ADDITIONAL REFERENCE MATERIALS

1. In addition to the Bylaws, Rules and Regulations promulgated herein, the members of the Medical Staff, the residents and the members of the Allied Health Professional Staff are bound to comply with all other policies and procedures that are currently in effect or that may hereinafter be developed by the Hospital, including those developed by their Department Director. The following is a list of documents, which are readily available on the nursing units and should be sought when questions related to their subject matter arise.

(a) Administration Policy and Procedure Manual
(b) Nursing Policy and Procedure Manual
(c) Infection Control Policy and Procedure Manual
(d) Safety Manual
(e) Emergency Operations Plan