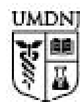
# The University Hospital Medical Staff

# 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. 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.
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, 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 longer than thirty (30) days prior to admission or within 24 hours after admission. This H&P shall be authenticated (signed) by a licensed independent practitioner or a licensed or permit-holding resident within 24 hours of admission, or as soon as possible.

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. 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 can be performed within 7 days prior to any elective, invasive, diagnostic or therapeutic procedure, but must meet all of the following requirements (CMS 42 CFR 482):

   a. The H&P was performed within thirty (30) days prior to surgery; and

   b. The H&P must be included in the patient's medical record prior to elective procedure.

   c. 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 30 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.

    b. 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. 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. If the ordering physician cannot authenticate the verbal/telephone order within 48 hours, a covering licensed physician may assume responsibility and authenticate the order.

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 will read back the order and the prescriber then will confirm accuracy 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 for his/her treatment and when it is impossible for the individuals listed in the applicable U.H. policy to come to the hospital to sign for the patient's treatment, it is permissible to accept consent from these individuals over the telephone. In such cases, two individuals, other than the physician who is to perform the procedure, must witness the consent over the phone. The chart must indicate that telephone consent was received, the name of the witnesses, time, date, and phone number of the person providing the consent, and relationship to patient.

**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:**

The Medical Staff provides for the supervision of resident staff members in the GME Program in carrying out his/her patient care responsibilities:

1. The responsibilities of the Medical Staff members 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 unlicensed or non-permit holding 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.

**Adjunct Staff:**

All orders, consultations, history and physicals, operative reports, and discharge summaries authored by adjunct staff, who are not Independent Practitioners, shall be countersigned by a supervising or collaborative attending physician.

**Medical Students**:

The Medical Staff provides for the supervision of medical students in all clinical programs in carrying out his/her patient care responsibilities:

1. The responsibilities of the Medical Staff members to the medical student include but may not be limited to:

   a. Conducting teaching rounds and constructive evaluation of a student's performance;

   b, Supervising the care provided by students on a daily basis.

   c. Supervising, as necessary, procedures performed by students to ensure the quality of educational experience, medical care, and proper utilization of Hospital resources;

   d. Supervising the instruction of Medical Students by the resident staff;

   e. Supervising proper conduct expected in professional humanistic interactions.

2. All orders and prescriptions issued by an unlicensed resident 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).

## 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.

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.

5. Physicians leaving Medical Staff without medical records completed will not be considered to be leaving in good standing.

## 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.