

University Hospital Medical Staff

Rules & Regulations



UNIVERSITY HOSPITAL
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 University Hospital (“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, the emergency department attending physician requests a consult from the appropriate on-call attending or designee for an admission decision. If there is no consensus about the admission decision, the Chief Medical Officer or designee will make the final decision determining admission and the assignment of the attending physician of record.

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 ordered and 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 Care Coordination 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 whenever feasible and, where indicated, the assigned Social Worker/Case Manager shall be notified whenever necessary.
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 by the recording person, dated, timed, written legibly, pertinent and complete for each patient. Such a medical record shall exclude The Joint Commission DO NOT USE abbreviations.
2. Each medical record (whether paper or electronic) shall contain the following, as it relates to the patient's admission or episode of care:
 - identification data
 - emergency care, treatment, and services provided to the patient before his/her arrival, if any
 - complaint
 - reason(s) for admission of care, treatment, and services
 - personal and family history
 - history of illness
 - history of allergies
 - current medication

- conclusions or impressions drawn from medical history and physical examination findings
- treating or admitting diagnosis
- diagnostic and therapeutic procedures, tests, and results
- diagnostic and therapeutic orders
- medications ordered and prescribed
- response to care, treatment, and services provided
- written informed consents, if indicated
- documentation of the existence, or nonexistence, of an advance directive and the hospital's inquiry of the patient concerning this
- anesthesia record
- PACU record
- for surgical patients, a pre-anesthesia note made by the anesthesiologist before administration of anesthesia and a post-anesthesia note made early in the postoperative period and after release from the recovery room by a member of the hospital's professional anesthesia team
- pathological findings
- clinical/progress notes made by authorized individuals
- relevant diagnoses/conditions established during the course of care, treatment, and services
- consultation reports
- condition on discharge
- discharge summary and care plan
- discharge instructions to patient and/or family
- any adverse incident, including patient injuries, complications, hospital acquired infections and unfavorable reactions to drugs or anesthesia
- when performed, results of autopsy. When an autopsy is performed by University Hospital, 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.

3. A medical history and physical must be completed for all inpatients and for those outpatients that require anesthesia services according to the following timeframes:

INPATIENT: within 7 days prior to admission or within 24 hours after admission,

but prior to surgery.

OUTPATIENT: within 30 days prior to surgery or a procedure requiring anesthesia services.

- a. The medical history and physical examination must be completed and documented by a physician, an oromaxillofacial surgeon, or other credentialed and licensed individual (i.e., advance practice nurse, physician assistant) in accordance with State law and Hospital policy.
 - b. The H&P may be handwritten or transcribed, but always must be placed within the patient's medical record within 24 hours of admission, or prior to surgery or a procedure requiring anesthesia, whichever comes first.
 - c. An H&P is required prior to surgery and prior to procedures requiring anesthesia services, regardless of whether care is being provided on an inpatient or outpatient basis.
 - d. A handwritten or transcribed H&P may be submitted prior to the patient's hospital admission by a physician who may not be a member of the Hospital's Medical Staff or who does not have admitting privileges at the Hospital, or by a qualified licensed individual who does not practice at the Hospital but is acting within his/her scope of practice under State law or regulations. Generally this will occur where the H&P is completed in advance of surgery by the patient's primary care practitioner.
4. Anytime the medical history and physical is completed prior to admission or surgery, an updated examination of the patient, including any changes in the patient's condition must be completed. For inpatient non-surgical admissions, the update must be documented within 24 hours after admission. In all cases where the patient is having surgery or a procedure requiring anesthesia services, the update must be documented prior to surgery or procedure.
- a. If, upon examination, the credentialed and licensed practitioner ("practitioner") finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed. Documentation that the attending medical staff member who is

performing the surgery (by name) is aware of the findings in the H&P must be included in the update note.

- b. Any changes in the patient's condition must be documented by the "practitioner" in the update note and placed in the patient's medical record within 24 hours of admission, but prior to surgery or a procedure requiring anesthesia services. Documentation that the attending medical staff member who is performing the surgery (by name) is aware of the findings in the H&P must be included in the update note.
 - c. If the "practitioner" finds that the H&P done before admission is incomplete, inaccurate, or otherwise unacceptable, the "practitioner" reviewing the H&P, examining the patient, and completing the update will disregard the existing H&P, and conduct and document in the medical record a new H&P within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia.
 - d. All update notes must be authenticated, dated, and timed prior to surgery or a procedure requiring anesthesia.
5. The extent of the history and physical examination shall be appropriate for the procedure and the patient's health status, and it is recommended it include at minimum:
- a. H&P date and time
 - b. chief complaint
 - c. past medical history
 - d. current medications
 - e. drug and other allergies/sensitivities
 - f. review of systems*
 - g. age, blood pressure, pulse, temperature, respirations
 - h. physical examination*
 - i. diagnosis
 - j. treatment/surgical plan

*The scope of the review of systems and physical examination should be appropriate to the clinical status of the patient and the procedure to be performed.

6. 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.

7. 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 within thirty (30) 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.
8. At the time services are rendered, 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.
9. Daily visitations by physicians or licensed independent practitioner shall occur and will be documented in progress notes. A progress note shall be written each time the treating physician, or licensed independent practitioner visits the patient. If issues have been raised in the medical record by other disciplines, the treating physician shall provide an appropriate response. .
10. 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;

- d. Hazardous behavioral problems;
 - e. Drug and other allergies, and;
 - f. A copy of the patient's advance directive, where available.
11. 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.
12. All original records are the property of the Hospital and may not be taken away from the Hospital without a court order, subpoena, in accordance with relevant State and federal laws, or as needed in the event of disaster. This includes all radiographic studies.
13. 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, dated, and timed 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 electronic orders whenever possible 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.
 - 1. Patient diets, including therapeutic diets, are ordered by the practitioner responsible for the patient's care, or by a qualified dietitian or qualified nutrition professional who is authorized by the Medical Staff and acting in accordance with state law governing dietitians and nutrition professionals.
 - d. Operative reports shall be written immediately after surgery, before the patient is transferred to the next level of care, as a mechanism for continuity of care while the operative dictation is pending. 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

The brief operative note does not replace the operative dictation, which will be dictated the day of the procedure.

- e. Verbal orders (including telephone orders) shall originate only from a member of the Medical/Adjunct Staff or a resident physician authorized to write orders. Verbal orders may be accepted and electronically transcribed by a Registered Nurse, Graduate Professional Nurse, Practical and/or Student Nurse, Registered Pharmacist, Respiratory Therapist, Radiologic Technologist and Medical Technologist; and, within their areas of respective specialties, Occupational Therapist, Physical Therapist, Perfusionist, Licensed Psychologist, Clinical Neuropsychologist, Certified Speech Pathologist, Certified Audiologist, or UMDNJ employed paramedics.

The following individuals are authorized to accept and transcribe verbal orders as outlined below:

- Manager of Admitting and his or her designee for admission and level of care bed;
- Dietitian for diet orders/changes;
- Clerical staff for diet, discharge, diagnostic tests, vital signs;
- Medical assistants and technical assistants within the scope of their described duties;
- Social workers and case managers for discharge planning.

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. Each verbal order shall be dated and timed, and identify the name of the individual who gave it and who received it, and the record shall indicate who implemented it.

Verbal communication of orders should only be used in situations where any delay in entering the electronic 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.

All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

- f. Obstetrical records must include all prenatal information, documentation of the course of labor, including fetal monitoring strip or any other comparable electronic data record, delivery, and the postpartum period and a copy of any vital records filed in accord with N.J.S.A. 26.
- 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, provisions for follow-up care, 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.
- h. The following documents require attending physician countersignature:
 - history and physical
 - consultation
 - operative report
 - discharge summary
- i. Recording errors in the medical record shall be corrected by drawing a single line through the incorrect entry. The date of correction and legible signature or initials of the person correcting the error shall be included.

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 or, in the case of non-emergencies, shall include reasons why an informed consent could not be obtained. Consent forms

- must be signed by the patient, legal guardian, or his authorized designee. The name of the physician(s) 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 medical 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 and ensuring that proper documentation of this supervision occurs in the medical record;
 - 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;
 - f. Ensuring that the medical record shall reflect ongoing evidence of attending or LIP supervision during the hospital stay; and,
 - g. 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 to review 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. When there is a clinical consultant, he/she shall issue a report that states at least the assessment mechanisms used, findings, and opinion. This report shall be included in the 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.
 - 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.