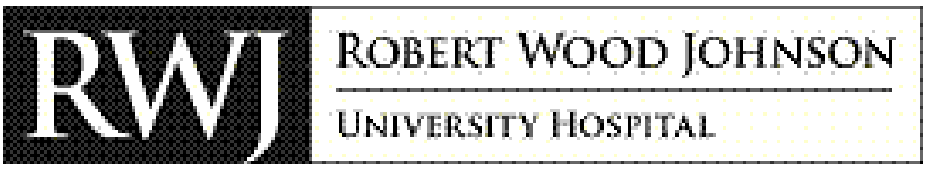

MEDICAL STAFF
RULES AND REGULATIONS

RULES AND REGULATIONS OF THE MEDICAL STAFF OF ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL

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ADOPTION

These Rules and Regulations of the Medical Staff at Robert Wood Johnson University Hospital are adopted and made effective upon approval of the Board of Directors, superseding and replacing any and all previous Medical Staff Rules and Regulations, and henceforth all activities and actions of the Medical Staff at this Hospital shall be
taken under and pursuant to the requirements of these Medical Staff Rules and Regulations.

The Rules and Regulations are placed into effect insofar as they are consistent with the Bylaws of the Medical Staff at Robert Wood Johnson University Hospital.
First Reading by the Medical Board on April 3, 1997.
Second Reading by the Medical Board on May 8, 1997.
Approved and adopted by the Professional Affairs Committee on May 21, 1997.
Approved and adopted by the Board of Directors on June 4, 1997.

Revisions Approved by the Medical Board on May 6, 1999.
Approved and adopted by the Professional Affairs Committee on May 19, 1999.
Approved and adopted by the Board of Directors on June 2, 1999.

Revisions Approved by the Medical Board on May 4, 2000
Approved by the Professional Affairs Committee on May 17, 2000
Approved by the Board of Directors on June 7, 2000

Revisions approved by the Medical Board on June 1, 2000.
Approved by the Professional Affairs Committee on June 21, 2000.
Approved by the Board of Directors on July 5, 2000.

Revisions approved by the Medical Board on November 2, 2000.
Approved by the Professional Affairs Committee on November 19, 2000.
Approved by the Board of Directors on December 1, 2000.

Revisions approved by the Medical Board on December 7, 2000.
Approved by the Professional Affairs Committee on December 20, 2000.
Approved by the Board of Directors on January 31, 2001.

Revisions approved by the Medical Board on February 8, 2001.
Approved by the Professional Affairs Committee on February 21, 2001.
Approved by the Board of Directors on March 7, 2001.

Revisions approved by the Medical Board on March 8, 2001.
Approved by the Professional Affairs Committee on March 21, 2001.
Approved by the Board of Directors on April 4, 2001.

Annual Approval by the Medical Board on May 3, 2001.
Approved by the Professional Affairs Committee on May 16, 2001.
Approved by the Board of Directors on June 6, 2001.

Annual approval by the Medical Board on June 6, 2002.
Approved by the Professional Affairs Committee on June 19, 2002.
Approved by the Board of Directors on July 3, 2002.

Revisions approved by the Medical Board on June 5, 2003.
Approved by the Professional Affairs Committee on June 18, 2003.
Approved by the Board of Directors on September 4, 2003

Revisions approved by the Medical Board on June 2, 2004.
Approved by the Professional Affairs Committee on June 16, 2004.
Approved by the Board of Directors on September 1, 2004

Revisions approved by the Medical Board on July 7, 2005.
Approved by the Professional Affairs Committee on August 17, 2005.
Approved by the Board of Directors on September 7, 2005

Revisions approved by the Medical Board on August 3, 2006.
Approved by the Professional Affairs Committee on August 16, 2006.
Approved by the Board of Directors on September 6, 2006.

Revisions approved by the Medical Board on September 2, 2010
Approved by the Board of Directors on October 6, 2010

DEFINITIONS

1. AFFILIATION AGREEMENT means the document detailing the relationship between Robert Wood Johnson University Hospital and the University of Medicine and Dentistry-Robert Wood Johnson Medical School originally executed on November 15, 1977 and modified on February 8, 1990.

2. ALLIED HEALTH PROFESSIONAL means an individual other than a Physician, Dentist or Limited Licensed Practitioner, who may or may not hold a Doctoral degree in a clinical health care profession, but who may be licensed, certified or registered in his profession or occupation by the State of New Jersey, whose practice in the fields of patient care, public health, and/or health research consists of providing services upon the order of a Physician, Dentist or Limited Licensed Practitioner, and which services assist, supplement, facilitate or complement the patient care services rendered by Practitioners. Allied Health Professionals may use independent judgment, within their areas of competence, as approved by a supervising Physician, Dentist or LLP. Examples of AHP's include, but are not limited to: Certified Registered Nurse Anesthetists, Nurse Practitioners/Clinical Nurse Specialists, Nurse Midwives, and Physician Assistants.

3. BOARD OF DIRECTORS or BOARD means the governing body of the corporation.

4. BOARD CERTIFICATION means certification by a body officially recognized by the Licensing Committee on Graduate Medical Education of the American Medical Association, the American Osteopathic Association or the American Dental Association, or in the case of other health professionals, the generally recognized national board or its equivalent in those fields where one exists.

5. CLINICAL PRIVILEGES or PRIVILEGES means the authorization granted to a practitioner to provide specific patient care services in the Hospital within well-defined limits, based on the following factors, as applicable: license, education, training, experience, competence, judgment, and the ability to perform the privileges requested.

6. CORRECTIVE ACTION means any restrictive modification in the Medical Staff membership or clinical privileges of a practitioner.

7. EX OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.

8. GOVERNING BODY means the Board of Directors.

9. HIS and HE, whenever used in this document, means HIS/HER and HE/SHE respectively.

10. HOSPITAL or RWJUH means Robert Wood Johnson University Hospital, New Brunswick, New Jersey.

11. HOSPITAL POLICIES AND PROCEDURES means hospital policies and procedures adopted by the Medical Board, Board, President or his designee.

12. HOUSESTAFF means those person who are graduates of an approved school of medicine and who are undertaking graduate education toward satisfying requirements for their recognized specialty training or for American Specialty Board eligibility. All Housestaff are appointed to programs at the Hospital conducted under the auspices of the School shall be considered full-time Housestaff of the School. They are supervised by Medical Staff members in carrying out their patient care responsibilities.

13. LIMITED LICENSED PRACTITIONER (LLP) means an individual other than a Physician, Dentist, or Podiatrist who holds a Doctoral degree in a clinical health care profession, who is required to be, and is currently, licensed to practice his profession in the State of New Jersey, whose license does not permit such individual to practice medicine and surgery in all its branches, and who regularly exercises independent clinical judgment within his areas of professional competence. Examples of LLP's include Optometrists (O.D.) and Clinical Psychologists (Ph.D. or Psy.D.).

14. MEDICAL BOARD means the governing body of the Medical Staff; its composition and duties are delineated in Section 12.2 of the Bylaws of the Medical Staff of Robert Wood Johnson University Hospital.

15. MEDICAL SCHOOL or SCHOOL means University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School.

16. MEDICAL STAFF or STAFF means the formal organization of all licensed Physicians, Dentists, Podiatrists, and Limited License Practitioners having professional privileges in the Hospital.

17. MEDICAL STAFF OFFICE means the office at the Hospital which coordinates the application process for Physicians, Dentists, Podiatrists, LLP's, and AHP's and maintains Medical Staff records.

18. MEDICAL STAFF ORGANIZATIONAL STRUCTURE means the designation of Services, Divisions, and Sections of the Medical Staff as delineated in the Table of Medical Staff Organization (Appendix A of the Bylaws of the Medical Staff of Robert Wood Johnson University Hospital).

19. MEDICAL STAFF YEAR means the period from July 1 to June 30.

20. MEDICO-ADMINISTRATIVE OFFICER means a practitioner, employed by or otherwise serving the Hospital on a full-time or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capability as a practitioner, such as to require the exercise of clinical judgment with respect to patient care and include the supervision of professional activities of practitioners under his direction.

21. PHYSICIAN means an individual who hold an unrestricted license to practice medicine in the State of New Jersey.

22. PRACTITIONER means, unless otherwise expressly limited, any Physician, Dentist, Podiatrist, or Limited License Practitioner applying for or exercising clinical privileges in this Hospital.

23. PREROGATIVE means a participatory right granted to a Staff member or Allied Health Professional, subject to conditions imposed in the Medical Staff Bylaws and in other Hospital and Medical Staff policies.

24. PRESIDENT means the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.

25. PROFESSIONAL AFFAIRS COMMITTEE means a committee constituted by the Board of Directors, under Article 7.1.7 of the Corporate Bylaws. This committee is comprised of Physicians as well as Board representatives, and acts as an intermediary deliberative and advisory body to the Board on all matters related to the medical professional activities at the Hospital.

26. RESOURCE-EFFECTIVE CARE shall mean care which is medically necessary, which utilizes hospital resources and services in the most economically efficient manner to achieve desired outcomes.

27. SERVICE CHIEF means the individual responsible for Physicians, Dentists, Podiatrists, Limited License Practitioners, and Allied Health Professionals in his Service.

I. PROVISIONS FOR RULES AND REGULATIONS IN THE BYLAWS OF THE MEDICAL STAFF AT ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL

The provisions for Medical Staff Rules and Regulations is made in Article XV (General Provisions) of the Bylaws of the Medical Staff at Robert Wood Johnson University Hospital. The reference is as follows:

ARTICLE XV: GENERAL PROVISIONS

15.1 STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Medical Board shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws and the Policies and Procedures of the Hospital. These shall relate to the proper conduct of Medical Staff organizational activities as well as the quality of practice and the standards of performance that is to be required of each practitioner. Such Rules and Regulations shall constitute a supplement to these Bylaws and shall be binding on all members of the Medical Staff, and all persons exercising clinical privileges or specified services at the Hospital. The Rules and Regulations may be amended or repealed at any regular meeting of the Medical Board at which a quorum is present and without previous notice, or at any special meeting on notice, by a two thirds vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. Neither the Board nor the Medical Board may unilaterally amend the Rules and Regulations.

15.2 SERVICE RULES AND REGULATIONS

Each Service shall formulate its own Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities. Such Rules and Regulations shall be reviewed and approved by the Medical Board, and by the Board, and shall be consistent with these Bylaws, the general Rules and Regulations of the Medical Staff, the Corporate Bylaws, and other Policies and Procedures of the Hospital. Service Rules and Regulations shall constitute a supplement to these Bylaws.

15.3 STAFF DUES

Subject to the approval of the Board, the Medical Board, through the Credentials Committee shall have the power to set the amount of the application fee and the dues for each category of Staff membership and to determine the manner of expenditure of funds received. Unless excused by the Credentials Committee from the obligation to pay such fees, each member of the Staff shall be obligated to pay such fees as a condition of their continued membership on the Staff. For initial appointment, the failure to pay such dues within a period of 90 days from the date of appointment shall be grounds for suspension from the Staff, and from the exercise of clinical privileges or specified services. For reapplication, dues payment must accompany the Medical Staff Reappointment Application. Reappointment to the Staff will not be processed until such payment is received. Members of the Staff who are suspended by reason of the foregoing shall be entitled to a hearing as specified in the Fair Hearing Plan.

Additional references to Medical Staff responsibilities include, but are not limited to:

ARTICLE XIII: MEETINGS

13.1 GENERAL STAFF MEETINGS

13.1-1 REGULAR MEETINGS

Two regular meetings shall be held each year in the months of May/June and November/ December. The Medical Board may authorize the holding of additional general Staff meetings by resolution. Notice of the time, date, and place of such meeting shall be provided to all members of the Medical Staff in good standing, not less than 10 days prior to the date fixed for such meeting. The meeting can transact any such business as may come before it.

13.1-2 ORDER OF BUSINESS AND AGENDA

The order of business at a regular meeting shall be determined by the President of the Medical Staff. The agenda shall include at least:

(a) Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.

(b) The election of officers and of representatives to Staff and Hospital committees, when required by these bylaws.

(c) Administrative reports from the President, the Chief of Staff, the President of the Medical Staff, and reports from Services and committees.

(d) Reports by responsible officers, committees and departments on the overall results of patient care and other quality review, evaluation and monitoring activities of the Staff and on the fulfillment of the other required staff functions.

(e) Recommendations for improving patient care within the Hospital.

(f) New business.

13.1-3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Board, the President of the Medical Staff, the Chief of Staff, or the Medical Board. The President of the Medical Staff shall call a special meeting of the Medical Staff upon the receipt of a petition requesting such meeting signed by not less than twenty members of the Active Staff. Notice of the time, date and place of such meeting shall be determined by the President of the Medical Staff, and shall be within 20 days of the receipt of said request for meeting, provided to all members of the active Medical Staff in good standing, not less than ten (10) days prior to the date fixed for such meeting, unless for good cause the Medical Board determines that a meeting should be held upon fewer than ten (10) days notice.

No business shall be transacted at any special meeting except that stated in the meeting notice.

II. ADMISSION, TRANSFER, CARE, AND DISCHARGE OF PATIENTS

2.1 ADMISSION

2.1-1 The Hospital shall accept patients regardless of gender, race, color, creed, religion, national origin, or ability to pay except where the facilities of the institution are not deemed adequate by the appropriate department director of the Hospital administration. However, no patient will be denied admission in an emergency situation.

2.1-2 A general consent form, signed by or on behalf of each patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer shall notify the attending physician whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the physician's obligation to obtain proper consent before the patient is treated in the Hospital. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature, risks, and alternatives/options for any special treatment or surgical procedure, consent for blood transfusion, and consent for photography must be obtained where applicable (See Appendix 21).

2.1-3 The Medical Staff shall have a means to assess individual competence to consent to treatment in conformance with current law. Measurement of patient competence may include such skills as ability to understand ones medical condition and the consequences of procedures and treatments, and to communicate a choice. The Hospital and physicians shall follow the procedures for appointment of a special medical guardian where required in accordance with the Civil Practice Rules at 4:83-12. The RWJUH Guardianship Policy outlines the mechanisms for obtaining a guardian (See Appendix 15).

2.1-4 The Hospital recognizes the right of competent adults to plan ahead for health care decisions through the execution of Advance Directives and to have their wishes respected, subject to applicable legal limitations. The Advance Directive policy includes the types of Advance Directives, process for obtaining, Medical Staff responsibility, and more (See Appendix 3).

2.1-5 Every New Jersey hospital patient has rights as stipulated by the Division of Health Care Systems Analysis of the New Jersey Department of Health and Senior Services (8:43G-4.1 Patient Rights). The Hospital shall provide patients with a copy of the Patient Bill of Rights, which are listed in the policy entitled Subchapter 4: Patient Rights (See Appendix 32).

2.1-6 A patient shall be admitted to the Hospital only by a practitioner on the Medical Staff with admitting privileges. The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.

2.1-7 Every patient in the Hospital shall at all times be under the direct and responsible care of a member of the Medical Staff who has appropriate clinical privileges for the diagnosis and treatment of the patient's condition. The appropriate practitioner shall be responsible for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to a referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Staff member, notes

covering the transfer and acceptance of transfer of responsibility shall be entered on an order sheet and progress notes of the medical record.

2.1-8 Each practitioner must assure timely, adequate professional care for his patients in the Hospital by being available or having available through his office an eligible alternate practitioner with whom prior arrangements have been made and who has appropriate clinical privileges at the Hospital. Failure of an attending practitioner to meet these requirements shall result in evaluation by Medical Board/Credentials Committee. The Chief of Staff or the Service Chief, or their designee shall have authority to assign a member of the active Staff to assure proper patient care in the event that an alternate practitioner is not designated.

2.1-9 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded promptly after admission.

2.1-10 In any emergency case in which it appears the patient will have to be admitted to a hospital, the physician shall, when possible, first contact the Admitting Department to ascertain whether there is an available bed.

2.1-11 Practitioners admitting emergency cases shall be prepared to justify to the Medical Board and the administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart promptly after admission.

2.1-12 A patient to be admitted on an emergency basis who does not have a practitioner or who does not designate a practitioner in the applicable Service/Division to attend him will be assigned to a member of the active Staff on duty in the appropriate Division or Service on a rotation basis. Each Service/Division Chief will provide a schedule for such assignments.

2.1-13 The chief admitting clerk will admit patients on the basis of the following order of priorities:

a) Emergency admissions - use of a hospital facility cannot be delayed for 48 hours without being detrimental to the patient.

b) Urgent admissions - use of a hospital can be delayed for approximately 48 hours without being detrimental to the patient.

c) Elective admissions - use of a hospital can be delayed beyond 48 hours without being detrimental to the patient.

Classification of patients is the attending practitioner's responsibility.

2.1-14 The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

2.1-15 Areas of bed utilization and assignment of patients should follow these guidelines:

Patient Care Units	Hospital Service
9 Tower	General Surgery, Trauma, Vascular
8 Tower	Medicine- Renal Dialysis
7 Tower	Neuroscience/Stroke Unit
6 Tower	Heart Failure Transplant
6 North	Surgical Oncology/Urology/Thoracic
5 Tower	Medical Cardiology
5 North	Medical Oncology
4 Tower	Medical Telemetry
4 East	Medical Cardiology
4 West	Medical Cardiology
4 North	Bone Marrow Transplant; Hem/Onc
3 North	CCU
3 East	Post Partum
Newborn Nursery	Newborn Nursery
Special Care Nursery	Special Care Nursery
3 West	Labor and Delivery
3 Tower	NICU & Special Care Nursery
~~2 East~~	~~Adult Medical/Surgical~~
2 West	Post Partum/Obstetrics/NBN
1 Tower	MSD Observation Unit ~~Short Stay Medicine~~
G CORE	Emergency Department – Admitted Patients

Pediatrics: (BMSCH)

CH1 - SDSS	Same day services suite for children (medical and surgical)
CH 2 - Hem/Onc	Pediatric Hematology Oncology
CH 2 - Adolescent	Adolescents 12 to 21 years
CH 3 - PICU	Pediatric Intensive Care Unit
CH 5 - Pediatrics	Children 0 to 12
CH 6 - NICU/SCN	Neonatal Intensive Care & Special Care Nursery

2 CORE	Cardiac Surgery
French Street Orthopedics~~Neuroscience~~	Orthopaedics~~/SBMU~~
Surgical Intensive Care Core (SICC)	Neuro Surgery Care
Surgical Intensive Care East (SICE)	Cardiac Surgery Intensive Care
Surgical Intensive Care West (SICW)	Trauma Surgery Care
Same Day Surgery Suite (SDSS)	Same Day Surgery
Bone Marrow Transplantation (BMT)	Bone Marrow Transplantation/ Oncology ICU
ED Admitted Patients(EDAD)	Emergency Department Admitted Patients
SBMU	Respiratory Medical Vents

When deviations are made from assigned areas as indicated above, the admitting clerk will correct these assignments at the earliest possible opportunity, in keeping with transfer priorities.

Each patient care area shall define admission criteria subject to approval by the Medical Board.

2.1-16 Family Practitioners and Admission to Special Units

a) All Family Medicine admissions to the MICU, CCU, or Telemetry Units from outside the Hospital shall go through the Emergency Room to be checked by the medical screening resident, who in turn will call the attending so that he may give his impressions and get the patient's history, medications, choice of doctor's consultant, etc.

b) Transfers to MICU or CCU from the floor shall require the attending practitioner to contact the screening resident.

c) Patients may be admitted in the name of the Family Medicine attending physician if an appropriate attending physician is consulting on the case. The Family Medicine physician may care for the patient jointly with the consultant or, if mutually agreed upon, the attending on consult may assume the care of the patient.

d) In all instances where medical residents respond to an emergency in a Family Medicine patient, in any patient care area, the resident shall notify the Family Medicine attending and the appropriate attending on consult if applicable.

2.1-17 Procedure for Managing Bed Shortage Crises

If bed management issues cannot be resolved at the Daily Bed Meeting, the Bed Management Team (BMT) will be convened. The BMT has the responsibility and authority to survey the Hospital's bed status, to coordinate daily bed management activities and to determine if a situation of potential overcrowding exists or may soon exist. The BMT consists of the:

Bed Manager
Administrator on Duty (AOD)
Medical Officer of the Day (MOD) who is one of the specialty unit
Medical Directors or his designee
Nursing Administrator
Director of Admissions or designee

The BMT will be convened by the AOD or any member of the BMT when all available resources have been utilized to accommodate Emergency Department patients, elective admission and admitted patients that are awaiting bed assignment. The policy entitled Bed Management Policy is included in Appendix 6.

2.2 TRANSFER

2.2-1 Transfer priorities include:

a) Transfer from the Emergency Room into the appropriate patient bed.

b) Transfer into the specialty units.

c) Transfer out of specialty units.

Communication between the Screening Resident and the patient's attending is mandatory. The only exception is in the event of a Yellow Alert / Disaster. Differences of opinion regarding bed allocation will be resolved by the Medical Director of the unit.

Transfer from other institutions are coordinated by the RWJUH Transfer Center. Details concerning in-house transfer and transfer from other institutions are included in the Bed Management Policy included in Appendix 6.

2.3 CARE

2.3-1 Care of Potentially Suicidal Patients, Patients with Acute Psychotic Episodes, Patients with Emotional Illness, or Patients with Drug Dependency.

For the protection of patients, the medical and Hospital staffs shall follow certain principles in the care of the potentially suicidal patients, patients with acute psychotic episodes, patients with emotional illness, or patients with drug dependency:

a) Responsibility for such determination is the physician's (e.g., attending, psychiatric consultant, resident).

b) The patient will be admitted to a critical care unit if medically necessary. When the patient is admitted to a general area of the Hospital, the attending physician will instruct the Admitting Office as to whether special environmental or care alterations are necessary.

c) It shall also be the responsibility of the attending physician to decide whether the patient should be placed in isolation, whether there should be a change in visiting regulations, whether the patient should be watched on a 24-hour basis, whether all potentially harmful items are to be removed from the patient.

d) Any health care professional (e.g., nurse) has the responsibility of raising with the attending physician the question as to whether special precautions should be taken for the patient.

e) Any patient known or suspected to be suicidal or have an acute psychotic episode must have consultation by a member of the Psychiatry Service with psychiatric consultation privileges.

f) Patients with suicidal tendency, acute psychotic episodes, drug overdose, alcoholism, or emotional illness shall be referred by physicians or staff for Social Work assessment, intervention, and evaluation.

g) The physician shall coordinate transfer to another institution, as appropriate for psychiatric care.

2.3-2 Utilization Management

The attending physician, or designee, is required to document the appropriateness of admission, the treatment plan, and the need for the continued stay as delineated by established medical guidelines. At the request of the attending physician, or his or her designated agent, appropriate guidelines will be made available.

This documentation in the patient's record must contain:

a) An adequate written record of medical necessity for non-urgent admission, including any pre-admission attempts at treatment as an outpatient prior to the admission.

b) A correlation between the admitting diagnosis and the formulation of the treatment plan based on appropriate rationale.

c) The necessity of any ordered diagnostic testing (e.g., stress testing, MRI/MRA, catherization, angiogram, etc…)

d) A proposed discharge plan following treatment, which may include but is not limited to Home Care needs, or the need for continued care at an alternate acute, sub acute, or skilled Nursing facility. If a specific facility is desired by the attending practitioner, patient, or family member, this should be documented in the record.

Hospital stay and diagnostic testing (e.g., stress testing, MRI/MRA, catherization, angiogram, etc…) at RWJUH must be justified by documentation in the medical record by the attending physician or designee (See Appendix 43).

The attending physician or designee will cooperate with appropriate Hospital personnel in resolving issues related to utilization denials. The Service Chief will be notified when the physician does not cooperate.

2.3-3 Outcomes of care

Patients, and, when appropriate, their families, are informed about the outcomes of care, including unanticipated outcomes. The LIP (licensed independent practitioner) or designee, clearly explains the outcome of any treatments or procedures to the patient/family whenever those outcomes differ significantly from the anticipated outcomes.

2.4 DISCHARGE

2.4-1 Patients shall be discharged only on the order of the attending practitioner. Should a patient leave the Hospital without the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record. Should a patient wish to leave against medical advice (AMA), he should sign a waiver that exempts the Hospital and the physician from liability as a result of the patient leaving the Hospital AMA. Patient refusal to sign such a waiver shall be documented.

2.4-2 Deaths and Autopsies

In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. The body shall not be released until an entry regarding the demise has been made and signed in the medical record of the deceased by a member of the Medical Staff and the death certificate certified. Policies with respect to release of dead bodies shall conform to local law. (See Appendix 7).

It shall be the duty of all Medical Staff members to secure autopsies whenever possible. The following conditions represent specific situations in which it is deemed particularly important to obtain consent for post-mortem examination:

a) Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.

b) All deaths in which the cause of death is not known with certainty on clinical grounds.

c) Cases in which autopsy may help to allay concerns of and provide reassurances to the family and/or public regarding the death.

d) Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.

e) Deaths of patients who have participated in clinical trials (protocols) approved by Institutional Review Boards.

f) Unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction.

g) Natural deaths that are subject to, but waived by, a forensic medical jurisdiction, such as persons dead on arrival at the Hospital; deaths occurring in the Hospital within 24 hours of admission; and deaths in which the patient sustained or apparently sustained an injury while hospitalized.

h) Deaths resulting from high-risk infectious and contagious diseases.

i) All obstetric deaths.

j) All neonatal and pediatric deaths.

k) Deaths in which it is believed that autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs.

l) Deaths known or suspected to have resulted from environmental or occupational hazards.

An autopsy may be performed only with a written consent, signed in accordance with State law. All autopsies shall be performed by a Hospital pathologist or by a member of the Pathology residency program under the direct supervision of a Hospital pathologist. Provisional anatomic diagnoses shall be recorded on the medical record within 48 hours and the complete autopsy report should be made a part of the record. The Hospital pathologist shall notify the attending practitioner when an autopsy is being performed.

2.4-3 Discharge criteria (e.g., vital signs, pain control, lab values) shall be considered by the practitioner in the discharge order process. Documentation in the progress note flowsheets, clinical pathways, or other documents in the medical record shall support the patient's readiness for discharge.

III. MEDICAL RECORDS

3.1 HISTORY AND PHYSICAL / ADMISSION

3.1-1 A history and physical examination must be performed, documented and signed within 24 hours of admission. The History should include the chief complaint, present illness, relevant past, personal, social and family history (appropriate to the patient's age), provisional diagnosis and an inventory by relevant body systems. The Physical examination should include a relevant and current physical assessment of the patient and the impressions or conclusion drawn by the physician. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission and the admitting physician at RWJUH is in agreement, a reasonably durable, legible copy of these reports may be used in the patient's Hospital medical record in lieu of the admission history and report of the physical examination. However, the History and Physical must be updated and signed within 24 hours of admission. For patients going for a surgical procedure, the History and Physical must be updated and signed before surgery. The update shall include: 1) update any components of the patient's current medical status that may have changed since the prior history and physical, or 2) address any area where more current data are needed, or 3) document that the history and physical is still current. The documentation shall include evidence that the procedure/care is still indicated and/or necessary. The updated note may be written on the history and physical or attached to the history and physical. An abbreviated history and physical may be used for ambulatory surgical patients or patients staying in the hospital less than 48 hours. In such cases, the abbreviated history and physical must contain at minimum the following documentation; history of present illness, reason for procedure or admission, significant past history, medications, and allergies. A physician exam must be present and should document the review of the organ systems pertinent to the procedure.

3.1-2 Except in emergency situations no patient will be admitted to the Operating Room, nor any potentially hazardous procedure performed without a history and physical examination being performed, documented and signed prior to procedure.

3.1-3 The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital before admission, but an internal admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

3.1-4 An additional, but limited, physical examination shall be performed, documented and signed by the practitioner immediately before performing an operative or invasive procedure. The physical examination shall at least be related to the body system involved (e.g., abdominal assessment immediately prior to a colonoscopy).

3.1-5 The history and physical (H&P) completed by Allied Health Professionals or unlicensed housestaff shall be confirmed and endorsed by an attending physician or licensed housestaff member before cardiac surgery procedures in the operating suite. Such confirmation and endorsement shall be evident by a signature before surgery begins. The Medical Board shall approve additions, modifications, and deletions to high-risk diagnostic or therapeutic interventions requiring confirmation and endorsement of H&Ps by qualified physicians.

3.2 PROGRESS NOTES

3.2.1 Pertinent progress notes shall be recorded by the patient's attending practitioner at least once daily. Clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Outcomes of care, including unanticipated outcomes (i.e., outcomes differ significantly from anticipated outcomes), shall also be documented.

3.2-2 Each time the attending physician visits the patient, the physician shall enter a note into the medical record describing the findings about the patient's condition. If issues have been raised in the record by other disciplines, this note shall respond to them.

3.2-3 For patients receiving continuing ambulatory care services, the medical record contains a Summary List of known significant diagnoses, conditions, procedures, drug allergies, and medications. The list is initiated for each patient by the third visit and maintained thereafter.

3.3 OPERATIVE REPORTS

3.3-1 Operative reports shall include a detailed account of the findings at surgery, details of the surgical technique, specimen(s) removed, postoperative diagnosis, and name of the primary surgeon and any assistant(s). Operative reports shall be written or dictated immediately following surgery and the report promptly signed by the surgeon and made a part of the patient's current medical record. Any practitioner with undictated operative reports 24 hours following the day of the operation shall be automatically suspended from operative privileges. Temporary reinstatement of privileges can be granted according to Section 3.7 (g) in these Medical Staff Rules and Regulations. If the operative report is dictated, a brief operative note shall be written immediately following the procedure to provide pertinent information (e.g., name of procedure, surgeon, complications, if any).

3.3-2 A pre-anesthesia assessment shall be made by the anesthesiologist to determine if the patient is an appropriate candidate. Prior to induction the patient is re-evaluated for anesthesia by the anesthesiologist. A record of anesthesia shall be made for each patient receiving anesthesia by the licensed practitioner. Post-anesthesia notes shall be entered into the patient's medical record by the anesthesia provider within 48 hours after the surgical procedure for inpatients.

3.4 CONSULTATION

3.4-1 The reason or reasons for requesting a clinical consultation shall be specified in the patient's record by the attending physician. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

3.5 FINAL DIAGNOSIS / DISCHARGE SUMMARY

3.5-1 Final diagnosis shall be recorded in full, without the use of symbols or abbreviations.

3.5-2 The medical record of patients receiving emergency, urgent, or immediate care notes the conclusions at termination of treatment, including final disposition, condition at discharge, and instructions for follow-up care. When authorized by the patient or a legally authorized representative, a copy of the emergency services provided is available to the practitioner or medical organization providing follow-up care.

3.5-3 A transfer record shall be completed for all transfers to acute care, rehabilitation, subacute, long-term care, correctional facilities, and other inpatient settings. The record shall contain at least the following information: diagnoses, physician orders in effect at the time of discharge, the last time medication was administered, nursing needs, hazardous behavioral problems, allergies, required therapies, and other orders to direct patient care. The transfer record shall be signed on-line via the computerized order system or in writing by a licensed physician. The Telephone and Verbal Order policy may be utilized if criteria are met.

3.5-4 A discharge summary shall be written or dictated on all medical records of patients hospitalized over 48 hours, except for normal obstetrical deliveries or normal newborns. The discharge summary should recapitulate concisely the reason for hospitalization; final diagnosis; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; medications on discharge; and any specified instructions given to the patient and/or family, as pertinent. Consideration should be given to instructions relating to physical activity, medication, diet, and follow-up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology, such as "improved". When preprinted instructions are given to the patient or family, the record should so indicate and sample of the instruction sheet in use at the time should be on file in the Medical Record Department. If authorized in writing by the patient or his legally qualified representative, a copy of the discharge summary should be sent to any known medical practitioner and/or medical facility responsible for the subsequent medical care of the patient.

Patients hospitalized for 48 hours or less, normal obstetrical deliveries, and normal newborns shall have a final summation type progress note, including at least the patient's condition on discharge, medications on discharge, and instructions given to the patient and/or family.

In the event of death, the pronouncement shall be noted in the progress note and the discharge summary dictated. The discharge summary should indicate the reason for admission, the findings and the course in the Hospital, and events leading to death. All summaries shall be authenticated by the responsible practitioner.

3.6 GENERAL

3.6-1 The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record should include identification data, complaint, personal history, family history, history of present illness, physical examination with provisional diagnosis, medical or surgical treatment, final diagnoses, progress notes, discharge summary or discharge note. To this record shall be appended all additional special reports such as clinical laboratory and radiological services, pathological findings, etc. which are the responsibility of the services and/or individuals concerned.

3.6-2 The attending practitioner or licensed housestaff shall countersign (authenticate) the history & physical examination, consultation, operative reports, and discharge summary and orders when they have been recorded by unlicensed housestaff.

3.6-3 All clinical entries in the patient's medical record shall be legible, accurately dated and authenticated. Authentication means that authorship has been established by written signature, identifiable initials, or computer signature. In the case of groups conducting a single practice in a single medical discipline, interchangeability of signatures is permissible.

3.6.4 Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive the information. In those cases where the patient cannot legally give consent, permission shall be obtained from his spouse, immediate next of kin or legal guardian.

3.6-5 Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Board.

3.6-6 Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning individual patients. All such projects shall be approved by the Institutional Review Board (IRB) before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital

3.6-7 A medical record at Robert Wood Johnson University Hospital is considered delinquent when case history and physical examination, consultation(s), discharge summary, report of operative or invasive procedures, and/or verbal orders have not been completed and/or signed within 30 days of discharge.

3.6-8 Authorized written requests for follow-up information may be sent to members of the Medical Staff from Registry or Registries duly approved in their operation by the Medical Board. Failure to respond to formal follow-up inquiry following no fewer than two separate written attempts will constitute permission on the part of that practitioner for the Registrar to attempt direct and discreet contact with the patient.

3.6-9 The following health care professionals are authorized to make entries in patient records as appropriate in accordance with hospital responsibilities:

Physicians and other Medical Staff Members
Housestaff
Physician Assistants
Advanced Practice Nurses
Certified Nurse Midwives
Certified Registered Nurse Anesthetists
Nursing Staff (RN, LPN, CCT)
Registered Dietitians
Registered Pharmacists
Licensed Therapists (Respiratory, Physical, Occupational, Speech, Audiologist)
Perfusionists
Outcomes Managers
Social Workers
Chaplains
Technician (EEG, EKG, Radiology, Pharmacy, Lab, other)
Admitting Registrars
Utilization/Managed Care Nurses (with special approval by the Outcomes Management Department)
Placement Coordinator
Managers on Duty
Administrators on Duty
Medical Students
Representatives from External Companies (e.g., infusion nurses) – with special approval according to policy.
Massage Therapists

Original source documents will be used by practitioners during report, change of coverage, and when completing chart documentation via dictation or manual entry.

The appropriate Department Head and Administrator is responsible for ensuring the policy meets regulatory requirements (e.g., Department of Health, JCAHO and Board regulations) and is modified as needed.

3.7 For the purpose of suspension, Robert Wood Johnson University Hospital considers a delinquent record to be any record which includes items referred to in the Rules and Regulations, Section 3.6-7 as well as other deficiencies delineated by the Medical Records Department, Peer Review and the Catheterization Laboratory. Physicians on suspension may not admit, operate, consult, schedule procedures, or treat any patients while on suspension. The following system will be used for notification and suspension for failure to comply with the above-mentioned medical record requirements:

a) If the practitioner has discharged records, a mechanism shall exist within the Medical Records Department to notify a practitioner of any impending suspension, prior to being placed on suspension. Notifications of impending suspension for failure to complete operative or invasive procedure reports and failure to perform Peer Review shall be generated in the appropriate department.

b) Such departments shall forward a list of practitioners who will be going on suspension to the Medical Records Department and will be compiled into a single Master Suspension List.

c) The physician will receive one suspension notification from the Medical Records Department after they are placed on suspension, noting the date of and reason for the suspension, as well as the appropriate department to contact to rectify the situation. Documentation of the above suspension shall be maintained within the practitioner's file in Medical Administration.

d) The following are the conditions that will result in suspension.
   1. Incomplete chart(s) thirty (30) days beyond date of discharge.
   2. Undictated operative or invasive procedure report(s) more than 24 hour after the date of the procedure.
   3. Failure to complete peer review 60 days beyond the date of request.
   4. Failure to respond within seven (7) days of a practitioner personally being made aware of an inquiry from Health Information Management or the Performance Improvement Department for quality related issues involving outside agencies, including but not limited the New Jersey Department of Health and Senior Services, the Joint Commission on Accreditation of Healthcare Organizations, New Jersey Board of Medical Examiners, Health Care Quality Strategies, (the Medicare-designated Quality Improvement Organization), and the Food and Drug Administration.
   5. In the event that a response is not possible within seven (7) days due to a practitioner's absence from place of practice, and regulatory compliance requires a response within that time period, the service chief will assign the responsibility to another physician.

e) Medical Records staff shall distribute suspension lists to all appropriate departments as well as making the list available on the Robert Wood Johnson University Hospital Intranet.

f) If the physician has received two (2) suspensions or a total of fifteen (15) days on suspension, a warning letter will be sent to the physician informing them of the impending reprimand pursuant to the paragraph below.

   If a physician receives three (3) suspensions or a total of twenty-one (21) consecutive days of suspension during the year for any combination of reasons, a letter of reprimand shall be generated and forwarded to the Service Chief to be signed and sent by the Medical Records Department via certified mail to the practitioner. A copy will be placed in the practitioner's file in the Medical Administration office. If the letter is not signed and returned to the Medical Records Department within one business day to be mailed, it will be forwarded to the Chief of Staff for signature and will be sent via certified mail to the practitioner.

g) If a practitioner becomes suspended when his/her patient is scheduled for a procedure, the physician must immediately complete all documentation necessary to be removed from suspension. Exceptions may be granted on a case by case basis by the Service Chief (with notice to the Chief of Staff) or by the Chief of Staff. To facilitate reinstitution of privileges, practitioners shall notify the Medical Records Department by phone if they believe they have fulfilled the requirements for removal from suspension.

h) Suspension for any cause in excess of 30 consecutive days shall be referred to the Chief of Staff for consideration of resignation from the Medical Staff. Suspension of privileges for any cause in excess of 90 consecutive days shall be considered a voluntary resignation from

the Medical Staff. In addition, the issuance of more than one reprimand in any twelve month period shall be referred to the Chief of Staff who shall consider whether further corrective action against the practitioner is warranted. Individuals who have resigned under this provision may reapply for privileges as a new applicant at any time after 30 days and be subject to applicable fees. Corrective action history shall be considered in the re-application process.

In the case of medical records that are incomplete because the responsible attending physician has moved from the area or, after appropriate warning and/or disciplinary action, has refused to complete the charts, the Medical Records Director may retire the charts. A retirement form will be placed in the record documenting administrative and other measures taken to obtain completion. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Director of Medical Records.

3.8 A signature, followed by a professional contact number, unless otherwise indicated on the Form or document in use.

3.9 Practitioners shall contact the Performance Improvement Department (who shall contact Risk Management) if the practitioner is asked to provide verbal or written information regarding a RWJUH patient to an accrediting or regulatory body such as the New Jersey Department of Health and Senior Services, the Joint Commission on Accreditation of Healthcare Organizations, New Jersey Board of Medical Examiners, Food and Drug Administration, or others. Such notification shall be made to RWJUH before providing the requested information.

IV. GENERAL CONDUCT OF CARE

4.1 ORDERING

4.1-1 All orders for treatment shall be in writing or entered directly into the computerized clinical information system. A verbal or telephone order shall be considered to be in writing if signed and dated by the responsible practitioner within 30 days. Verbal and phone orders shall be given, accepted, and processed according to the Telephone / Verbal Order Policy (See Appendix 41).

4.1-2 The practitioner's orders must be clear, legible, and complete. Orders which are illegible or improperly written will not be carried out until rewritten or clarified and fully understood by the nurse. The use of "Renew", "Repeat", and "Continue Orders" is not acceptable.

4.1-3 Standing orders are canceled when patients go to surgery. Exceptions to this policy include consults that are ordered and specific orders that the physician has requested not be discontinued through the pre-op discontinue process on TDS.

4.1-4 All standing orders for laboratory tests shall be for a period not to exceed 72 hours from the time the first related specimen is obtained.

4.1-5 Orders for particular patient populations shall be requested according to the policy entitled Personal / Department Order Sets (See Appendix 34).

4.1-6 All drugs and medications administered to patients shall be those listed in the latest edition of: United Stated Pharmacopoeia, National Formulary, American Hospital Formulary Services,

A.M.A. Drug Evaluations, or Physicians Desk Reference. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

4.1-7 An automatic stop order policy for all medications, including categories of potentially hazardous drugs has been established (See Appendix 5).

4.1-8 All medication orders shall specify the name of the drug, dose, frequency, and route of administration, and shall be dated and signed (or approved by authorization code if ordered through computer entry) by the prescriber.

4.2 CONSULTS

4.2-1 The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit such consultation.

4.2-2 Where appropriate consultation is needed and has not been obtained, the Service Chief or designee may request that consultation be obtained.

4.2-3 All patients in the MICU shall have a physician consultant on the RWJUH Medical Staff who is board-certified or board eligible in Critical Care Medicine (CCM), unless the attending physician is board-certified or board eligible in CCM.

4.3 PERFORMANCE IMPROVEMENT

The Performance Improvement Program at RWJUH is consistent with the Hospital mission to provide Care, Outreach, Research, and Education and is incorporated in the Hospital's Plan for Improving Organizational Performance (See Appendix 33). The Medical Staff shall provide leadership for the measurement, assessment, and improvement of processes which at least include: medical assessment and treatment of patients, use of medications, use of blood and blood components, use of operative and other procedures, efficiency of clinical practice patterns, and significant departures from established patterns of clinical practice.

4.4 PATIENT CARE

4.4-1 Restraint Use

Restraints shall be ordered according to the Policies for medical/surgical patients and behavioral management patients.

4.4-2 Sedation and Analgesia by Non-Anesthesiologists

"Sedation and analgesia" describes a state which allows patients to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal command and/or tactile stimulation.

The policy and procedure for Sedation and Analgesia by Non-Anesthesiologists (See Appendix 16) was developed to allow patients to obtain the benefits of sedation/analgesia while

minimizing the risks under circumstances when an anesthesiologist is not in attendance. It identifies four categories of individuals who can prescribe sedation: 1) a physician who is privileged to do so; 2) a resident physician under the supervision of a privileged physician; 3) a certified registered nurse anesthetist (CRNA) under the supervision of a privileged physician; and 4) a dentist trained in anesthesiology who is privileged to do so. This individual should be continuously present at the patient's bedside during the entire procedure. Patient evaluation, pre-procedure preparation, monitoring, staff training, staff availability, equipment, administration, recovery care, guidelines for discharge, documentation and special situations are incorporated in the policy and procedure.

4.4-3 Post Anesthesia Discharge

Patients who have received an anesthetic other than a local anesthetic will be examined prior to discharge and, if deemed necessary, will be accompanied home by an individual competent to perform care for patients in the post-anesthesia state. The examination may be conducted by any member of the Medical Staff with admitting privileges. In addition, written instructions for follow-up care and the way to reassess medical services will be provided to either the patient or a family member/guardian responsible for the patient's care.

4.5 RESEARCH

4.5-1 Research Review Committee

A multidisciplinary committee meets monthly to review the impact of research studies on Hospital resources (e.g., personnel, equipment). The policy outlining the process is included in Appendix 37.

4.5-2 Scientific Misconduct

The Hospital has established a policy and procedure for the response to allegations and apparent occurrences of misconduct in scientific research sponsored by the Hospital or conducted under the direction of any employee of the Hospital in connection with his institutional responsibilities or use of any property or facility of RWJUH (See Appendix 34).

4.6 YELLOW ALERT / DISASTER
The Hospital Disaster Plan is included in Appendix 44.

4.7 HOSPITAL POLICIES AND PROCEDURES (Available in the Medical Administration Dept.)

VI. Appendices-Attached