

## **CONNECTICUT VALLEY HOSPITAL RULES AND REGULATIONS OF THE MEDICAL STAFF**

### **Preamble**

The Medical Staff of Connecticut Valley Hospital (CVH) shall review its Rules and Regulations at least biannually, and shall review and/or modify them whenever the results of Performance Improvement activities or changes in the accepted standards of care suggest such a need. Any member of the Medical Staff may propose a review of the Rules and Regulations during a regular Medical Staff meeting or by a written request of the Executive Committee of the Medical Staff and subsequent approval by the Governing Body. Amendments to the Rules and Regulations shall be accomplished by means of a majority vote at the Executive Committee of the Medical Staff meeting with subsequent approval by the Governing Body

Any Rule or Regulation that is inconsistent with appropriately approved revisions or amendments to the Medical Staff By-Laws shall be considered repealed once the change in Medical Staff By-Laws becomes effective.

Nothing in these Rules and Regulations shall prohibit the Hospital administration from establishing Policies and Procedures to facilitate the efficient management of patient care services, or from complying with government and departmental regulations, except that: (1) such policies shall occur only after consultation with the Medical Staff Executive Committee, (2) such policies shall be clearly communicated to the Medical Staff in writing, and revised texts of such shall be supplied, and (3) such policies shall be consistent with ensuring professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff.

As a condition of appointment to the Medical Staff, members agree to abide by the provisions set forth in the Medical Staff Bylaws, Rules and Regulations and Hospital Policies and Procedures.

### **ARTICLE I: MEETINGS**

1. As a condition of appointment to the Active Medical Staff, members agree to actively participate in Medical Staff meetings and committees. Participation in such committees helps fulfill the Medical Staff's obligation to assure the quality of care to the patients of Connecticut Valley Hospital.
2. Attendance requirements for Medical Staff and committee meetings are stipulated in Article XII of the Connecticut Valley Hospital Medical Staff By-laws.
3. It is recommended, but not required, that each Active member of the Medical Staff serve on at least one (1) Medical Staff or Hospital committee. Attendance requirements at committee meetings shall be the same as that for Medical Staff Meetings.

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### **ARTICLE II: ADMISSIONS**

1. All patients shall be assigned an Attending Psychiatrist on admission. This individual shall be responsible for all the clinical care rendered to his/her patient and shall be the clinical supervisor to all members of the treatment team.
2. All patients shall have a psychiatric history and mental status examination completed and entered into the record within 24 hours of admission. This shall be completed by the attending psychiatrist or, in his/her absence, a covering physician.
3. All patients shall have an admission medical history and physical examination completed and entered into the record within 24 hours of admission. This medical history and physical examination shall be completed by a physician or an advanced practice registered nurse (APRN) or a physician assistant. If the examination is performed by the Night & Weekend Duty physician, the regularly assigned Ambulatory Care Services (ACS) physician, shall review the history and physical on the next business day and take further action as appropriate, providing documentation of the same in a progress note (see Article X, section 6 for further details). The history and physical examination shall include an assessment of pain (see Article X, section 10 for further details).
4. Patients shall be admitted to the hospital pursuant to state law by a physician member of the Medical Staff. All admissions shall be in accordance with the established admission criteria of the hospital.
5. The Attending Psychiatrist shall be responsible for the diagnostic formulation and all attendant care and treatment of each patient at the hospital, for necessary special instructions, for transmitting reports of the condition of the patient to referring professionals and to relatives of the patient, for assuring continuity of care upon transfer or discharge of each patient.
6. No patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated.
7. Psychiatric diagnoses should be clinically justifiable and consistent with current assessments and in accord with criteria contained in the most current Diagnostic and Statistical Manual of Mental Disorders.
8. Differential diagnoses, "rule out" diagnoses and diagnoses listed as "Not Otherwise Specified" will be addressed in a timely fashion through the use of clinically appropriate assessments and resolved to the extent possible in a clinically justifiable manner. In the use of "Not Otherwise Specified" diagnoses, the presentation may conform to the general symptom pattern but may not meet criteria for the specific disorder or there has been insufficient opportunity for data collection or inconsistent information to allow for more specification.

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9. A routine electrocardiogram (EKG) shall be performed within 10 days of admission for all patients over age 40. This requirement may be waived if the patient has no symptoms of heart disease and there is documentation of an EKG obtained within the past six months. Before initiating any potentially cardiotoxic medications, physicians shall consult the Pharmacy & Therapeutic Committee's Drug Utilization Guidelines for EKG recommendations.
10. All women of childbearing potential who are admitted to CVH shall have a pregnancy test performed as part of their initial laboratory assessment.

### **ARTICLE III: DISCHARGES**

1. Patients shall be discharged only on a physician's order.
2. Discharge plans including arrangements for follow-up care, as appropriate, must be completed for each patient discharged. The Attending Psychiatrist is responsible for assuring that continuity of care will occur and that referrals have been properly completed.

### **ARTICLE IV: MEDICAL RECORDS**

1. All medical records shall be the property of Connecticut Valley Hospital and shall not be removed from the Hospital.
2. Each member shall be responsible for maintaining complete and legible records for each of his/her patients.
3. The admission psychiatric evaluation shall include a preliminary treatment plan.
4. A Master Treatment Plan (MTP) shall be completed under the direction of the Attending Psychiatrist within 10 days of admission or transfer of a patient. This master treatment plan shall be based on the assessments completed by all members of the treatment team including, nurses, social workers, psychologists, Ambulatory Care Services physician, dietitians and/or other allied health professionals as stipulated by hospital policy.
5. Progress notes shall be entered into the medical record of each patient by the psychiatrist on a weekly basis for the first 8 weeks after admission and monthly thereafter in the General Psychiatry Division and the Whiting Forensic Division. In the Addictions Services Division progress notes shall be entered into the medical record of each patient three times per week for the first two weeks and then twice weekly thereafter. The Attending Psychiatrist will document treatment rendered to his/her patients and will indicate progress made towards treatment goals.

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6. All progress notes shall be legible and shall be signed, dated, and timed in accordance with Health Information Management requirements.
7. At the time of discharge, the Attending Psychiatrist or covering physician shall be responsible for completeness of the clinical material in the patient's record, that the final diagnosis has been stated, and that all records have been duly signed within thirty (30) days of discharge.
8. In the case of the readmission of a patient, all previous records on file shall be made available for the use of the Attending Psychiatrist and other members of the treatment team. This shall apply whether the patient is being attended by his/her previous psychiatrist or another.
9. All members of the Medical Staff shall familiarize themselves with and adhere to the Health Information Management guidelines for timeliness of completion of required documentation.
10. Abbreviations, symbols, and acronyms that have been approved by the Medical Staff shall be the only abbreviations, symbols, and acronyms used in the medical record. Abbreviations, symbols, and acronyms shall have only one meaning. Only standard abbreviations, symbols, and acronyms as approved by the Medical Staff shall be used when writing medication and other orders. An official list of prohibited abbreviations, symbols, and acronyms and an approved legend of the same shall be kept on file. Each physician shall be given a copy of both lists. The only exception shall be generally accepted English abbreviations such as for the months of the year, days of the week, etc.
11. Diagnostic nomenclature shall be that used in the Diagnostic and Statistical Manual of Mental Disorders- IV (DSM-IV) or future revisions published by the American Psychiatric Association; and the latest edition of the International Classification of Diseases published by the United States Public Health Service.
12. A progress note shall be entered in the medical record by the Attending Psychiatrist assigned and/or ACS clinician whenever a patient is discharged, sent to, or returned from another hospital or hospital ER that clarifies the rationale for the assessment, or diagnostic evaluation received, the therapeutic interventions rendered, and the recommendations provided for follow-up care. After hours, this function is provided by the covering physician.
13. The Medical Staff complies with the relevant Section of the General Statutes of Connecticut (CGS Chapter 899) concerning the confidentiality of patient records, Federal Confidentiality Regulations (CFR 42, Part 2) concerning confidentiality of alcohol and drug dependency records, as well as all Health Insurance Portability and Accountability Act (HIPAA) requirements.

**ARTICLE: V. PHYSICIAN ORDERS**

1. All orders for medication and treatment shall be recorded in the medical record on the physician's order sheet. All orders should include the required components specified in the HIM policy 2.23 Physician Orders and Pharmacy Policy 5.4 Physician Order Sheet. These components include the name of the medication, form of the medication, dose, time the medication is to be given, duration and indication for use.
2. Except for Schedule II Drug orders (narcotics), orders may be given verbally to a Registered Nurse by the responsible ordering clinician.
3. Telephone or verbal orders given to a Registered Nurse shall be signed by the nurse with the name of the ordering clinician, and shall be read back by the nurse to the ordering clinician after the verbal order has been transcribed, so as to assure accuracy. The ordering clinician must sign, date, and time all telephone and verbal orders within 24 hours. Repeated failure to sign, date, and time verbal or telephone orders may result in the loss of ability to give such orders. Physicians may countersign any verbal/telephone order. Please note that telephone orders for seclusion and restraint must be assessed and signed within one hour. Telephone/verbal orders should be reserved for appropriate situations and not merely used for staff convenience. Generally, these orders should be reserved for situations where the physician is not physically on the unit, or where the chart is not available, and when delay in giving the order will have a negative impact on patient care.
4. Certain defined "critical test results" shall be subject to the "read back" procedure described in section 3 above. Any laboratory result defined as a "critical laboratory value," as established by the Department of Ambulatory Care Services in collaboration with the Hospital's contracted clinical laboratory, any test or procedure ordered STAT, and the result of any test or procedure verbally communicated to the unit of care by the party responsible for carrying out the test or procedure shall be transcribed into the medical record by a Registered Nurse and read back to the reporting party so as to assure accuracy. The Registered Nurse shall immediately notify the physician of record and document such in the medical record.
5. All written orders shall be legible and written in ink or typed, and shall include the date and time of the order. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the nurse.
6. All medication orders must be reviewed and renewed at least every 30 days.
7. CVH Practitioners with prescriptive authority are prohibited from prescribing for anyone other than CVH patients utilizing CVH prescription pads.

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#### **ARTICLE VI: PSYCHIATRIC CARE**

1. Psychiatric care will be based on the documentation and integration of assessments and ongoing reassessments. This care will be reflected in Treatment Plans. The attending psychiatrist is the clinical leader of the team.
2. The care will be reflected in documentation in progress notes and clinical summaries of developments in the individual's clinical status and appropriate psychiatric follow-up.
3. The psychiatrist will document timely and justifiable updates of diagnosis and treatment as clinically appropriate, and these changes will be reflected in the Treatment Plan.
4. The documentation will reflect analyses of risks and benefits of chosen treatment interventions and consideration of the integration of psychiatric and behavioral/psychosocial treatments.
5. The psychiatrist will pay particular attention to high risk behaviors, for example assaults, self harm, suicidality, falls, and include appropriate and timely monitoring of individuals and documentation of interventions to reduce risks.
6. The prescriber will document responses to and side effects of prescribed medications (see Article VII and HIM Manual).

#### **ARTICLE VII: MEDICATION**

1. Drug use shall meet the standard of the U.S. Pharmacopoeia, National Formulary, or New and Non-Official Drugs, with the exception of drugs used in bona fide clinical investigations approved by the Research Committee. The Hospital formulary is a listing of drugs and dosage forms selected by the Pharmacy and Therapeutics Committee and considered most useful therapeutically at this Hospital from among the numerous medicinal agents available. The formulary indicates to the Medical Staff, the nursing staff and the pharmacy staff the therapeutic agents officially approved for use in the Hospital, together with the composition, strengths, and routes of administration. Drugs listed in the formulary are also listed by generic name. The Hospital Pharmacy is given permission by the Medical Staff to dispense the generic preparation whenever a staff member prescribes by the proprietary title, unless concurrently with the writing of the medication order, the physician indicates that the brand name product only shall be dispensed. The Pharmacy and Therapeutics Committee shall approve every drug to be used at Connecticut Valley Hospital, subject to the final approval of the Medical Staff. A copy of the Hospital formulary shall be maintained in the Hospital's pharmacy and at each nursing station and by each physician. Non-formulary medications may be ordered in accordance with policies established by the Pharmacy and Therapeutics Committee.
2. Psychotropic medications shall be used only when clearly indicated, at the lowest dosage producing the desired effect, and only as long as clinically indicated. Each patient, and/or conservator, if applicable, will be fully informed about all medications and must participate in discussion concerning medications. Medications should be matched to current, clinically justifiable diagnoses and prescribed at therapeutic doses as dictated by the needs of the individual patient. The effectiveness of the medication should be monitored against the objectives of the individual's treatment plan. Patients are monitored for side effects. This process is documented.

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3. PRN medication is monitored to ensure these medications are clinically justified and administered on a time limited basis. PRN medications are ordered for specific indications. When considering PRN medication, of particular concern is the use of more than one antipsychotic, and the chronic use of anticholinergic medications greater than six months and benzodiazepines. These medications are of particular concern in people suffering from cognitive impairments, fall risk, or substance abuse.
4. Each patient receiving antipsychotic medication should be regularly observed for tardive dyskinesia, as well as more familiar complications of such therapy. If early signs of tardive dyskinesia occur, the risk benefit ratio for continuing use should be considered and appropriate steps taken. Clinical benefits versus risks of the continued use of antipsychotic medication in the face of signs of tardive dyskinesia, whenever occurring, should be clearly documented in the medical record. Consultation from a peer may be requested if any question of risk/benefit exists.
5. An examination for the presence of abnormal involuntary movements (AIMS) will be performed at the initiation of treatment with an antipsychotic medication, or at the time of admission for those newly admitted patients already prescribed an antipsychotic agent, and will be repeated every six months thereafter until thirty (30) days subsequent to the discontinuation of the medication.
6. Blood monitoring is required for all patients prescribed clozapine should follow Pharmacy Drug Therapy Guidelines. Orders for clozapine shall include the most recent WBC (white blood cell count) and ANC (absolute neutrophil count) as well as the date these were completed.
7. To implement the Controlled Substances Act of 1970 and it's Amendments, Schedule II, narcotic drugs (e.g. morphine, codeine, etc.) shall be ordered for not longer than seventy-two (72) hours. If the drug is required beyond this time, the order must be rewritten.
8. Schedule II, non-narcotic drugs (e.g. stimulants such as amphetamine, and methylphenidate, and sedatives such as amobarbital, secobarbital, pentobarbital) and Schedule III drugs (such as paregoric, combinations of opioids/non-opioids, some short acting barbiturates) shall be ordered for a period up to seven (7) days, and be reordered in increments of seven (7) days if needed.
9. Orders for antibiotic medications will be recorded on an order form for that purpose and instructions for that form will be followed.
10. Birth control tablets shall be reordered every cycle.

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11. Orders for medications other than those specifically mentioned in sections 2-6 above will terminate after thirty (30) days, at which time the order must be rewritten to be continued.
12. Medications ordered on a PRN basis shall be valid for 30 days unless the prescribing physician indicates a shorter duration.
13. All suspected adverse drug reactions (ADR's) and Medical Events shall be reported by the clinician recognizing the problem, as per Pharmacy protocol. These ADRs and Medication Events will be reviewed by the Pharmacy, Nutrition, and Therapeutics committee for analysis and follow-up as indicated. Feedback to individual practitioners and aggregate educational and corrective actions based upon identified trends, when indicated will occur.
14. Where more than one medication in the same pharmacological class is used, the ordering clinician must provide clear and sufficient documentation of the rationale in the progress notes.
15. Orders for new or changed medications shall be accompanied by a progress note that shall include the following: reasons for the medication, target symptoms, dosage and schedule of administration and notation of when the medication's effectiveness shall be assessed.
16. A follow-up progress note shall document the patient's response to the medication ordered, any changes in dosage or schedule, whether the medication shall be continued or modified, any side effects or adverse drug reactions noted (with plan for treatment), and notation of when the next assessment regarding effectiveness of the medication shall be made.

### **ARTICLE VIII: EMERGENCY CARE**

1. In life-threatening situations, personnel on the scene, if appropriately trained, will initiate life-sustaining treatment pending the arrival of the emergency team. A physician will assume responsibility for the assessment and treatment until the paramedics arrive or the emergency ends.
2. Connecticut Valley Hospital provides Level IV emergency care, offering reasonable care in determining whether an emergency exists, rendering lifesaving first aid, and making appropriate referral to the nearest facility capable of providing the required services.



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#### **ARTICLE IX: SPECIAL OBSERVATION STATUS**

1. Special observation status (e.g. one to one observation or 15 minute checks) requires a physician's order. These orders shall be renewed every 24 hours. Discontinuation of special observation status also requires a physician's order.
2. For all patients on special observation status, the minimum requirement is for an assessment of the patient's condition and documentation in the progress note every 24 hours.
3. Restrictions on patient's rights must be made in accordance with statutory requirements in Connecticut General Statutes Section 17a-540 through 17a-549 and relevant Operational Policies and Procedures.

#### **ARTICLE X: SPECIAL PROCEDURES**

1. Medical staff members should consider seeking consultation in circumstances including, but not limited to:
  - Patient dissatisfaction
  - Diagnostic uncertainty
  - Lack of therapeutic progress
  - Risk concerns
  - Need for diagnostic procedure beyond the scope of the treatment team's scope of practice
  - Need for therapeutic intervention beyond the scope of the treatment team's scope of practice
2. Electroconvulsive therapy (ECT) is provided to CVH patients through the services of a contracted vendor. CVH patients are transported to the vendor's facility when the treatment is provided through the vendor's ECT service. CVH patients are registered as outpatients at the vendor's facility. Scheduled appointments are arranged directly with the vendor's ECT Service by the Attending Psychiatrist or his/her designee. A copy of each ECT treatment session is provided by the vendor for inclusion in the patient's medical record.

Electroconvulsive therapy necessitates the informed consent of the patient or legal guardian, when applicable. If the informed consent by the patient and/or guardian is denied, administration of electroconvulsive therapy can only be ordered by the Probate Court as stipulated in Section 17a-543 of the Connecticut General Statutes.

Pre-ECT studies must be done no earlier than one week prior to these studies and will include physical examination, lumbosacral spine films if indicated, EKG, CBC with differential, SMAC-24 and chest x-ray if indicated. (See OP&P #3.18).

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3. The use of restraint and seclusion shall be in accordance with Connecticut Valley Hospital policies and procedures. The use of restraint and seclusion shall be in strict conformity with relevant Connecticut General Statutes, Federal regulations and the DMHAS Commissioner's Policies on restraint and seclusion.
4. The use of behavior modification procedures that use painful stimuli shall not be employed at Connecticut Valley Hospital.
5. Surgical procedures, except for certain minor medical and dental surgical procedures, are not performed at Connecticut Valley Hospital. Arrangements for patients to undergo surgery shall be made with the appropriate community-based facilities.
6. Psychosurgery is not performed at Connecticut Valley Hospital.

### **ARTICLE XI: MEDICAL CARE OF PATIENTS**

1. The Medical Director of Ambulatory Care Services or designee provides professional supervision to all clinicians assigned to ACS, including medical physicians, dentists, optometrists, podiatrists, physician assistants, and APRNs.
2. In the case of life-threatening emergencies, the evaluating CVH physician shall present the case to the Emergency Department clinician.
3. Referral to an Emergency Department of an acute care hospital for non-emergency treatment or evaluation shall be arranged through consultation with the ACS Medical Director or designee.
4. A special consent form is required for initial HIV (Human Immunodeficiency Virus) testing. This form must be completed by the ordering clinician and signed by the patient or his/her conservator. Progress notes must document that the patient/conservator has given informed consent for such tests.
5. The admission/annual medical history shall include (see form CVH-341):
  - Chief Complaint
  - Present Illness
  - Past Surgical History
  - Past Medical History
  - Gynecological History (if applicable)
  - Family History
  - Present Medications
  - Allergies and Adverse Drug Reactions
  - Life Style (e.g. tobacco, alcohol, and illicit drug usage)
  - Review of Systems (including major body systems and pain assessment)

Any information unobtainable will be documented as such.

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6. The admission/annual medical physical examination shall include (see form CVH-341):  
General Appearance  
Vital Signs and Height/Weight  
Skin  
Head  
Neck  
Breasts  
Lungs  
Heart and circulatory system  
Abdomen  
Genitourinary and rectal  
Extremities  
Neurological examination  
Any information unobtainable will be documented as such.
7. A patient who refuses his/her admission medical history and physical examination shall be approached at least monthly thereafter, until such time as the patient consents to such an examination. Documentation of the initial refusal shall be written in the margins of the Medical History and Physical Examination form; subsequent refusals shall be documented in the Physical Health Progress Notes at the time of the monthly medication renewals. Competency to consent to or refuse needed medical examinations and/or treatments are a question to refer to the Attending Psychiatrist for discussion with his/her Medical Director and potential referral to the Probate Court.
8. All patients shall receive an annual physical examination during the anniversary month of their admission (as defined by CVH policy). The Ambulatory Care Services clinician must document patient refusals of the annual physical examination at the time of the monthly medication renewals.
9. All admission/annual Medical History and Physical Examination(s) shall outline assessments, additional diagnostic tests, consultations, and/or treatments for all non-psychiatric (medical) physical problems.
10. Pain assessments are completed in accordance with the Hospital's OP&P 2.5.
11. Chest X-rays will be performed based upon physical findings and/or clinical symptomatology. Chest X-rays are not part of Connecticut Valley Hospital's routine admission or annual medical assessments.

#### **ARTICLE XII: PATIENT DEATHS**

1. In the event of a patient death, a physician shall pronounce the deceased as soon as possible but no later than four hours following the initial discovery of the body. The

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body shall not be released until an entry has been made and signed by the physician in the medical record of the deceased. (See OP&P 2.34).

2. Post mortem care is not initiated until the patient has been examined and pronounced dead, and the family has been notified. Policies with respect to the release of dead bodies shall conform to state law. (See OP&P 2.34).
3. Meaningful autopsies shall be sought whenever possible. An autopsy, unless required by the Medical Examiner's Office, may be performed only after obtaining written consent in accordance with state law and Hospital policy. (See OP&P 2.34) Every member of the Medical Staff is expected to be actively interested in securing an autopsy when the death of a patient occurs. No autopsy shall be performed without the written consent of a relative or legally authorized agency.

#### **Medical Staff Criteria for Autopsy:**

- To help explain unknown and unanticipated medical complications to the attending physician.
  - Cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.
  - Unexpected or unexplained deaths occurring during or following any diagnostic procedures and/or therapies.
  - Patients who are (at the time of death) participating in clinical research trials approved by an IRB.
  - Patient sustained or apparently sustained an injury while hospitalized that may relate to their cause of death.
  - Death resulting from high-risk infections and contagious disease.
  - Death in which it is believed that autopsy would disclose a known or suspected illness that may have a bearing in recipients of transplant organs."
  - Death known or suspected to have resulted from environmental or occupational hazards.
4. A Death Review will be convened within 30 days of a patient death at the direction of the Chair of the Peer Review Committee. The Death Review Committee will consist of a Chair, a general medical physician, and a psychiatrist from the division where the patient resided. None of the Committee members will have recently cared for the patient. The Committee members will provide an independent review of the quality and appropriateness of the care received by the patient through a review of the patient record and interviews with care providers. (*See Peer Review Committee Manual for details of the Death Review Process.*)

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### **ARTICLE XIII: LABORATORY SERVICES**

1. Clinical laboratory services shall be provided by an approved clinical laboratory.
2. A list of "critical laboratory results," the results of which must be called to the unit of care at the time the abnormal result is ascertained, shall be established from time to time as described in Article V, section 4.

### **ARTICLE XIV: PHYSICIAN RESPONSIBILITIES RELATED TO THE SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSE CLINICIANS**

1. Physician's Assistants are each assigned a primary supervising physician as stipulated in Connecticut General Statute 20-12a-g and the Hospital's OP&P 3.3.2. Each physician assistant is supervised by a designated physician, in compliance with applicable State regulations and CVH policy. They function at all times under the supervision of a physician and in accordance with written protocols.
2. Each APRN is assigned and works with a collaborating physician, in compliance with Connecticut General Statutes Section 20-94a and CVH Policy.
3. The Physician Assistant requires co-signatures on Schedule II and Schedule III medications within 24 hours of prescribing.

### **ARTICLE XV: PROFESSIONAL DEVELOPMENT**

1. There shall be a working medical library and journal file.
2. All members of the Active Medical Staff shall be encouraged to continue their professional development through in-house training opportunities, recognition and pay incentive or passing specialty boards, and an opportunity to receive additional training in areas found deficient through peer review mechanisms. Additionally, all members are encouraged to attend courses and conferences related to clinical or administrative work. It is expected that each Medical Staff member earn one hundred (100) continuing education credits per two-year period, at least forty (40) credits being category one credits. It is understood that resident physicians performing night & weekend duty shall satisfy this requirement by means of their documented continued participation in an ACGME approved residency training program. The Continuing Medical Education Committee shall arrange for appropriate educational opportunities to be held at the Hospital.
3. All members of the Medical Staff except consultants are expected to maintain current certification in Cardiopulmonary Resuscitation (CPR), and must be CPR certified prior to performing direct patient care. The CVH CPR course is the American Red Cross Adult completion of the CVH CPR course satisfies the Medical Staff requirement for a one-year period. Advanced Cardiac Life Support (ACLS) satisfies the requirement for two years.

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4. All members of the medical Staff endorse the concept of "best practice" and support the development and implementation of selected "practice guidelines" at both the facility and agency level.

#### ARTICLE XVI: IMMUNITY FROM LIABILITY

1. Section 4-165, Immunity of State Officers and Employees from Personal Liability, of Connecticut State Statutes, reads as follows: "No State officer or employee shall be personally liable for damage or injury, not wanton, reckless or malicious, caused in the discharge of his duties or within the scope of his employment. Any person having a complaint for such damage or injury shall present it as a claim against the state under the provisions of this chapter. For the purposes of this section "scope of employment" shall include, but not be limited to, representation by an attorney appointed by the public defender services commission as a public defender, assistant public defender or deputy assistant public defender or any attorney appointed by the court as a special assistant public defender of an indigent accused or of a child on a petition of delinquency, representation by such attorneys, referred to in section 4-141, of state officers and employees, in action brought against such officers and employees in their official and individual capacities, the discharge of duties as a trustee of the state employees retirement system, the discharge of duties of a Commissioner of Superior Court hearing small claims matter or acting as a fact-finder, arbitrator or magistrate or acting in any other quasi-judicial position, and the discharge of duties of a person appointed to a committee established by law for the purpose of rendering services to the judicial department; provided such actions arise out of the discharge of the duties or within the scope of employment of such officers or employees..."

#### ARTICLE XVII: EMERGENCY MANAGEMENT PLAN

1. The Hospital maintains an internal disaster plan in which members of the Medical Staff actively participate. Members of the Medical Staff are required to be familiar with their duties and roles in the event of a disaster. Selected members of the Medical Staff participate on the Connecticut Valley Hospital Management of the Environment of Care Committee. This committee periodically updates the plan. The mechanism for granting Disaster privileges is outlined in the Medical Staff By-laws.

#### ARTICLE XVIII: SELECTION OF NEW MEDICAL STAFF

1. When a position for a physician becomes available, either through vacancy or through the creation of a new position, the Medical Staff shall play an active role in the selection of new members of the Medical Staff. The Executive Committee of the Medical Staff shall have the right to interview any applicant for membership on the Medical Staff and

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to make recommendations about the appropriateness of candidates for membership and for particular clinical positions. The names of approved applicants will be sent to the administration of the Hospital for further consideration and personnel action.

2. Once approved for hiring, the physician's completed application file will be forwarded to the Credentialing and Privileging Committee of the Medical Staff for review of credentials. Recommendations for privileges are forwarded to the Executive Committee of the Medical Staff. The Executive Committee, through the President of the Medical Staff, recommends the applicant for privileges to the Governing Body. The Governing Body has final authority for granting of privileges.
3. No physician shall practice in a clinical capacity at Connecticut Valley Hospital without the Executive Committee of the Medical Staff first recommending appointment to the Medical Staff. When necessary, interim clinical privileges may be granted by the Chief Executive Officer for up to one-hundred and twenty days (120) days at the request of the President of the Medical Staff (or designee) and based on the recommendation of the Chair of the Credentialing and Privileging Committee (or designee).

### **ARTICLE XIX: PROFESSIONAL CONDUCT**

1. Medical Staff members agree to conform to the requirements of professional dignity in their conduct and attire.
2. Professional staff members recognize their obligation to report to their Service Medical Director or Medical Director, the Chief of Professional Services, Chief of Staff, Chief Executive Officer, or the Executive Committee of the Medical Staff any act(s) of unethical conduct, or any case(s) of gross negligence or professional incompetence on the part of any clinician.
3. Members shall not exert pressure on their co-workers or subordinates on behalf of a part or organization, be it political, cultural, religious or charitable.
4. All Medical Staff members agree not to exceed the privileges granted to them by the Governing Body except as necessitated by a life-threatening emergency.
5. As participating and voting members of a democratic organization, members of the medical staff agree to be bound by decisions of the duly constituted meetings of the Total Medical Staff or the Executive Committee of the Medical Staff.
6. Medical Staff members may not engage in outside private practice while on duty time at the Hospital. Any such outside practice shall be in accordance with applicable policies of the Department of Mental Health and Addiction Services and the State Personnel Policy Board.

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7. It is improper for a Medical Staff member to promote one's own private practice among patients and staff at the Hospital.
8. Medical Staff members may hold college or university appointments.

#### **ARTICLE XX: REVIEW, EVALUATION AND MONITORING OF MEDICAL STAFF PRACTICE**

1. All members shall participate and cooperate in review, evaluation, and monitoring activities of the Medical Staff and the Hospital.
2. Permanent records shall be maintained of all review functions. When important problems in clinical care and clinical performance or opportunities to improve care are identified, there shall be documentation of all actions taken. The effectiveness of the actions taken shall be evaluated and reported to the appropriate committees, Service Medical or Medical Director, the Chief of Professional Services, Chief of Staff, and/or the Chief Executive Officer.
3. The Medical Staff shall be active participants in the Hospital's Performance Improvement, Operational, and Strategic Plans. They provide oversight of these functions at a team level.

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