University HOSPITAL
Newark, NJ

Medical Staff

Rules and Regulations

June 2024

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ARTICLE I. INTRODUCTION

1.1 INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Directors, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges. Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws. This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

The specific responsibilities of each individual Practitioner are to render specific professional services at the level of quality and efficiency equal to, or greater than, that generally recognized and accepted among Practitioners of the same profession, in a manner consistent with licensure, education and expertise, and in an economically efficient manner, taking into account patient needs, available Hospital facilities and resources, and Case Management/utilization standards in effect in the Hospital.

ARTICLE II. STANDARDS OF PRACTICE

2.1 ADMITTING, ATTENDING AND DISCHARGING PHYSICIAN

2.1.1 Responsibilities

Each patient admitted to the Hospital shall have an admitting physician who is an appointee of the Medical Staff with admitting privileges.

The admitting physician, or designee, is responsible for the admission orders and the history and physical examination.

The attending physician, or designee, will be responsible for:

a. the medical care and treatment of each patient in the Hospital;
b. making daily rounds;
c. ordering consultations, if appropriate;
d. the prompt, complete, and accurate preparation of the medical record; and
e. necessary special instructions regarding the care of the patient.

Changes in the attending physician of record must be promptly made in the medical record. The attending physician at the time of discharge, or designee, is responsible for the discharge orders and the discharge summary.

2.1.2 Identification of Attending Service

At all times during a patient's hospitalization, the identity of the Attending Service shall be clearly documented in the medical record.

2.1.3 Transferring Attending Service Responsibilities

Whenever the responsibilities of the Attending Service are transferred to another Service, a note covering the transfer of responsibility will be entered in the medical record by the transferring attending physician, or designee.

2.2 RESPONDING TO CALLS AND PAGES

a. Telephonic Response: Practitioners are expected to respond within thirty (30) minutes either telephonically or through secure HIPAA-compliant texting when a priority message is sent, unless a sooner timeframe is required under contract.

b. Physical Response: Practitioners are expected to respond within a timeframe as specified in the communication with the requesting party. If needed urgently, the physician should be able to respond within sixty (60) minutes after the telephonic contact unless contractually obligated sooner.

2.3 ORDERS

2.3.1 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it electronically. Verbal orders are given directly practitioner-to-hospital staff; telephone orders are given practitioner-to hospital staff via telephonic communication means. Verbal/telephone orders must comply with the following criteria:

a. The order must be given to an authorized individual who can transcribe or document the order as defined in hospital policy.

b. Verbal/telephone orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal/telephone orders, like written/electronic orders, should be conveyed in plain English without the use of prohibited abbreviations.

c. The order must be read back to the prescribing practitioner by the authorized person receiving the order.

d. All telephone and verbal orders must be signed preferably within thirty (30) days after discharge by the ordering practitioner or another practitioner involved in the patient's care.

e. Orders for cancer chemotherapy may not be given verbally.

f. Verbal/telephone orders may be given only by practitioners privileged at the hospital or working under training protocols.

g. Verbal/telephone 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 University Hospital employed paramedics.

h. The following additional individuals are authorized to accept and transcribe verbal orders:

    a. Manager of Admitting and his or her designee for admission and level of care bed;

    b. Dietitian for diet orders/changes;

    c. Clerical staff for diet, discharge, diagnostic tests, vital signs;

    d. Medical Assistants and technical assistants with the scope of their described duties;

    e. Social workers and case managers for discharge planning.

2.3.2 Orders Transmitted by Secure Electronic Means

Orders transmitted by secure electronic means shall be considered properly authenticated and executable provided that:

a. The transmittal is legible and received as it was originally transmitted by facsimile or computer;

b. The order is legible, clear, and complete

c. The identity of the patient is clearly documented;

d. The transmittal contains the name of the ordering practitioner, address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law; and

e. The transmitted order contains the practitioner's electronic or written signature.

2.3.3 Medication Reconciliation

Medication reconciliation is performed when the patient:

a. is admitted,

b. after a procedure with general anesthesia;

c. is transferred to or from a critical care area,

d. is transferred to, and readmitted from, another hospital or health care facility, or

e. is discharged.

New orders shall be specifically written following surgery or the aforementioned transfers. Instructions to "resume previous orders" will not be accepted.

2.3.4 Drugs and Medications

Orders for drugs and medications must follow Hospital Pharmacy policies referred to in the hospital's electronic policy portal. "Medication Orders".

2.4 CONSULTATION

a. Consultation is to be considered when the clinical presentation of a patient is not within the scope and expertise of the primary physician, and consultation with an appropriate physician is recommended.

b. Any qualified practitioner with clinical privileges may be requested for consultation within their area of expertise. The attending physician or designee, will provide authorization as a written order in the EMR requesting the consultation, permitting the consulting practitioner to attend or examine their patient. This request shall specify the reason for the consultation.

c. For all consultations, practitioner to practitioner communication is required through either verbal communication or through secure HIPAA-compliant texting

d. All consultations will be for "consultation and recommendation" unless otherwise noted as "consultation and treatment".
e. Consultants should not usually order consultations with other specialists unless it is an emergency or is related to surgery.

f. APPs may perform the consultation, including recommendations for ordering diagnostics or therapeutics. The supervising/collaborating physician will make the final assessment by cosigning the APP consultation note, or entering their own note, in compliance with Section 4.17.b.

g. In general, the on call list is utilized for consultations. The attending physician may utilize consultants of their choice.

2.5 CRITICAL CARE UNITS

2.5.1 Critical Care Unit Privileges

The privilege to admit patients to, and manage patients in, critical care units shall be specifically delineated. When there are concerns regarding the continued stay within a critical care unit, consultation with the medical director of the unit will be obtained.

2.5.2 Prompt Evaluation of Critical Care Patients

Unstable patients admitted or transferred to a critical care unit shall be assessed by the critical care team within one (1) hour. Each stable patient admitted or transferred to a critical care unit shall be assessed within four (4) hours following admission or transfer unless that transfer is solely for non-critical care reasons such as monitoring of certain IV infusions or for one-on-one observation.

2.5.3 Critical Care Services

Certain services and procedures may be provided to patients only in critical care units. The Medical Executive Committee shall establish policies that specify which services may be provided only in a critical care unit.

2.6 DEATH IN HOSPITAL

2.6.1 Pronouncing and Certifying the Cause of Death

In the event of a Hospital death which is considered natural, the deceased shall be pronounced dead by a physician, APRN, or PA within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Policies with respect to the release of dead bodies shall conform to local law.

For hospitalized patients (admitted or placed in observation status), the Service Attending, or APRN or PA, at the time of death is responsible for certifying the cause of

natural death and completing the Death Certificate within twenty-four (24) hours in the New Jersey Electronic Death Registration System (EDRS), in accordance with law.

In cases of death that are not deemed to be natural, the Medical Examiner shall certify the cause of death.

For deaths in the ED, the following shall be followed:

a. If the patient has a primary care physician who has seen that patient, or ordered a prescription for that patient, within the past year the primary care physician can be asked to certify the cause of death.

b. If the patient does not have a primary care physician and the death is deemed to be natural, the ED physician will certify the cause of death.

2.6.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable.

2.7 AUTOPSY

It is the responsibility of the attending physician to consider an autopsy in all cases of unusual deaths, in cases of medico-legal, or of special educational interest. For all autopsies done in the Hospital, a provisional anatomic diagnosis will be recorded on the medical record within seventy-two (72) hours, and the complete autopsy report will be made part of the medical record within thirty (30) days unless an explanatory note is written. When autopsies are performed off-site, a provisional diagnosis and the complete autopsy report will be obtained as soon as possible.

2.8 DEATHS REPORTABLE TO THE MEDICAL EXAMINER

- Deaths will be reported to the Medical Examiner when required by New Jersey law.
- Autopsies are required in cases in which criminal activity is suspected.

2.9 SUPERVISION OF ADVANCED PRACTICE PROFESSIONALS

2.9.1 Definition of Advanced Practice Professionals

Advanced Practice Professionals, which includes Advance Practice Registered Nurses (nurse midwives, CRNAs, nurse practitioners, and clinical nurse specialists providing direct patient care) and Physician Assistants, are licensed or certified health care practitioners whose license or certification does not permit and/or the hospital does not authorize the independent exercise of clinical privileges. The qualification and prerogatives of Advanced Practice Professionals are defined in the Medical Staff Bylaws. Advanced Practice Professionals may provide patient care only under the supervision/collaboration of a physician(s) who is an appointee to the Medical Staff.

2.9.2 Guidelines for Supervising Advanced Practice Professionals

a. The physician(s) is(are) responsible for managing the health care of patients in all settings.

b. Health care services delivered by physicians and by Advanced Practice Professionals under their supervision/collaboration must be within the scope of each practitioner's authorized practice, as defined by state law.

c. The physician(s) is(are) ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Professional, ensuring the quality of health care provided to patients.

d. The role of the Advanced Practice Professional in the delivery of care shall be defined through mutually agreed upon Scope of Practice Guidelines that are developed by the physician and the Advanced Practice Professional.

e. The physician(s) must be available for consultation with the Advanced Practice Professional at all times, either in person or through telecommunication systems or other means. A physician must be able to respond telephonically within thirty (30) minutes, or physically within sixty (60) minutes, when needed by the Advanced Practice Professional.

f. The extent of the involvement by the Advanced Practice Professional in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the Advanced Practice Professional, as determined by the physician(s).

g. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.

h. The physician(s) and Advanced Practice Professional together should review all delegated patient services on a regular basis, as well as the mutually agreed upon Scope of Practice Guidelines.

i. The supervising/collaborating physician(s) is(are) responsible for clarifying and familiarizing the Advanced Practice Professional with supervising methods and style of delegating patient care.

j. Each Advanced Practice Professional must document the identity of their supervising or collaborating physician and any alternate supervising physician(s), as applicable.

2.9.3 Collaborative Practice Agreements

Each Advanced Practice Professional must have on file in the Medical Staff Office written Supervision/Collaboration Agreement, if applicable, that describes all health care-related tasks which may be performed by the Advanced Practice Professional. This document must be signed by the Advanced Practice Professional and the supervising/collaborating physician. The Supervision/Collaboration Agreement shall be submitted to the Credentials Committee and the Medical Executive Committee for approval before the Advanced Practice Practitioner can provide services to patients at the Hospital.

2.9.4 Supervising/Collaborating Physician

An Advanced Practice Professional may provide services to patients only if the supervising/collaborating physician, or alternate physician, is within normal backup coverage range. A physician may not supervise more APPs than is allowed by state law.

A Medical Staff appointee who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of or collaboration with an Advanced Practice Professional or other dependent health care professional shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

2.9.5 Medical Record Documentation

Advanced Practice Professionals medical record documentation is noted in Section 4.17.

2.9.6 Other Limitations on Advanced Practice Professionals

An Advanced Practice Professional may not:

a. provide a service which is not listed and approved in the Supervision Agreement on file in the Medical Staff Office, or
b. provide a medical service that exceeds the clinical privileges granted to the supervising/collaborating physician.

2.10 INFECTION CONTROL

All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties, including hand hygiene.

ARTICLE III. ADMISSION & DISCHARGE; TRANSFERS, AND CALL SERVICE

3.1 ADMISSIONS

3.1.1 In-Patient Admissions

The hospital accepts short-term patients for care and treatment provided suitable facilities are available.

a. **Admitting Privileges**: A patient may be admitted to the hospital only by a practitioner on the Medical Staff with admitting privileges.

b. **Admitting Diagnosis**: Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been documented in the medical record. In the case of emergency, such statement will be recorded as soon as possible.

c. **Admission Procedure**: Admissions must be scheduled with the Hospital's Admitting Office/Bed Management. A bed will be assigned based upon the medical condition of the patient and the availability of hospital staff and services. Except in an emergency, the attending practitioner or designee shall contact the Hospital's Admitting Office/Bed Management to ascertain whether there is an available bed.

3.1.2 Admission Priority

Admission/Registration personnel will admit/register patients on the basis of the following order of priorities:

a. **Emergency Admission**: Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. The patient requires immediate attention and is likely to expire without stabilization and treatment. The emergency admission patient will be admitted immediately to the first appropriate bed available.

b. **Urgent Admissions**: Urgent admission patients meet the criteria for inpatient admission; however, their condition may not be life threatening. Urgent admission patients will be admitted as soon as an appropriate bed is available. Urgent admissions include admissions for observation as determined by Center for Medicare/Medicaid Services (CMS) criteria.

c. **Elective Admissions**: Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for their health's sake. These patients may be admitted on a first-come, first-serve basis. A waiting list will be kept, and each patient will be admitted as soon as a bed becomes available.

3.1.3 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area. Patients greater than twenty (20) weeks' gestation and with a pregnancy related complaint will be evaluated in Labor and Delivery, per hospital policy.

3.1.4 Patients Not Requiring Admission

a. In cases where the Emergency Department determines that the patient does not require admission, the ED physician shall consult with the call physician and it is determined no admission is deemed necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care.

b. If the Emergency Department physician and the Service agree that the outpatient visit can serve in lieu of the consultant coming into the Emergency Department, the consultant is obligated to see the patient in the office regardless of their ability to pay, within an agreed upon timeframe.

c. If the consultant, in disagreement with the emergency physician, feels 1) that inpatient admission is not warranted, or 2) the patient requires transfer to another facility, then the consultant is required to come into the Emergency Department to make appropriate arrangements and document their decision.

3.2 PROMPT ORDERS AND ASSESSMENT

3.2.1 All new unstable ICU admissions should be seen as soon as possible, but no later than one (1) hour after arrival to the ICU. All new stable ICU admissions must be assessed by the intensivist, or their designee, within four (4) hours; this excludes patients boarded in the ICU solely for reasons of drug titration or 1:1 observation.

3.2.2 All new admissions must be assessed within four (4) hours, unless 1) the patient's conditions warrants an earlier assessment, or 2) unit policy mandates an earlier timeframe. A history and physical examination must be completed and on the record within twenty-four (24) hours.

3.3 DISCHARGE

3.3.1 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

3.3.2 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician or privileged designee who shall provide, or assist Hospital personnel in providing, written or electronic discharge instructions in a form that can be understood by all individuals and organizations responsible for the patient's care. These instructions should include, if appropriate:

a. A list of all medications the patient is to take post-discharge;

b. Dietary instructions and modifications;

c. Medical equipment and supplies;

d. Any restrictions or modification of activity;

e. Follow up appointments and continuing care instructions;

f. Referrals to rehabilitation, physical therapy, and home health services; and

g. Recommended lifestyle changes, such as smoking cessation.

3.3.3 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient leave the hospital against the advice of the attending physician, or without a discharge order, hospital policy shall be followed. The attending physician shall be notified that the patient has left against medical advice.

3.3.4 Patient Follow-up After Discharge from the Hospital

a. For patients discharged from the hospital after a procedure, the proceduralist, or care team, will have responsibility for follow-up of the patient for the thirty (30) days post procedure, regardless of their ability to pay.

b. For all other patients discharged from the hospital, the patient care team will ensure that the patient has appropriate follow up to ensure a safe discharge.

3.4 TRANSFERS

3.4.1 Transfers To and From Other Acute Care Facilities

Patients who are transferred to or from another hospital must follow the Hospital policies "Patient Transfer Process from University Hospital to Other Hospitals (EMTALA)", and "Transfer of Patients from other Acute Care Hospitals to University Hospital (EMTALA)" to ensure EMTALA compliance.

3.4.2 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. All practitioners actively providing care to the patient will be notified of all transfers per the methods noted in hospital policy.

3.5 CALL SERVICE

3.5.1 Clinical Service Policies On Call

Pursuant to the Medical Staff Bylaws, clinical services may adopt rules, regulations, and policies that are binding on the members of their clinical service. The following rules should be used in developing service policies regarding emergency call obligations:

a. Call duties should be based on the appointee's specialty/subspecialty and will be determined by their designated clinical service. Physicians with admitting privileges are expected to serve on the call roster as determined by their designated clinical service; the Medical Executive Committee shall determine which specialties are required to have call schedules.

b. Call duties shall be assigned by the Chief of Service including substitutions when assigned physician is unavailable to take call.

c. Call may be covered under a contractual obligation.

d. Call duties may be divided by clinical service, specialty, or subspecialty.

e. Physicians must be listed by name on the call list; they cannot be listed by group. Call responsibilities, including substitute shall be noted in AMION, or other electronic system designated by the Hospital.

f. Physicians on call may take call at more than one hospital simultaneously, as long as they have back-up coverage in case of emergencies occurring simultaneously at two different hospitals.

g. Physicians may perform elective surgery while on call, as long as they have back-up coverage in case of emergencies that occur while performing elective procedures.

h. The ED practitioner must make the first call for admission or other disposition out of the Emergency Department regarding a patient to the physician on the call list when needed; they cannot call an APP taking call for the physician on the initial call.

i. An impairment which is alleged to limit an appointee's ability to provide call services shall also be grounds for limiting the appointee's privileges for providing care to their assigned or private patients.

j. Any issues that arise out of compliance with call responsibilities will be forward to Medical Staff leadership for definitive decision-making.

3.5.2 Use of the Call Roster

The call roster may be used as default consultation coverage for inpatient consultation. However, the Attending physician may use the consultant of their choice.

3.5.3 Failure to Meet Call Obligations

All failures to meet call responsibilities shall be reported to the Chief of Service, CMO, and the Medical Executive Committee. Recurrent failure to meet call obligations may result in corrective action per the Medical Staff Bylaws.

3.6 RESPONDING TO CALLS AND PAGES

a. Telephonic Response. Practitioners are expected to respond within thirty (30) minutes either telephonically or through secure HIPAA-compliant texting when a priority message is sent, unless a sooner timeframe is required under contract.

b. Physical Response: Practitioners are expected to respond within a timeframe as specified in the communication with the requesting party. If needed urgently, the physician should be able to respond within sixty (60) minutes after the telephonic contact, unless contractually obligated sooner.

3.6.1 Emergency Call Service

a. **Emergency Call Schedule**: The Hospital is required to maintain a list of physicians who are on call for duty for their designated service after the initial examination to provide evaluation and management necessary to stabilize an individual with an emergency medical condition. Each Medical Staff Chief of Service, or designee, shall provide the on call electronic system as designated by the hospital with a list of physicians who are scheduled to take emergency call on a rotating basis.

b. **Response Time**: It is the responsibility of the on-call physician, or designee, to respond in an appropriate time frame. The on-call physician, or designee, should respond to calls from the Emergency Department no longer than thirty (30) minutes by telephone, and must arrive at the Hospital, if requested to see the patient, in a timeframe based on the communication between the ED practitioner and the on-call physician. The on-call physician should be able to respond with thirty (30) minutes unless a shorter timeframe is noted in policy. If there is disagreement on the timeframe, the ED practitioner shall define the timeframe. If the on-call physician does not respond to being called or paged, the physician's Chief of Service shall be contacted; if the Chief of Service is unavailable the CMO shall be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action.

c. **Substitute Coverage**: It is the on-call physician's responsibility to arrange for coverage and notify their Chief of Service if they are unavailable to take call when assigned. Failure to make timely changes to the hospitals on call system may result in the initiation of disciplinary action. The Emergency Department must be notified of unexpected / urgent changes to call coverage.

3.7 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The attending practitioner, or designee, is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Practitioners who have patients who are a danger to themselves and/or others should follow the hospital "Suicidal Homicidal Patient Risk Assessment" policy.

3.8 EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must, at a minimum, provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The Hospital policies are "Medical Screening Examination (EMTALA)", "Patient Transfer Process from University Hospital to Other Hospitals (EMTALA)", and "Transfer of Patients from other Acute Care Hospitals to University Hospital (EMTALA)".

ARTICLE IV. MEDICAL RECORDS

4.1 GENERAL REQUIREMENTS

The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. Only authorized individuals may have access to and make entries into the medical record. The attending physician is responsible for the preparation of the physician components to ensure a complete and legible medical record for each patient.

In order to practice medicine, all healthcare providers who exercise privileges in the facility are required to utilize the electronic health record (EHR) in order to meet regulatory requirements and provide efficiencies in delivering healthcare to the community. All healthcare providers will undergo appropriate EHR training, and comply with security guidelines, per the hospital's policy on use of the EHR.

Evidence-based order sets provide a means to improve quality and enhance the appropriate utilization and value of health care services. Evidence-based order sets assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions.

The Medical Executive Committee may adopt evidenced-based order sets upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care providers who are expected to implement the guidelines.

4.2 AUTHENTICATION OF ENTRIES

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means.

4.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the paper medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately. The authorized individual will contact the practitioner and request an electronic/written correction of the improper order or may request a verbal order for clarification, read back the order, and document the clarification in the medical record. This verbal order must be signed by the ordering practitioner as described in Subsection 2.3.1.

4.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in written documents. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

Prohibited Abbreviations, Acronyms, and Symbols: The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record entries or orders. These will include at a minimum:

- U or u for Units
- IU for International Units
- qd or QD for Daily
- qod or QOD for Every Other Day
- Trailing Zero (X.0mg)
- Lack of Leading Zero (.Xmg)
- MS or MSO4 for Morphine Sulfate
- MgSO4 for Magnesium Sulfate

Situations Where Abbreviations Are Not Allowed: Abbreviations, acronyms, and symbols may not be used on informed consents.

4.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

4.5.1 Time Limits

Time limits for performance of the history and physical examination are noted in the medical staff bylaws.

4.5.2 Who May Perform and Document the Admission History and Physical Examination

Who may perform the history and physical examination are noted in the medical staff bylaws.

4.5.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

A complete history and physical examination is required for all admissions, all inpatient surgeries requiring anesthesia (general, regional, MAC, or deep sedation), and all observation patients. A complete history and physical examination report must include the following information:

a. Chief complaint or reason for the admission or procedure;

b. A description of the present illness;

c. Past medical history, including current medications, allergies, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;

d. An age-appropriate social history;

e. A pertinent family history;

f. A review of systems;

g. Thorough physical examination and relevant physical findings; and

h. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

A focused history and physical examination or outpatient assessment, used for outpatient procedures needing nothing other than local anesthesia or moderate sedation, should include the following information:

a. Chief complaint or reason for the admission or procedure;

b. A description of the present illness;

c. Past medical history, including current medications, allergies, and current diagnoses;

d. Cardiac, respiratory, and other body areas relevant to the diagnosis; and

e. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

4.5.4 Admitting Physician is Responsible for the Admission History and Physical Examination

Completion of the patient's admission history and physical examination is the responsibility of the admitting physician, or designee.

4.6 PREOPERATIVE DOCUMENTATION

4.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to procedures requiring moderate sedation or above pertaining to:

a. all invasive procedures performed in the Hospital's surgical suites;

b. certain procedures performed in the Radiology Department and Catheterization Lab (including but not limited to: angiography, angioplasty, myelograms, abdominal and intrathoracic biopsy or aspiration, pacemaker and defibrillator implantation, electrophysiologic studies, and ablations); and

c. certain procedures performed in other treatment areas (including but not limited to: bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, and elective electrical cardioversion).

When a history and physical examination is required prior to a procedure, and the procedure is not deemed an emergency, the procedure will be cancelled if an H&P is not completed. In cases of procedures performed by dentists, the pre-anesthesia evaluation performed by the dentist may suffice for the update to the history and physical examination.

4.7 PROGRESS NOTES

The attending physician, or designee, will see the patient and record a progress note each day, and for each significant patient encounter, on all hospitalized patients. Progress notes must document the reason for continued hospitalization. Progress notes documented by APPs do not require cosignature. Patients in the ICU must be seen daily and cosign the APP's note, or write their own note, by the Attending physician.

All patients with extended Emergency Department stays, pending admission or placement, should be seen daily by inpatient care team, and a progress note written, by the care team to determine the need for continued stay in the Emergency Department.

4.8 OPERATIVE / PROCEDURE REPORTS

Operative reports will be entered or dictated immediately after surgery, and in no case later than twenty-four (24) hours after the end of the procedure, and the report promptly authenticated by the surgeon and made a part of the patient's current medical record. Operative/procedure reports will include:

a. name and hospital identification number of the patient,

b. date and times of the surgery,

c. the name of the surgeon(s) who performed the procedure and any assistants and a description of their tasks,

d. the pre-operative and post-operative diagnoses,

e. the name of the procedure performed,

f. a description of the procedure performed,

g. the type of anesthesia administered,

h. findings of the procedure,

i. complications, if any,

j. any estimated blood loss,

k. any specimen(s) removed, and

l. any prosthetic devices, transplants, grafts, or tissues implanted.

4.9 BRIEF OPERATIVE / PROCEDURE NOTES

If there is a delay in getting the detailed operative/procedure report in the medical record, a brief operative/procedure note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. This note needs to be finalized prior to transfer out of the Post Anesthesia Care Unit (PACU) or in an intensive care unit if the surgeon accompanies the patient to the intensive care unit. Operative/procedure notes will include:

a. the name of the surgeon(s) who performed the procedure and any assistants,

b. post-operative diagnoses,

c. the name of the procedure performed,

d. description of each procedure finding,

e. any estimated blood loss, and

f. any specimen(s) removed.

4.10 PRE-ANESTHESIA NOTES AND PRE-SEDATION ASSESSMENTS

4.10.1 Pre-anesthesia notes

Anesthesia is defined as general, regional, monitored anesthesia care (MAC), and deep sedation. A pre-anesthesia note shall be made by an individual qualified to administer anesthesia, reflecting evaluation of the patient and review of the patient record prior to administration of anesthesia, the administration of anesthesia and entered into the medical record of each patient receiving anesthesia at any anesthetizing location and shall contain the following information:

a. A review of the medical history,

b. An interview and examination of the patient,

c. A documented airway assessment,

d. An anesthesia risk assessment,

e. An anesthesia, drug and allergy history,

f. Performed by an individual, qualified, and privileged to administer anesthesia/sedation, within 48 hours prior to inpatient or outpatient surgery or procedure requiring anesthesia services. (Delivery of the first dose of medications for the purpose of inducing anesthesia marks the end of the 48-hour time frame).

4.10.2 Pre-sedation assessments

Patients who will be receiving moderate sedation must be monitored and evaluated before, during and after a procedure by a trained practitioner, however a pre-anesthesia evaluation is not required because moderate sedation is not considered to be “anesthesia”. The pre-sedation assessment shall follow the guidelines in the “Moderate Sedation/Analgesia Policy.”

4.11 ANESTHESIA RECORD

A record of anesthesia that conforms to the policies and procedures developed by the Clinical Service of Anesthesia shall be made for each patient receiving sedation or anesthesia at any anesthetizing location.

4.12 POST-ANESTHESIA NOTES AND POST-SEDATION NOTES

4.12.1 Post-anesthesia notes

A post-anesthesia evaluation shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving anesthesia or deep sedation. The note shall be entered by an anesthesia provider or by the physician who administered the deep sedation. This note should contain the following information:

a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;

b. Cardiovascular function, including pulse rate and blood pressure;

c. Mental status;

d. Temperature;

e. Pain;

f. Nausea and vomiting; and

g. Postoperative hydration.

4.12.2 Post-sedation notes

A post-sedation note shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving moderate sedation. The note shall contain follow the requirements in the Moderate Sedation / Analgesia Policy.

4.13 CONSULTATION REPORTS

The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. The Consultation Report should be completed and entered in the patient's chart within the time frame agreed upon between the referring and consulting practitioners for urgent or emergent consultations and no later than twenty-four (24) hours after receipt of notification of the routine consult request. If a full consult note is not readily available after the consultation, a note should be documented in the record containing the consultant's time-sensitive recommendations for the patient. If a consultation is performed by an APP, the consulting physician must cosign the consultation or enter their own note within one (1) day.

If the report is not in the record within the prescribed time, an explanatory note should be recorded in the record. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation/procedure.

4.14 OBSTETRICAL RECORD

The obstetrical record must include a medical history, including a complete prenatal record if available, and an appropriate physical examination. A copy of the practitioner's office prenatal record may serve as the history and physical for uncomplicated vaginal deliveries if it is legible and complete and the last prenatal visit was within thirty (30) days of admission. If the office prenatal record is used as the history and physical examination, an update must be performed as described in the bylaws and documented.

4.15 FINAL DIAGNOSES

The final diagnoses will be recorded in full, dated and signed by the discharging physician in the discharge summary, transfer note, or death summary of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the practitioner will be required to document such in the patient's record.

4.16 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. The discharge summary should be completed within three (3) days after discharge. All discharge summaries are the responsibility of the discharging physician on the day of discharge, or privileged designee.

a. **Content**: A discharge summary will be written or dictated upon the discharge or transfer of hospitalized patients. The discharge summary is the responsibility of the discharging physician and will contain:

   1. Reason for hospitalization;
   2. Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;
   3. Condition of the patient at discharge;
   4. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
   5. Final diagnoses.

b. **Short-term Stays**: A discharge summary is not required when the patient is discharged alive, not transferred to another facility, and meets the following criteria: Uncomplicated inpatient and observation hospital stays of less than 48 hours, uncomplicated vaginal deliveries, and normal newborn infants, provided the discharging physician, or designee, enters a final progress note documenting:

   1. The condition of the patient at discharge; and
   2. Instructions given to the patient and family, including medications, referrals, and follow-up appointments.

c. **Deaths**: A discharge summary is required on all inpatients who have expired and will include:

   1. Reason for admission;
   2. Summary of hospital course, events leading to death, and cause of death; and
   3. Final diagnoses.

d. **Timing**: A Discharge Summary is encouraged to be entered and signed in the medical record within three (3) days after discharge, transfer, or death.

4.17 ADVANCED PRACTICE PROFESSIONALS

Advanced Practice Professionals are Physician Assistants (PAs) and Advanced Practice Registered Nurses (certified nurse midwives (CNMs), nurse practitioners (NPs), and certified registered nurse anesthetists (CRNAs).

a. The collaborating/supervising physician will cosign the APP's H&P, within thirty (30) days after discharge;
b. The collaborating/supervising physician will either enter their own note or cosign to the APP's note, within one (1) calendar day, for all consultations with the exception of the palliative care service;
c. Progress notes performed by APPs on the Primary Service do not require cosignature by a physician on the Attending Service, or designee;
d. Consult notes performed by APPs on consulting services require attending physician cosignature.
e. Routine orders of an APPs do not need cosignature by a physician except for the order to admit;
f. All operative notes, other than CNM delivery notes, entered by an APP must be cosigned by a physician on the operative service within thirty (30) days after discharge;
g. Delivery notes done by CNMs do not require cosignature by a physician;

h. The collaborating/supervising physician will review and authenticate all discharge summaries prepared by all Advanced Practice Professionals within thirty (30) days after discharge.

4.18 REGISTERED DIETITIANS

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 the state law governing dietitians and nutrition professionals.

4.19 STUDENTS, RESIDENTS, AND FELLOWS IN TRANING

Residents and fellows in a formal training program, who are not licensed in New Jersey, must have their:

a. History and physical examinations cosigned within twenty-four (24) hours by the attending physician, or their physician designee;
b. Progress notes by residents/fellows on the primary Attending service need to be cosigned by a physician on the primary Attending service;
c. Progress notes by residents/fellows on consulting services do not need to be cosigned by a physician on the consulting service;
d. Consultations must be cosigned within one (1) day of the consultation;
e. Residents and fellows in non-surgical residencies may not enter the operative report;
f. Operative notes and operative reports, cosigned within thirty (30) days after discharge by the attending physician, or their physician designee;
g. Discharge summaries are to be cosigned within thirty (30) days after discharge; and
h. Orders and prescriptions of PGY1 residents in the inpatient setting require countersignature by a licensed physician;
i. Orders of the PGY2 and above residents or fellows do not need to be cosigned, except for the order for admission.

Residents shall be permitted to function clinically only in accordance with the written training protocols developed by the Designated Institutional Officer (DIO), or designee, in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

Students who are 4th year or equivalent, may make entries in the medical record consistent with the following:

a. History and physical examinations cosigned within twenty-four (24) hours by the attending physician, or their physician designee;
b. Progress notes by students need to be cosigned by a physician on the primary Attending service within one (1) day;
c. Students may not enter the operative report or brief operative note;
d. Discharge summaries are to be cosigned within thirty (30) days after discharge; and

e. Orders of students will not be implemented until after cosignature by a licensed practitioner or PGY2 resident or above.

4.20 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, personal health information (PHI) contained in the record will be made available to any member of the Medical Staff attending the patient, to members of medical staffs of other hospitals, and to others in accordance with HIPAA. Records must be retained pursuant to the Hospital medical record retention policies.

a. **Access to Old Records**: In case of readmission of a patient, all records still maintained will be available to the attending practitioner whether the patient was attended by the same practitioner or by another practitioner.

b. **Unauthorized Removal of Records**: Unauthorized transmission or deletion of medical records from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the Medical Executive Committee.

c. **Access for Medical Research**: Access to the medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects must have prior approval of the Institutional Review Board and by the UH Administration. The written request will include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. (4) the process for maintaining medical record confidentiality and security, and for patient informed consent. All approved written requests will be presented to the Administrative Director of Clinical Research Services.

d. **Access for Former Members**: Former members of the Medical Staff will be permitted access to PHI from the medical records of their patients specifically covering all periods during which they attended such patients in the Hospital.

4.21 MEDICAL RECORD COMPLETION

A medical record will not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the MEC.

4.21.1 Requirements for Timely Completion of Medical Records

Medical records must be completed in accordance with the following standards:

a. An Admission History and Physical Examination or Updated History and Physical Examination must be entered in the medical record in the timeframes noted in the bylaws, Section 2.6.12;

b. A Preoperative History and Physical Examination or Focused Preoperative History and Physical Examination must be entered in the medical record prior to the surgery or procedure;

c. An Admission Prenatal Record with update, or a de novo history and physical, must be entered in the medical record by the attending physician or designated covering

practitioner within twenty-four (24) hours after an obstetrical admission and prior to delivery;

d. An Operative Report must be entered in the medical record by the performing practitioner immediately, but in no case later than twenty-four (24) hours, following the surgery or procedure;

e. If the Operative Report is not immediately available, a Post-Operative Note must be entered in the medical record by the performing practitioner prior to transfer of the patient to the next level of care;

f. An Inpatient Progress Note must be recorded and authenticated by the attending physician, or designee, each day and for each significant patient encounter on all hospitalized patients;

g. An Emergency Department Record must be completed by the responsible practitioner for:

   i. Transferred patient – prior to transfer,

   ii. Admitted patient – written and signed by the resident prior to transfer to the floor; cosigned within twenty-four (24) hours by the Attending ED physician, and

   iii. Patient discharged home – within twenty-four (24) hours;

h. A Consultation Note must be completed by the consulting physician, or designee, within twenty-four (24) hours of notification of the consult request for acute care facilities and in the timeframe agreed to by the referring and consulting physician;

i. Diagnostic reports, after availability of the test to read:
   a) Inpatient and observation cardiac diagnostic reports (including but not limited to EKGs, echocardiograms, stress tests, Doppler studies, EEGs and EMGs) must be read by the physician scheduled to provide the interpretation service within one (1) calendar day after the test is available to read, and

   b) Outpatient ambulatory cardiac diagnostic reports (including but not limited to EKGs, echocardiograms, stress tests, Doppler studies, EEGs, and EMGs) must be read by the physician scheduled to provide the interpretation service within five (5) calendar days after the test is available to read;

j. A Discharge Summary must be entered in the medical record by the discharging physician or designee:

   i. On the day of discharge when transferred to a nursing facility,

   ii. Within three (3) days after an inpatient or observation discharge, and

   iii. Within three (3) days after the death of a patient.

k. The Inpatient or Observation Medical Record must be completed within thirty (30) days after discharge, unless otherwise defined in policy. This includes the authentication of all progress notes, consultation notes, operative reports, verbal and written orders, final diagnoses, and discharge summary. The timeframe will be tolled if the practitioner notified HIM of an absence.

l. Clinic notes in provider-based clinics must be completed within one (1) day of the visit and the entire encounter must be finalized within five (5) days.

4.21.2 Policy on Incomplete Records

Penalties for noncompliance with medical record completion are outlined in Hospital policy.

4.22 ELECTRONIC RECORDS AND SIGNATURES

"Electronic signature" means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

4.23 COPY AND PASTE FUNCTIONALITY

Previously documented information that is carried forward, imported, or supplied by use of a template must be reviewed and edited to accurately reflect the services provided and the current condition of the patient during the current encounter. "Cut and Paste" or "Copy and Paste" of entries in the Medical Record is governed by Hospital medical records policy.

4.24 ORGANIZED HEALTH CARE ARRANGEMENT

a. For the purposes of complying with provisions of the federal Health Insurance Portability and Accountability Act ("HIPAA"), the Medical Staff of University Hospital are deemed to be members of, and a part of, an *Organized Health Care Arrangement* ("OHCA") as that term is defined within HIPAA. This designation is required to comply with the privacy regulations promulgated pursuant to HIPAA based upon the fact that the members of the OHCA operate in a "clinically integrated care setting." As such, members of Medical Staff shall, upon acceptance to membership, become part of the OHCA with the Hospital and the hospital's medical staff. No member shall be liable for any actions, inactions, or liabilities of any other member. Each member of the OHCA shall be responsible for its own HIPAA compliance requirements related to services and activities performed outside the clinical setting of the OHCA.

b. The members hereby adopt the Hospital Notice of Privacy Practices that will be distributed by the Hospital to all patients of the Hospital and agree to comply with all requirements contained in the joint Notice of Privacy Practices.

c. The members of the Medical Staff shall have access to protected health information of the patients of other members of the OHCA for purposes of treatment, payments and healthcare operations, as those terms are defined by HIPAA and the HIPAA Privacy Regulations; Provided that any member of the Medical Staff that downloads, saves or otherwise stores any protected health information, or has access to any Hospital electronic data systems, though any portal that is not solely operated by the Hospital, shall enter into a Colleague Agreement, which shall require that member of the Medical Staff to observe certain requirements, and to assume responsibility for anyone who accesses any Hospital information through a portal maintained by the member.

d. Members of the Medical Staff shall be entitled to disclose protected health information of a patient to other members of the OHCA for any health care operations of the OHCA, including peer review, mortality and morbidity meetings, tumor board, and other similar health care operations of the OHCA, as permitted in the HIPAA Privacy Regulations.

ARTICLE V. PATIENT RIGHTS

5.1 PATIENT RIGHTS

All practitioners shall respect the patient rights as delineated in Hospital Patient Rights and Responsibilities policy.

5.2 INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make their own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical and legal obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow the Hospital "Informed Consent Policy."

5.3 ADVANCE DIRECTIVES

The Hospital policies on 1) Advance Directive for Healthcare and, 2) Making Medical Decisions on Behalf of Patients Without Decisional Capacity and Without a Surrogate Decisions Maker including Withdrawal of Life Sustaining Medical Treatment delineates the responsibilities, procedure, and documentation that must occur regarding Advance Directives and when withdrawing or withholding life-sustaining treatment.

5.4 DO-NOT-RESUSCITATE ORDER

The Hospital policy on Do Not Resuscitate Order Issue delineates the responsibilities, procedure, and documentation that must occur when initiating or cancelling a Do Not Resuscitate order.

5.5 DISCLOSURE OF UNANTICIPATED OUTCOMES

The Hospital "Adverse Event Policy" delineates the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur.

5.6 RESTRAINTS

The Hospital policies Restraints and Seclusion for Violent or Self-Destructive Behavior and Use of Restraints for Non-Violent or Non-Self-Destructive Beha delineates the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

5.7 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Department of Clinical Research Services. When patients are asked to participate in investigational studies, Hospital policy should be followed.

ARTICLE VI. SURGICAL CARE

SURGICAL CARE

6.1 SURGICAL PRIVILEGES

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the Medical Executive Committee. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The Medical Staff Office will maintain a roster of practitioners specifying the surgical privileges held by each practitioner.

6.2 SURGICAL POLICIES AND PROCEDURES

All practitioners shall comply with the Hospital's surgical policies and procedures. These policies and procedures will cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

6.3 ANESTHESIA

A complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition must be completed for each patient receiving general/regional/MAC anesthesia. Only anesthesiologists, certified registered nurse anesthetists, or physicians privileged to perform deep sedation (which is part of MAC) shall be able to perform these procedures.

Moderate sedation may only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The practitioner responsible for the ordering the administration of moderate sedation will document a pre-sedation evaluation and post-sedation follow-up examination.

Moderate and deep sedation is performed under the authority of the Chief of Anesthesia, or designee.

6.4 TISSUE SPECIMENS

Specimens removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens, as defined in pathology policy, are exempt from pathology examination. The pathologist's report will be made a part of the patient's medical record.

6.5 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID with the patient's name and a second identifier as chosen by the hospital. The Hospital policies on 1) Patient Identification: Two Patient Identifiers Policy and 2) Verification of Correct Patient, Correct Procedure and Correct Site/Side for Invasive or Surgical Procedures shall be followed.

ARTICLE VII. RULES OF CONDUCT

7.1 PROFESSIONALISM

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital. Professionalism is defined as the expectation for all medical professionals to treat all people with respect, compassion, and dignity. Patient needs will supersede a provider's self-interest. And providers accept and understand that they are accountable to not only the patient but also to their colleagues and society as a whole. Professionalism adheres to the principle of treating all the diverse patient populations with sensitivity and respect. A professional provider will understand and recognize the unique effects of age, gender, gender identity, culture, race, religion, disability, sexual orientation and the social determinants of health on a patient's health and well-being and act accordingly to provide care that is cognizant of these cultural ramifications. The Medical Staff "Provider Professionalism Policy" and the UH "Code of Conduct Policy" shall be followed.

7.2 IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall follow the guidelines outlined in the Medical Staff policy on practitioner health and impairment.

7.3 TREATMENT OF FAMILY MEMBERS

The following is based on the AMA *Code of Medical Ethics*' Opinion on Physicians Treating Family Members. In general, practitioners should not treat themselves or their family members. Family members are deemed to include: spouses, domestic partners, parents, parents-in-law, children, stepchildren, and siblings. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians are discouraged to serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

7.4 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

Practitioners shall follow the Hospital policy Availability and Accessibility of Medical Records regarding access to medical records of themselves or family members to maintain compliance with HIPAA. Practitioners must utilize the Patient Portal to access their own medical records.

7.5 COMPLIANCE WITH HOSPITAL HEALTH REQUIREMENTS

All practitioners must comply with the Hospital's policy on testing/vaccinations.

7.6 COMMUNICATION METHODS

All practitioners must maintain a current accessible e-mail address on file in the Medical Staff Office, as well as a current cell phone number.

All practitioners must use the accepted method of communication determined by the MEC.

ARTICLE VIII. ORGANIZATION AND FUNCTIONS OF THE MEDICAL STAFF

8.1 Organization of the Medical Staff

The medical staff shall be organized as a departmentalized staff; a Service Chief shall head each Service with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC. The current Services are:

- Anesthesiology
- Dental Medicine
- Emergency Medicine
- Family Medicine
- Medicine,
- Neurology
- Neurosurgery
- Obstetrics and Gynecology Women's Health,
- Ophthalmology
- Orthopedics
- Otolaryngology
- Pathology and laboratory Medicine,
- Pediatrics
- Physical Medicine & Rehabilitation
- Podiatry
- Psychiatry,
- Radiation Oncology
- Radiology
- Surgery

8.2 Responsibilities for Medical Staff Functions

The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 8.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The Medical Staff Officers, Service Chief, hospital and medical staff committee chairs, are responsible for working collaboratively to accomplish required medical staff functions. This process may include periodic reports as appropriate to the appropriate Service or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory and accreditation compliance and appropriate standards of medical care.

8.3 Description of Medical Staff Functions

The Medical Staff, acting as a whole or through committee, participates in or has oversight over activities in the following areas:

1) governance, 2) medical care evaluation/performance improvement/patient safety activities, 3) hospital performance improvement and patient safety programs, 4) credentials review, 5) information management, 6) bioethics 7) emergency preparedness, 8) strategic planning, 9) bylaws review, 10) nominating process, 11) infection prevention and control, 12) pharmacy and therapeutics, 13) practitioner health, and 14) utilization management.

ARTICLE IX. MEDICAL STAFF COMMITTEES

9.1 General Language Governing Committees

The following shall be the standing committees of the Medical Staff: Medical Executive, Credentials, Nominating, Bylaws, Bioethics, and Quality Improvement Steering Committee. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The President of the Medical Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the President of the Medical Staff when establishing the committee. The President of the Medical Staff and the CEO, or their designees, are ex officio members of all standing and ad hoc committees.

Committee members may be removed from the committee by the President of the Medical Staff or by action of the MEC for failure to remain a member of the Medical Staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

In addition to the standing committees of the Medical Staff, the Medical Staff shall carry out its responsibilities through participation in committees of the Hospital and/or through individual members who act as liaisons to Hospital departments, or services.

Medical Staff members may be appointed to hospital committees such as Cancer, Clinical Practice, Infection Control, Medical Records, Operating Room, and Pharmacy and Therapeutics by the President of the Medical Staff in consultation with the respective committee chair. Actions taken by hospital committees that affect the practice of practitioners with privileges must have those actions approved by the MEC prior to going into effect. A list of these committees and the respective charter will be available in the Hospital's electronic policy portal. Committee charter shall include description, composition, appointment process, responsibilities, and meeting frequency.

9.2 Medical Executive Committee (MEC)

Description of the MEC is in Part I: Governance; Section 6.2 of the Bylaws

9.3 Credentials Committee

Description of the Credentials Committee is in Part III: Credentials Procedures Manual; Section 1 of the Bylaws.

9.4 Quality Improvement Steering Committee

9.4.1 **Composition:** The composition and responsibilities of this committee shall be noted in the committee charter located in the Hospital's electronic policy portal.

9.5 Bylaws Committee

9.5.1 **Composition:** The bylaws committee shall consist of at least four (4) Members of the Active staff, and one (1) representative from Administration, who shall be an ex-officio member.

9.5.2 **Responsibilities:** This committee shall be responsible for 1) Conduct periodic review of the Medical Staff Bylaws, Rules and Regulations 2) Submit written recommendations to the MEC and to the Board for amendments to the Medical Staff Bylaws, Rules and Regulations.

9.6 Nominating Committee (ad hoc)

9.6.1 **Composition:** The Nominating Committee shall consist of at least three (3) of the Governing Council and at least one Medical Staff committee chair

9.6.2 **Responsibilities:** The committee shall provide an annual slate of nominees for the elected Medical Staff positions.

9.7 Utilization Management Committee (hospital committee)

9.7.1 Composition: The utilization management committee shall consist of at least two (2) physician members of the Medical Staff. The CEO shall appoint the hospital representatives to the committee.

9.7.2 Responsibilities: This committee shall be responsible for the functions described in the Hospitals Utilization Management Plan.

9.8 Joint Conference Committee (Board committee)

9.8.1 Composition: The Joint Conference Committee shall consist of the Officers of the Medical Staff and an equal number of Board members.

9.8.2 Responsibilities: This committee serves as a conflict resolution mechanism when issues arise between the Medical Staff and the Board of Directors.

SECTION X. CONFIDENTIALITY, IMMUNITY, RELEASES, AND CONFLICT OF INTEREST

10.1 Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential:

- Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or Medical Staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and
- Contributions to teaching or clinical research; or
- Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

10.2 Immunity from Liability

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of their duties as an official representative of the hospital or Medical Staff. No representative of this healthcare organization acting in good faith and without malice shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

10.3 Covered Activities

10.3.1 The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

a. Applications for appointment/affiliation, clinical privileges, or specified services;

b. Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services.

c. Corrective or disciplinary actions;

d. Hearings and appellate reviews;

e. Quality assessment and performance improvement/peer review activities;

f. Utilization review and improvement activities;

g. Claims reviews;

h. Risk management and liability prevention activities; and

i. Other hospital, committee, Clinical service, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

10.4 Releases

When requested by the President of the Medical Staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

10.5 Conflict of Interest

A member of the Medical Staff requested to perform a Board designated Medical Staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under review, their spouse, or their first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the practitioner involved as a direct competitor, partner, or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case-by-case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.

Adopted and Approved:

Medical Executive Committee: April 9, 2024
Hospital Board of Directors: June 27, 2024