

**The University
Hospital
Medical Staff**

**Rules
And
Regulations**



The UNIVERSITY HOSPITAL

University of Medicine & Dentistry of New Jersey

NEWARK, NEW JERSEY

**UNIVERSITY HOSPITAL
MEDICAL STAFF RULES AND REGULATIONS**

The Medical Staff shall adopt Rules and Regulations as may be necessary to implement the general Principles as described in the Medical Staff Bylaws and the policies of the Hospital in accordance with current DOHSS Regulations. Such Rules and Regulations shall be accepted or amended on approval by a majority of votes cast by the Executive Committee of the Medical Staff (MEC). Rules and Regulations discussed herein shall relate to the proper conduct of Staff organizational activities in the care of all patients treated at University Hospital and its Clinics, as well as the quality of practice and the standards of performance that are to be required of each practitioner. These Rules and Regulations shall constitute a supplement to the Medical Staff Bylaws; and be binding on all members of the Medical Staff.

SERVICE RULES AND REGULATIONS

Each clinical department shall adopt internal rules and regulations to supplement, as necessary, those of the Medical Staff, as long as they are not in conflict with the Bylaws or the Rules and Regulations of the Medical Staff.

Admissions:

1. All patients shall be admitted to University Hospital without restriction based upon race, color, religion or ability to pay.
2. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis is made or valid reason for hospitalization has been stated. In the case of an emergency, a provisional diagnosis shall be recorded as soon after admission as possible.
3. The patient shall be assigned to the admitting service, or in case of having no admitting service, to the appropriate service for treatment. In the case of a patient requiring admission who has no private practitioner, he or she shall be assigned to the on call attending for the service by the attending physician of the emergency room. If possible, patients who are without a private practitioner shall be given an opportunity to select an appointee of the medical staff to be responsible for his or her care while in the Hospital.

4. Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds:
 - a) Emergency
 - b) Urgent
 - c) Elective

5. Elective admissions to the Hospital shall occur preferably in the morning.

Consultations:

When the clinical presentation of a patient is not within the scope and expertise of the primary physician, consultation with an appropriate physician is recommended.

1. When an emergency department physician or the attending physician of record determines that a patient might require hospital admission or services not within the referring physician's scope of expertise, consultation with an appropriate physician will be obtained.

2. Consultations will be considered to be routine OR emergent.
 - a. Routine Consultation Requests: Consult requests designated as "routine" indicate that the requesting clinical provider wishes to present a patient to the on-call physician, but that the patient's condition does not require emergency consultation. The on-call physician response time should be no greater than 24 hours, but will be discussed by the requesting and consulting physicians if needed in a shorter time frame.

 - b. Emergent Consultation Requests: Consult requests designated as "emergent" indicate that the requesting clinical provider wishes to present a patient to the on-call physician and that the patient's condition requires the on-call physician's prompt response. Since patient outcome in emergent cases may be directly related to care provided by the on-call physician, that physician shall respond by telephone preferably within 20 minutes of receiving a call from hospital clinical staff. In addition, the treating physician present in the hospital and the on-call physician shall discuss and agree upon an appropriate in-person response time for the on-call physician. If the physicians are unable to reach an agreement as to an appropriate in-person response time for the on-call physician, then the opinion of the treating physician present in the hospital shall govern. However, with regard to patients aged 18 or under, the in-

person response time shall not be longer than 60 minutes after the initial call to the on-call physician unless a longer time frame has been agreed upon by the treating physician.

Discharges:

1. A discharge plan shall be initiated within 24 hours of the admission.
2. Referrals should be made to the Social Work Services Department as indicated.
3. Attendance at discharge planning or multi disciplinary service rounds is expected.
4. The Discharge Order shall be completed 24 hours in advance of the intended discharge date and, where indicated, the assigned Social Worker shall be notified whenever necessary.
5. The Home Care Coordinator of patients who need home care services shall be notified 48 hours in advance of the intended discharge date whenever possible.
6. The Discharge Summary shall be completed within, or prior to, 30 days of discharge in accordance with regulatory requirements.

Medical Records

1. The attending physician shall be responsible for the preparation of a medical record for each patient according to regulatory guidelines. All entries shall be signed, dated, timed, legible, pertinent and complete for each patient. Such a medical record shall exclude the JCAHO-specified DO NOT USE abbreviations.
2. Each medical record shall contain the following, as it relates to the patient's admission or episode of care: identification data; complaint, personal history; family history; history of illness; history of allergies, current medication, physical examination findings; treating or admitting diagnosis; laboratory data; medical and surgical treatment; anesthesia record; PACU record, pathological findings; progress notes; final diagnosis; condition on discharge, discharge summary and care plan; discharge instructions to patient; attestation and certification/recertification statements, where applicable, and when performed, results of autopsy. When an autopsy is performed, provisional anatomic diagnoses are recorded in the medical record within 3 days, and the complete protocol is included in the record within 60 days. Specialty clinic records may provide problem-focused data, as appropriate for good medical care. The same rules apply to the electronic record.
3. Each medical record shall contain evidence of a critical review of the

patient's written record by the attending practitioner. The medical record must include a history and physical exam, including a provisional diagnosis performed by the admitting physician, no more than 30 days before or within 24 hours after admission. When the H&P is completed within 30 days of the admission, there must be an updated medical record entry* documenting an exam for any changes in the patient's condition. This H&P shall be authenticated (signed) by a licensed independent practitioner or a licensed or permit-holding resident within 24 hours of admission.

* This update can be brief as long as the update adequately addresses any changes in the patient's medical condition since the H&P was conducted. An update should be an entry in the patient's medical record stating that the H&P (whether performed by a University Hospital provider or external source) has been reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed.

4. There must be a complete history and physical in the chart of every patient prior to surgery (ambulatory, same-day or in-patient) or any invasive or diagnostic or therapeutic procedure in any setting in which general anesthesia is used; or upon any admission. Indicated preoperative diagnostic tests, and the preoperative diagnosis shall be completed and recorded in the patient's medical record as well. In emergency situations, in which there is inadequate time to record the history and physical examination before surgery, a brief note including the preoperative diagnosis, shall be recorded prior to surgery. The History and Physical shall be performed within 30 days prior to any elective, invasive, diagnostic or therapeutic procedure, or within 24 hours of admission, but must meet all of the following requirements:
 - a. The H&P was performed within 30 days prior to the procedure or within 24 hours after admission (but prior to surgery); and
 - b. The physician or other individual qualified to perform the H&P must write an update note within 24 hours of admission (but prior to the procedure) confirming the necessity for the procedure is still present and addressing the patient's current status and/or any changes in the patient's status, regardless of whether there were any changes in the patient's status. All H&Ps performed prior to admission must be updated. The update note must be on or attached to the H&P; and
 - c. The H&P, including all updates and assessment, must be included in

the patient's medical record prior to elective procedure.

- d. In any setting where Local Anesthesia or Procedural Sedation is administered, the extent of the history and physical examination shall be appropriate for the procedure and the patient's health status, and shall include at minimum:
 - Indications for the procedure
 - Known allergies and adverse medication reactions
 - A list of current medication and dosages
 - A statement of general health, vital signs and mental status
5. An "emergency situation" is defined as one in which the patient presents with a life-threatening, critical condition that requires immediate transport to the Operating Room, bypassing the routine assessment process. The physician must, however, document the emergency nature of the procedure and condition for which it is being applied.
6. No medical record shall be permanently filed until it is completed or otherwise ordered by the Medical Records Committee. Medical records of discharged patients are to be completed no later than thirty days following the date of discharge. If a chart is not completed by the resident within 15 days after it is made available to the resident, the record will automatically be reassigned to the attending physician. It is the responsibility of the attending to complete said chart. The Chief of Service may retire the chart for the resident with an explanation if the attending is no longer on staff.
7. Progress notes shall be legibly recorded with date, discipline and signatures in a manner that gives a chronological report of the patient's condition in the hospital, a reflection of any change in the patient's condition and results of tests and treatment, and a continuous update and modification of the treatment plan stating the reasons for continuous hospitalization.
8. Daily visitations by physicians or licensed independent practitioner will be documented in progress notes. A progress note shall be written each time the treating physician, or licensed independent practitioner visits the patient. These notes and any procedures, treatment or diagnoses noted may be coded by Medical Records as long as they are authenticated by a licensed independent practitioner, or by a permit holding resident (a person authorized in the State of New Jersey to engage in the practice of medicine in the second or later years of an approved graduate medical education program). If issues have been raised in the medical record by

other disciplines, the treating physician shall provide an appropriate response. Documentation by licensed independent practitioners in consultation reports and pathological diagnoses recorded by attending physicians may also be used for coding purposes.

9. If the patient is transferred to another health care facility, that facility must have an accepting physician. A transfer note shall be made by the patient's treating physician to reflect the patient's immediate needs. A copy of the entire medical record along with this transfer note shall accompany the patient, of which the details shall include:
 - a. Diagnosis, including history of any serious physical condition unrelated to the proposed treatment which might require special attention to keep the patient safe;
 - b. Physician orders in effect at the time of discharge and the last time each medication was administered;
 - c. The patient's nursing needs; and
 - d. Drug and other allergies.
10. The attending physician who fails or refuses to complete or maintain medical records as described in these Rules and Regulations shall be subject to disciplinary action in accordance with Article VI of the Medical Staff Bylaws.
11. All original records are the property of the Hospital and may not be taken away from the Hospital without a court order, subpoena or in accordance with relevant statute. This includes all radiographic studies.
12. Other general guidelines are as follows: (Additional details are available In the Medical Records Department.)
 - a. All entries in the medical record must be signed and dated by the physician.
 - b. Each consultation report shall contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record.
 - c. All requests for treatment, restraints and/or medications shall be in writing and documented on the Physician's Order Sheet and shall be signed, dated and timed by the prescribing physician. Restraint

orders must be episode-specific, time-limited with specific starting and end times as outlined in the Restraints Policy and Procedures.

- d. Operative reports shall be dictated immediately after surgery. In addition, a brief operative note must be written in the record immediately after surgery. Brief operative note forms are available for this purpose, which shall include:

- Primary surgeon and assistants
- Findings
- Procedures performed and description of the procedures
- Estimated blood loss
- As indicated, specimens removed
- Postoperative diagnosis

- e. A licensed independent practitioner or physician may give verbal or telephone orders which can be accepted by a registered nurse, a physician assistant, or a respiratory care practitioner, and must be authenticated within forty-eight (48) hours by the prescribing practitioner. A licensed independent practitioner or physician may give verbal or telephone orders which can be accepted as per University Hospital policy (Verbal Orders- Issue No. 831-200-271) on verbal orders, and must be authenticated within forty-eight (48) hours by the prescribing practitioner. Authentication must include signature, date, and time.

Verbal communication of orders should only be used in situations where any delay in writing the order prior to its being carried out would cause patient harm or have an otherwise negative outcome. It should not be used for convenience of staff. The transcriber of the verbal or telephone order should repeat back the order; if not, the prescriber should request a read-back of the order to conform to JCAHO patient safety initiatives. Each verbal order shall be dated and identify the name of the individual who gave it and who received it, and the record shall indicate who implemented it.

- f. Obstetrical records must include all prenatal information.
- g. The discharge summary may be written no more than 24 hours before hospitalization ends and shall include the reason for admission, findings, treatment, condition on discharge, medication on discharge, final diagnosis, and, in the case of death, the events leading to death and the cause of death. For cases where the patient is discharged alive within 48 hours of admission and is not transferred to another facility," for normal newborns, and for

uncomplicated deliveries, a discharge note may be substituted for the discharge summary. The discharge note includes at least the patient's condition on discharge, diagnosis on discharge, medications on discharge, and discharge instructions.

Informed Consent

1. The treating physician is responsible for obtaining a valid consent in accordance with University Hospital policy before initiating treatment. The medical records shall contain evidence of informed consent for procedures and treatments for which it is required by Hospital policy. Consent forms must be signed by the patient or his authorized designee. The name of the physician who is to perform the procedure or treatment should be written on the consent in the space provided for this information. There are to be no additions, modifications or deletions to the Informed Consent once it has been signed by the patient or his/her legal representative.
2. No autopsy shall be performed without a properly completed written informed consent by the authorized next of kin or the legal representative.
3. Except in emergencies, patients are entitled to receive, in terms or language that they can understand, as much information about the proposed procedure or treatment as may be needed to make an informed decision.

Telephone Consent:

When a patient is unable to consent to his/her treatment and when it is impossible for the relatives to come to the hospital to sign for the patient's treatment, it is permissible to accept consent from these relatives over the telephone. In such cases, the consent must be witnessed over the phone by two individuals, other than the physician who is to perform the procedure. The medical record or consent form must indicate that telephone consent was received, the names of the witnesses, time, date, and phone number of the person providing the consent.

Emergency Consent:

In the case of an emergency, and when no consent is able to be obtained from the patient or next of kin (life-threatening situation when death, loss of limb or function of a major organ would probably ensue if medical intervention is not

immediately implemented), administrative review is not required. The physician documents the emergency in the medial record and proceeds with appropriate treatment.

Resident Staff:

In hospitals participating in professional Graduate Education Program(s), the organized medical staff has a defined process for the supervision by a Licensed Independent Practitioner with appropriate clinical privileges of each member in the program in carrying out his/her patient care responsibilities:

1. The responsibilities of the LIP Medical Staff to the Resident staff include but may not be limited to:
 - a. Conducting teaching rounds and constructive evaluation of a resident's performance;
 - b. Supervising the medical/surgical care provided by residents on a daily basis.
 - c. Supervising, as necessary, procedures performed and/or ordered by residents to ensure the quality of medical care and proper utilization of Hospital resources;
 - d. Supervising the instruction of Medical Students by the resident staff;
 - e. Supervising the completion of the medical record in accordance with established procedures and deadlines; and
 - f. Supervising proper conduct expected in professional humanistic interactions.
2. All orders and prescriptions issued by first year residents shall be countersigned by a licensed physician or permit holder (a person authorized in the State of New Jersey to engage in the practice of medicine in the second year of a graduate medical education program or beyond).
3. A job description for each level of residency training, in each department, is provided to the resident. Resident procedure privileges must be available to all who need them, including nursing.

General Conduct:

1. All Medical Staff members shall support the concept of basic human rights for all patients treated at University Hospital without distinction as to race, creed, religion, sex or ability to pay. An unabridged version of the Patient's Bill of Rights and the Hospital procedure for handling patient complaints may be obtained through the Hospital's Admitting Services Department.
2. Any Medical Staff member with approved clinical privileges may be called to provide consultation in his/her scientific field or specialty. All requests by the treating physician for consultation shall be in writing and documented in the patient's medical record and must be acknowledged within 20 minutes of receipt.
3. Any physician/practitioner who shall be absent from the Hospital shall name the individual who is to provide coverage and provide this information to the Chief Executive Officer or his designee. All outstanding medical records should be completed if at all possible prior to departure.
4. In the event of a disaster, all available Medical Staff members shall be assigned to posts either in the Hospital or in a satellite station based upon his/her level of clinical expertise. The UMDNJ-University Hospital Disaster Plan and Drill should be reviewed by all medical staff. The Medical Director for the Hospital shall make these assignments in consultation with the Director of Trauma Services and the Clinical Department Chairmen. In the case of patient evacuation from the Hospital, the Medical Director will authorize the movement of patients in consultation with the Chief Executive Officer for the Hospital.
 - a. All Medical Staff shall comply with approved recommended practices in specialty clinical areas.

Emergency Medical Treatment and Active Labor Act

All practitioners who are members of the Medical Staff must abide by all provisions in this act including the provision of a Medical Screening Evaluation and prompt response, as defined by New Jersey Department of Health Hospital Standards, to the request for consultation for emergencies. Each clinical department must maintain an on-call list to address the timeliness of response, consistent with the Hospital Policy and the NJ DOHSS Licensing Standards.

The following qualified members of the Medical Staff may perform medical screening examinations:

- a. attending physicians
- b. physician assistants
- c. advanced practice nurses

Medical screening examinations may also be performed by resident physicians under supervision by attending physicians.