

The University  
Hospital  
Medical Staff

Rules  
And  
Regulations

Revised:  
February 2002

**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. 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.

### **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.
5. 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 and then dated and timed, legible, pertinent and complete for each patient. Such a medical record shall include the use of symbols and abbreviations only when they have been approved by the Medical Records Committee.
2. Each medical record shall contain the following: 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 90 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 patients written record by the attending practitioner. The medical record must include a provisional diagnosis performed by the admitting physician no sooner than seven (7) days prior to admission or within 24 hours after admission. The medical record must include a history and physical exam performed within 24 hours as well as a provisional diagnosis. This H&P must be authenticated (signed) by a licensed independent practitioner or a licensed or permit-holding resident within 24 hours.

4. Any surgery (ambulatory, same day or in-patient) is performed only after a history, physical examination, and indicated diagnostic tests, and the preoperative diagnosis have been completed and recorded in the patient's medical record. 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, is recorded prior to surgery.

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 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 30 days, after it is made available to the resident, it is the responsibility of the attending and/or Chief of Service to complete said chart.

7. Progress notes shall be legibly recorded with date, time, 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.

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 this 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 provision 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 authenticated to include signature, identification number, date and time.
- 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.
- 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 thirty (30) days by the prescribing practitioner.
- 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 and witnessed by a second party. The witness should not be the practitioner who is obtaining the consent. 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.

### **Administrative Review:**

Contact should be made with an administrator under the following conditions:

- 1) when the hospital staff is unable to contact the relatives;
- 2) when there is a question about the patient's mental capacity to make decisions about treatment;
- 3) when, in the physician's opinion, the patient's refusal of treatment will result in an immediate threat to the patient's life;
- 4) when the family refuses to consent to medically indicated procedures which, in the physician's opinion, will result in an immediate threat to the patient's life.

### **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 medical record and proceeds with appropriate treatment.

### **Resident Staff:**

- 1) The responsibilities of the 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.

**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.
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.

5. 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.