Hackensack Meridian Health

Riverview Medical Center

Medical Staff Rules & Regulations

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Article I

General

1.1 **Definitions**

The definitions that apply to terms used in all Medical Staff documents, including these Rules and Regulations, are set forth in the HMH Riverview Medical Center Bylaws.

1.2 **Delegation of Function**

Unless otherwise provided, when a function is to be carried out by a member of HMH management, by a Medical Staff leader, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

1.3 **Patient Rights**

Riverview Medical Center and the Medical and Dental Staff organization respects the rights of each patient and recognizes that each patient is an individual with unique healthcare needs.

1.4 **Primary Division**

In accordance with HMH RMC Medical Staff Bylaws Article 4.2.5, all members of the Medical staff, except members of a contracted service, must select a Primary Division.

1.4.1 Only members of the medical staff who have selected Riverview Medical Center as their Primary Division are eligible to serve as Officers, Department Chairs, Section Chiefs, and members of the MEC.

1.5 **Allied Health Professional**

Allied Health Professional means an individual other than a licensed Physician, Dentist or Podiatrist whose patient care activities require that his/her authority to perform specific patient care services be processed through the usual Medical and Dental Staff credentialing process. This definition includes advanced practice nurses, physician assistants, RN first assistants, and certified nurse midwives, who are not members of the medical staff.

1.5.1 Allied Health Professionals applying to HMH Riverview Medical Center must have a sponsor on the medical staff, be approved by the Credentials Committee and recommended by the Medical Executive Committee to the Board of Trustees of HMH for initial acceptance. Reapplication at two-year intervals will follow the same process.

Sponsoring medical staff members will evaluate respective Allied Health professionals regarding quality of performance and adherence to the HMH Riverview

Medical Center Bylaws, Medical Center Rules and Regulations, and appropriate Department Rules and Regulations and report this information to the Credentials Committee every eight months or at a shorter interval if necessary.

Allied Health Professionals may not hold office or vote. They may attend Department Meetings if approved by the Department Chairman and Committee Meetings if approved by the Committee Chairman.

Article II

Application Process

2.1 **Pre-Application for Initial Appointment**

In accordance with the HMH Riverview Medical Center Bylaws Article 7.2, all new applicants to the Medical Staff are sent a pre-application.

2.1.1 Form: In accordance with the HMH Riverview Medical Center Bylaws, article 7.2.3, the pre-application form will be standardized across the HMH Network Hospitals.

2.1.2 Criteria: The information requested in the pre-application shall include a curriculum vitae, NJ Professional License, DEA, CDS, Board Certification (if appropriate), malpractice insurance face sheet, and other questions pertinent to membership on the HMH-Riverview Medical Staff.

2.1.2.1 Membership on the Active Medical Staff at HMH-RMC requires that the member be actively practicing his/her profession in the area served by HMH-RMC or produce evidence of a firm commitment to actively practice in the area served by HMH-RMC.

2.1.2.1.1 Patients will have timely access to the physicians, especially if an urgent medical problem occurs. Therefore, any individual taking call in the Emergency Room or covering his/her patients at HMH-Riverview Medical Center must maintain his/her personal and principle residence and a clinical office within 30 minutes driving time of HMH-Riverview Medical Center with the exception of HMH-Riverview Medical Center physicians who are in house when on call, and members of the Department of Pediatrics who have 24/7 Pediatric coverage supplied by the hospital. The 30-minute requirement also excludes physicians from the general medical call who admit to a hospitalist group. However, all staff members who admit to the hospital and all specialists are bound by the 30-minute requirement for the specialty service they provide especially staff members in the surgical specialties and subspecialties, including the Department of Surgery, Orthopedic Surgery, Ophthalmology, and Obstetrics and Gynecology. Members of the Department of Medicine whose patients' general medical care is not assigned to the hospitalists and specialists in the Department of Medicine will be bound by the 30 minute requirement for specialty care excluding those specialists whose specialty, in the judgement of the Chairman of the Department of Medicine, does not require emergency call. This should be outlined in the Rules and Regulations of the department. The application of the 30-minute requirement to contracted services such as Pathology or Radiology will be determined by the Department Chairs with the exception of Interventional Radiology and

Anesthesiology where the 30-minute requirement must apply or on call staff members must be in house when on call.

- Determination of driving time will be determined by Google Maps.
- The term "office" shall mean an actively functioning professional office which is regularly open to the public.
- The term "personal residence" shall mean the location at which the member legally resides, i.e. his/her principal residence.

2.1.2.2 A Department may "waive" the 30-minute requirement based on absolute community need of a specific service as determined by the Department Chair, the Credentials Committee, the Medical Executive Committee, and the HMH Board of Trustees.

2.1.3 **Processing of Pre-Application**

Upon submission of a completed pre-application, the Department Chair/Section Chief shall, within 10 business days, review the pre-application and determine whether the individual meets the necessary criteria.

2.1.3.1 If the individual meets criteria, he/she will be sent a full application.

2.1.3.2 If the individual does <u>not</u> meet criteria, the Department Chair/Section Chief or designee will notify the individual and explain the reason.

2.1.4 Oversight of the pre-application process will be through Article 7.2.6 of the HMH-RMC Bylaws.

2.2 <u>Temporary Privileges</u>

2.2.1 Temporary privileges will be granted in accordance with Article 8.3 of the HMH-RMC Bylaws:

2.2.1.1 HMH-RMC Bylaws 8.3.1 (a) allows for temporary privileges for a pending application. In addition to the requisites outlined in 8.3.1(a), temporary privileges will be granted only where the application is both complete and "clean".

2.2.1.2 Temporary privileges may be granted only with pendency of an application to fulfill an urgent patient care need.

2.3 <u>Definition of a Complete Application</u>

A <u>complete</u> application is defined as one in which all questions have been answered, all requested materials have been received and evaluated, and there are no pending documents.

2.4 **Definition of a "Clean" Application**

A "clean" application is defined as one in which there are no negative or marginal comments, no medical liability suits, settlements, or payments, and no issues with the original application for further evaluation.

2.5 **Locum Tenens**

Locum tenens is defined in the HMH-RMC Bylaws. In order for a locum tenens applicant to receive temporary privileges he/she must adhere to Article 8.3.1b of the HMH-RMC Bylaws. If the recommendation for temporary privileges was not requested by his/her department chair, it must be approved by the department chair, the Credentials Committee, and the Medical Executive Committee of the Division before it is passed on to the HMH Board for approval.

Article III

Medical Staff Governance

3.1 **Medical Staff Departments**

Each member of the Medical Staff is assigned to a department. The departments of the Medical Staff are:

- Medicine
- Surgery
- Obstetrics & Gynecology
- Orthopedics
- Ophthalmology
- Anesthesia
- Radiology
- Pathology
- Emergency Medicine
- Psychiatry
- Pediatrics

3.1.1 Creation of a New Department

A new department may be created within the structure of the Medical Staff as follows:

(a) Application is made in writing to the CMO addressing the following elements:

(1) The reason for creation of the Department, which may include an explanation as to why simply establishing a section within an existing Department would not suffice;

(2) Documentation demonstrating that the Department is a specialty or subspecialty recognized by the American Board of Medical Specialties (ABMS); and

(3) The criteria for Medical Staff membership in this Department (including certifications).

(b) Membership of a new Department must consist of no fewer than ten (10) members of the Medical Staff, whose primary division is HMH RMC.

(c) The written request will be reviewed by the CMO for the appropriate elements and forwarded to the President of the Medical Staff.

(d) The President of the Medical Staff will then appoint an ad hoc committee of the Medical Executive Committee, which will then investigate the advisability and feasibility of the creation of the requested department. The ad hoc committee shall include the existing "department" chair if the new department is a spin-off of an existing department or a section of an existing department.

(e) The ad hoc committee will make a formal report of its findings and recommendations to the Medical Executive Committee. The Medical Executive Committee may approve creation of a new department subject to a final decision by the HMH Board at the next meeting. The Board shall appoint members to this new department after approval by the Credentials Committee and the Medical Executive Committee.

3.2 **Sections and Subsections within Medical Staff Departments**

Each of the departments may have specialty sections. The specialty sections of the HMH-RMC Medical Staff are:

- Medicine
    - Cardiology
    - Dermatology
    - Family Medicine
    - Gastroenterology
    - General Medicine
    - Hematology & Oncology
    - Hospital medicine
    - Infectious Disease
    - Nephrology
    - Neurology
    - Physical Medicine & Rehabilitation
    - Pulmonary medicine
    - Rheumatology
- Surgery
    - Colorectal Surgery
    - Breast Surgery

- Dentistry & Oral Surgery
- General Surgery
- Neurosurgery
- Otolaryngology
- Plastic Surgery
- Thoracic Surgery
- Urology including Pediatric Urology and Female Urology
- Vascular Surgery

- Anesthesia
  - Pain Management
- Orthopedics
  - Podiatry
- Psychiatry
  - Psychology
- Obstetrics & Gynecology
  - Maternal-Fetal Medicine
  - Reproductive Endocrinology
  - Uro Gynecology
  - Gyn Oncology
- Radiology
  - Breast Imaging
  - Diagnostic Radiology
  - Interventional Radiology
  - Nuclear Medicine
  - Radiation Therapy
  - Ultrasound

3.2.1 Creation of a New Section

A new section within a department (either existing or new) may be created within a department as follows:

(a) Application is made to the CMO with the following elements:

(1) Reason for creation of the section; and

(2) Criteria for Medical Staff membership in this section (including certifications).

(b) The request will be reviewed by the CMO for the appropriate elements and forwarded to the Chairperson of the department.

(c) The Chairperson of the department will then evaluate the request for a new section and make a recommendation to the Medical Executive Committee. The request for creation of a new section must be approved by the Medical Executive Committee and the HMH Board.

3.3 **Selection of Medical Staff Officers, Department Chairs, and Members of the Medical Executive Committee**

No later than the second week in September, the MEC will advise the Medical Staff Office to post, via email, the positions on the MEC that will become available. This will include the positions for Officers of the Medical Staff whose term in office will expire and the four at-large seats on the MEC that are available annually.

3.3.1 **Nominating Committee**

3.3.1.1 Nominating Committee for Medical Staff Officers and Members of the MEC

(a) Each department will elect or appoint a member of the department to serve on the Nominating Committee.

(b) The Committee will elect its own Chair annually.

(c) The Committee will meet annually in the fall to review candidates for Medical Staff Officers and positions for Members at Large on the MEC.

(d) Members of the Nominating Committee are not eligible for nomination by the Committee for either a position as a Medical Staff Officer or Member at Large.

(e) Members of the Committee must complete a Conflict of Interest statement.

(f) the Nominating Committee will submit a report to the MEC regarding the candidates who were recommended no later than the November MEC meeting.

(g) Other processes for candidacy are provided in Article 3.3.2 of these Rules and Regulations.

3.3.1.2 **Nominating Committee for Department Chair**

- The Chair of each department will be elected by those members of the department eligible to vote.

- Election of Department Chairs will occur in the fall and results of the election are reported at the November MEC meeting.
- The term for all Department Chairs is one year.

3.3.1.3 The qualification and selection of Department Chairs is as outlined in 12.2.1 and 12.2.2. of the HMH/RMC Bylaws.

3.3.1.4 Leave of absence of each Department Chair is outlined in 12.2.4 of the HMH/RMC Bylaws.

3.3.1.5 Department Vice Chair

The qualifications, selection, term of office, and duties of the Department Vice Chair are as outlined in Article 12.3.1 and 12.3.2 of the HMHR/MC Bylaws.

3.3.1.6 Section Chief

(a) Qualifications of Section Chief are to be approved by the Department Chairman, the Credentials Committee, and the MEC before being forwarded to the HMH Board of Trustees.

(b) Section Chief may be elected by members of the section who are eligible to vote or appointed by the Department Chair. If a Section Chief is elected, he/she must be approved by the Department Chair, the Credentials Committee, and the MEC before being approved by the HMH Board of Trustees. If a Section Chief is appointed by the Department Chair, the appointment must be approved by the Credentials Committee and the MEC before being forwarded to the HMH Board of Trustees.

(c) Term of office for Section Chiefs is one year.

(d) Duties of Section Chief are outlined in 12.2.3 of the HMH/RMC Bylaws.

3.3.1.7 Subspecialties of Departments and Sections

(a) Subspecialties are listed in 3.2 of these Rules and Regulations.

(b) Each subspecialty will report to and be accountable to its department and/or section.

(c) Subspecialties' quality review will be performed by their department and they will be required to follow the rules and regulations for their department.

3.3.2 Other Means of Nomination

3.3.2.1 Medical Staff Officers and MEC Member-at-Large

(a) Nominations by petition:

- Nominations may be made by a petition signed by at least 25 members of the active Medical and Dental Staff eligible to vote.
- This petition is filed with the Chair of the Nominating Committee no later than 10 days after posting the nominations by the Nominating Committee.

- Nomination(s) by petition will be immediately posted via email by the Medical Staff Office.

(b) Nominations from the floor:

- At the December annual meeting, nominations for the Officers of the Medical Staff or Members at Large will be accepted from the floor.
- Nominations from the floor must be properly seconded by proper parliamentary procedure.

3.4 **Composition of the MEC**

The MEC is composed of:

- President of the Medical Staff
- Officers of the Medical Staff (Vice President, Secretary, Treasurer, and Past President)
- Chair of each Clinical Department
- 12 at-large members
- President of the Medical Center (without vote)
- Chief Medical Officer (without vote)
- Other members of the Medical Staff at the request of the President of the Medical Staff (without vote). The other members of the Medical Staff should be invited by the President of the Medical Staff for each meeting they are requested to attend.

3.4.1 Members-at-Large

(a) Must designate HMH-RMC as their Primary Division.

(b) Term is 3 years.

(c) Members-at-Large will be elected annually.

(d) No more than 3 members of a department may serve as "at-large" members at any time, unless the department has greater than 100 Primary Division Members.

(e) Departments with fewer than 15 Primary Division Members from Riverview Medical Center will be restricted to one at-Large Member on the Medical Executive Committee at HMH RMC.

3.5 **Committees of the Medical Staff**

3.5.1 The Appointed Committees of the Medical Staff include:

- Bioethics Committee
- Blood Usage Review Committee

- Bylaws Committee
- Credentials Committee
- Critical Care Committee
- Emergency Care Committee
- Joint Conference Committee
- Nominating Committee
- Operating Room Committee
- Pharmacy & Therapeutics Committee
- Professional Assistance Committee
- Quality Improvement & Outcomes Committee

3.5.1.1 The President of the Medical Staff appoints the Chairs and members of all of the above committees, except the Credentials Committee, the Nominating Committee, and the Chairman and certain members of the Operating Room Committee.

3.5.2 **Credentials Committee**

3.5.2.1 The Credentials Committee is a Medical Staff Committee and is composed of the Chairs of each department and the Vice President of the Medical Staff.

3.5.2.2 The Hospital President or designee, Chief Operating Officer, Chief Medical Officer, and Chief Nursing Officer are members of the Credentials Committee without vote.

3.5.2.3 The Chair of the Credentials Committee is the Vice President of the Medical Staff.

3.5.3 **Operating Room Committee**

3.5.3.1 The Operating Room Committee is a Medical Staff Committee and is composed of:

- Chairman of Surgery
- Chairman of OB/GYN
- Chairman of Orthopedic Surgery
- Chairman of Anesthesia
- Chairman of Ophthalmology
- Section Chiefs in these departments
- Other members appointed by the President of the Medical staff

- Members of Administration including, but not limited to the CMO, CNO, COO, Hospital President, OR Manager, Business Manager of OR, Nursing Director of OR, and Manager of SPD

3.5.3.2 The Chairman of the OR Committee is the Chairman of Surgery

3.5.4 **Medical and Dental Staff Quality Committee**

3.5.4.1 Composition: at least one Medical and Dental staff member from each department, the CMO or designee without vote, the CNO or designee without vote, and any other Medical Staff Members appointed by the President of the Medical and Dental Staff.

3.5.4.2 The Chair of the Committee will be appointed by the President of the Medical staff and approved by the Credentials Committee, Medical Executive Committee, and the HMH Board of Trustees.

3.6 **Organized Medical and Dental Staff Meetings**

3.6.1 The Organized Medical and Dental Staff shall meet twice per year.

3.6.1.1 The meetings are held in June and December.

3.6.1.2 The date, time, and place for these meetings is determined by the President of the Medical Staff and approved by the Medical Executive Committee.

3.6.1.3 Notifications of the meetings will be in accordance with HMH Riverview Medical Staff Bylaws Article 14.3.1.

Article IV

Admissions

4.1 **Admissions**

4.1.1 Riverview Medical Center shall accept all patients for care and treatment regardless of race, religion, national origin, sex, age, sexual preference or ability to pay.

4.1.2 A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission.

4.1.3 The patient may be admitted to the hospital only by a member of the Medical Staff who has admitting privileges.

4.1.3.1 Members of the Dental Staff may admit patients according to the rules set forth:

4.1.3.1.1 The scope and extent of surgical procedures that a dentist may perform in the hospital is delineated and recommended in the same manner as other clinical privileges.

4.1.3.1.2 The dentist is responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. A medical history and physical examination of each patient is performed by a physician who is a Medical Staff member before dental surgery is performed. A designated physician is responsible for the medical care of the patient throughout any period of hospitalization.

4.1.3.1.3 Dentists may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations, and in compliance with the Medical Staff Bylaws and policy in 4.1.3.1 of these Rules and Regulations.

4.1.3.2 Oral surgeons who admit patients without medical problems may complete an admission history and physical and assess the medical risks of the procedure on ASA Class 1 and 2 patients with an age range from 16 to 65 years of age. All patients not fitting into this category must have a medical or pediatric consultation pre-operatively.

4.1.3.3 Podiatrist members may perform the podiatric history and physical if privileged to do so.

4.1.3.3.1 The scope and extent of surgical procedures that a podiatrist may perform in the hospital is delineated and recommended in the same manner as other clinical privileges.

4.1.3.3.2 Surgical procedures performed by podiatrists are under the overall supervision of the Chairman of the Department of Orthopedics. In accordance with the State of New Jersey

regulations, a medical history and physical examination is performed by a physician who is a Medical Staff member for all patients ASA 2 and above. A designated physician, privileged at Riverview Medical Center, is responsible for the medical care of the patient throughout any period of hospitalization.

4.1.3.3.3 The podiatrist is responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record. Podiatrists may write orders that are within the scope of their licenses, consistent with the Medical Staff Rules and Regulations, and in compliance with the Medical Staff Bylaws.

4.1.4 Unless the admitting physician has seen the patient in his/her office or another facility, performed a complete assessment of the patient, and completed a history and physical examination within 4 hours of the admission, the admitted patient must be seen by the attending physician or his/her designee and a history and physical examination must be performed within 4 hours of the admission. Critically ill patients must be seen within 2 hours. The responsibility for care of the patients begins with the agreement to accept a patient, no matter where in the hospital that patient is located.

4.1.5 All patients will have a physician order regarding billing status: (inpatient/outpatient/observation)

4.1.5.1 The physician order for billing status must be signed, dated, and timed prior to discharge.

4.1.6 It is the admitting physician's responsibility to assure that his/her patient has pre-admission testing completed in accordance with the Medical Staff Rules and Regulations and Policies.

4.2 **Emergency Admissions**

4.2.1 Except in a dire emergency, no patient is admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of a dire emergency, such statement is recorded as soon as possible in the medical record.

4.2.2 Practitioners admitting emergency cases are prepared to justify that the admission was a bona fide emergency.

4.2.2.1 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 as soon as possible after admission.

4.2.3 Emergency admissions to the ICU must be seen and evaluated by the admitting/attending physician within 2 hours of arrival in the ICU.

4.2.3.1 It is the responsibility of the admitting physician to contact the tele-intensivist and discuss the patient's treatment plan prior to the patient's arrival in the ICU.

4.2.3.2 Evaluation by the tele-intensivist within 1 hour may serve *in lieu* of the attending physician seeing the patient initially, but does not absolve the attending physician of timely care.

4.2.4 **Unassigned Patients**: A patient to be admitted on an emergency basis who does not have a private physician is assigned to the Medical Staff member on duty for assigned coverage in the department or section of service. Medical Staff coverage will be assigned according to department/section rules. Each department/section chairperson shall provide a schedule to the Medical Staff Office and Emergency Department for such assignments. Unassigned patients must be seen by the attending on call within 4 hours. If the patient is not seen within 4 hours, care will be transferred to the hospitalist group. Critically ill patients must be seen within 2 hours or care will be transferred to the hospitalist group.

4.3 **Specific Patient Circumstances**

4.3.1 The admitting practitioner is responsible for giving such information as may be necessary to assure protection of the patient from self-harm and to assure the protection of others whenever his or her patients might be a source of danger from any cause whatsoever.

4.3.2 Rules governing the admission of Behavioral Health patients to Behavioral Health units will be developed by the Department of Psychiatry and ratified by the Medical Executive Committee.

4.3.3 Pregnant women and women up to 4 weeks' postpartum are admitted to the Labor and Delivery unit, unless their condition requires the services of another specialty unit.

4.4 **Documentation at the Time of Admission**

4.4.1 Complete History and Physical:

All patients admitted to the hospital or registered for outpatient surgery will have a complete history and physical documented in the medical record. The history and physical will conform to the following requirements to ensure quality of care and comply with Joint Commission, CMS, and New Jersey state regulations.

A history and physical must be performed within 30 days prior to admission for registration to be valid.

- If a medical history and physical has been done within 30 days of inpatient admission, it must be updated within 24 hours of admission, but in all cases prior to surgery or a procedure requiring anesthesia service, noting any changes in the patient's condition or physical findings. If no changes have occurred, the absence of change must be documented and the update signed, dated, and timed.

- If an assessment has been done *within 30 days of outpatient surgery*, the history and physical must be updated within 24 hours of the outpatient surgical procedure, but in all cases prior to surgery or a procedure requiring anesthesia service, noting any changes in the patient's condition or physical findings. If no changes have occurred, the absence of change must be documented and signed, dated, and timed.
- If the history and physical examination and pertinent laboratory data are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure will be canceled.
- The history and physical requirement does not apply to emergency (immediately life-threatening) surgery. If the complete history and physical is not documented prior to this surgery, it must be completed as soon as possible after surgery.

An H&P performed by a physician who is not a member of the HMH Riverview Medical Center Medical Staff is not a valid document.

4.4.1.1 **A complete history and physical** has the following components: history, physical examination, assessment, and treatment plan.

History includes:

- Presenting diagnosis/condition (chief complaint, reason for visit)
- Description of symptoms
- Current medications
- Allergies (drug, other)
- Significant past medical or surgical history
- Review of symptoms
- Significant family history
- Psychosocial status
- Nutritional evaluation (if GI, pediatrics, or elderly)

For surgery/invasive procedure requiring a moderate sedation or anesthesia:

- Indications
- Proposed procedures
- ASA classification (when anesthesia not providing care)

In the case of *pediatric patients*, immunizations and neonatal history (if applicable).

4.4.1.2 Physical examination should include, as appropriate, an examination of body areas/organ systems:

- Vital signs

- Cardiovascular system
- Respiratory system
- Neurological system
- Gastrointestinal system
- Eyes
- Ear, nose, throat (ENT)
- Genitourinary system
- Musculoskeletal system
- Skin
- Psychiatric
- Hematologic/lymphatic/immunologic
- Assessment
- Treatment plan

4.4.2 **Updated History and Physical**:

An updated history and physical will be completed within 24 hours of admission or within 24 hours prior to a surgical procedure (but in all cases prior to surgery or a procedure requiring anesthesia service) for all cases in which the history and physical contained in the medical record is older than 24 hours. The updated history and physical will contain an update to the patient's current medical history that may have changed since the original history and physical or to address any areas where more current data is available. The patient's medical record will also reflect an update to the physical examination. The updated history and physical must contain either the changes in medical history or physical exam, or a statement indicating that no changes have occurred. For surgical cases, the history and physical will confirm that the indications for the procedure are still present. In all cases, the updated history and physical will be in sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status since the original history and physical. An updated history and physical is not valid in cases where the history and physical exceeds 30 days.

The updated history and physical must document any components of the patient's current medical status, regardless of whether or not there were any changes, and confirm that the necessity of the procedure is still present.

4.4.3 **Focused History and Physical**:

A focused history and physical is required for outpatient registrations (Emergency Department, observation, or any surgical or invasive procedure not requiring moderate sedation or anesthesia). The focused history and physical should provide an account of the chief complaint, the present illness (including an assessment of contributing factors), relevant past medical history, an appropriate review of body

systems, a clinical impression, and a proposed initial plan of evaluation and treatment. The focused history and physical should, in all cases, contain sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status.

The focused history and physical includes:

- History
- History of present illness (including chief complaint)
- Pertinent past medical and surgical history
- Pertinent family history
- Pertinent review of symptoms
- Current medication list
- Allergies (drug, other)
- Indications and proposed procedures, if patient is scheduled for surgery or an invasive procedure
- Physical examination, as indicated
- Assessment
- Treatment plan

4.5 **Specific Admission Record Circumstances**

4.5.1 The **Newborn Medical Record** shall include a summary of the mother's obstetric and relevant medical history, reason for induction of labor and operative procedures, if performed, a record of the newborn assessment, initial physical examination, and physical examination on discharge or transfer to another facility.

4.5.2 The **Current Obstetrical Record** shall include a complete prenatal record. The prenatal record may be a legible copy of the practitioner's office record transferred to the hospital before admission, but an updated admission note must be provided that includes pertinent additions to the history and any subsequent changes in the physical findings.

4.6 **Elective Admission Outpatient Testing**

All patients electively admitted to the hospital (excluding emergent or urgent admissions), including same day patients, shall have on admission those laboratory and diagnostic studies specifically ordered by the admitting physician (or a hospital staff physician having responsibility for the patient where there is no admitting physician) which are necessary or pertinent for the diagnosis or treatment of the condition for which the patient is admitted. It is strongly recommended that all outpatient testing be performed in the Riverview Medical Center Laboratories for continuity of care.

Article V

Inpatient Hospital Care, Treatment, and Services

5.1 **Responsibilities of Attending Physician**

5.1.1 A member of the Medical staff is responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, pertinent observations and significant findings, and for communicating the condition of the patient to the referring practitioner and to the relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note indicating the transfer of responsibility is entered in the order sheet and progress note of the medical record.

5.1.2 It is the obligation of the Medical Staff members to provide their patients, in terms they can understand, an explanation of the patient's medical condition, recommended treatment, risk(s) of treatment, expected results, and reasonable medical alternatives. If disclosure of the information is detrimental to the health of the patient or the patient is unable to understand the information, the explanation should be provided to the patient's legal proxy and documented in the medical record.

5.1.3 Every acute care patient must be seen at least daily by the attending physician, designated covering physician, or dependent practitioner, in accordance with department/section rules governing such practitioners. Such visits must be legibly documented at least daily, including findings, assessment of the patient's progress, and plan of care. If there is a clinical basis to justify the patient not receiving such a visit, this must be documented in the medical record by the practitioner.

5.1.3.1 A specialist visit does not absolve the attending physician from the responsibility of daily rounding.

5.1.4 The attending physician is responsible for the appropriate oversight of all clinical services provided to the attending physician's patients. Any issues regarding quality of care will be referred to and handled by the quality management process in place within the clinical department. Members of the Medical Staff are responsible for compliance with all HMH/Riverview Medical Center patient care policies and rules (e.g. Restraint Policy).

5.1.5 The attending physician is required to document the need for continued hospitalization and plan of care, in accordance with the policies of the Case Management Department.

5.1.6 The attending physician will cooperate with the Case Management Department to expedite care of his/her patient. This will include, but is not limited to, returning telephone calls in a timely manner, discussing care and discharge planning with family members, and assisting in overturning denied days.

5.1.6.1 It is the attending physician's responsibility (in conjunction with the Case Management Department) to determine and document the administrative determination of whether a patient is an "inpatient" or "observation" status.

5.1.6.2 All orders must be signed, dated, and timed prior to discharge.

5.2 **Consultations**

5.2.1 The attending physician is responsible for requesting a consultation from a qualified practitioner when indicated. Judgement as to the serious nature of the illness, the question of doubt as to diagnosis and treatment, and timeliness of the consultation rests with the attending physician. The consultation request must indicate the reason for the consultation.

5.2.2 Unless the attending physician's expertise is in the area of the patient's problem, consultation with a qualified physician is **required** in the following areas:

5.2.2.1 when required by law;

5.2.2.2 when the Medical Executive Committee or the practitioner's own department/section has mandated it; or

5.2.2.3 when any patient is known or expected to be suicidal.

5.2.3 Consultation is strongly **recommended** in the following circumstances:

5.2.3.1 there are problems of critical illnesses about which any significant question exists of appropriate procedure or therapy;

5.2.3.2 when the patient is at a high risk for operation or treatment;

5.2.3.3 in cases of difficult or equivocal diagnosis or therapy; or

5.2.3.4 when requested by the patient or family.

5.2.4 A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty board or by a comparable degree of competence based on equivalent training and extensive experience. In either case, a consultant must have demonstrated the skill and judgment requisite to evaluation and treatment of the condition or problem presented and have been granted the appropriate level of clinical privileges.

5.2.5 Advanced Practice Nurses/Clinical Nurse Specialists and Physician Assistants may perform consultative services under their collaborative practice agreement protocols and in accordance with department/section policies.

5.2.5.1 Consultations performed by APN/CNS/PA must be reviewed and countersigned by the collaborating/supervising physician within 24 hours.

5.2.6 Medical Staff members must respond to consultation requests as follows:

Routine Requests: The Medical Staff member must respond within 24 hours of the request being made.

Emergency Requests: If the consultation is urgent or needs to be completed sooner than 24 hours, *the requesting physician must speak with the consultant directly in addition to the transcribed request*. Once a call is placed, the Medical Staff member, designee, or on-call practitioner must respond by telephone within 30 minutes of

receiving a consultation request. Treating Medical Staff members and on-call Medical Staff members shall confer about the appropriate in-person response time, with the treating physician having final say in the appropriate in-person response time. If there is a discrepancy in the treating physician's requested in-person response time and the time the on-call physician arrives, the matter should be forwarded to the on-call physician's department chairman, and if appropriate, reviewed at the Credentials Committee.

5.2.6.1 Even in non-emergent cases, for any patient under the age of 18, the inpatient response time shall not be longer than 60 minutes after the initial call to the on-call Medical Staff member if required by the requesting physician, except as otherwise required by state, federal, or other regulatory requirements.

5.2.7 At the time of the consultant's examination of the patient, the consultant must dictate and sign a report of his/her findings, opinions, and recommendations that reflects an actual examination of the patient and the medical record. The consultation report will be made a part of the patient's medical record.

5.2.8 In cases of required consultation when the attending physician does not agree with the consultant, he or she shall either seek the opinion of a second consultant or refer the matter to the applicable departmental chairman for final advice. If the attending physician obtains the opinion of a second consultant and does not agree with it either, he or she shall again refer the matter to the applicable departmental chairman.

5.3 **Specialty Units**

Each division and/or hospital shall create guidelines regarding admission and discharge from specialty units, including the Intensive Care Unit(s), Pediatric Observation Unit(s), and Behavioral Health Unit(s). These will be created by the relevant Critical Care Committee or relevant department, as appropriate, and approved by the Medical Executive Committee.

5.4 **Treatment of Family Members**

5.4.1 Members of the Medical Staff are strongly discouraged from acting as a physician to their immediate family members (first-degree relatives, spouse, and children) who are treated at the HMH Riverview Medical Center and its associated facilities and should only do so when no viable alternative treatment is available in the area.

5.4.2 The policy governing caring for family members at HMH-RMC is in the HMH policy for Caring for Family Members. This policy includes but is not limited to:

5.4.2.1 any procedure requiring written informed consent in any setting;

5.4.2.2 any procedure that might be life-threatening or that uses life-threatening modalities in treatment (e.g. cancer chemotherapy);

5.4.2.3 any condition that involves the use of Schedule III or greater drugs; and

5.4.2.4 any hospital-based treatment of any kind (ambulatory, day stay treatment, or inpatient).

5.5 **Progress Notes**

5.1.5 Progress notes are transcribed for each patient visit at the time the visit is made. At a minimum, progress notes will be recorded on the patient chart daily by the attending physician, designee, or nurse practitioner/clinical nurse specialist. Progress notes are sufficiently detailed to describe the condition of the patient, describe the practitioner's treatment plans, and permit continuity of care or transfer ability to another service should circumstances warrant.

5.5.2 Each progress note must be dated, timed, and signed at the time of entry.

5.5.3 Progress notes will respond to issues that have been raised in the record by other disciplines.

5.5.4 Progress notes must be legible.

5.5.5 Progress notes shall reflect the practitioner's examination of the patient on that particular day.

5.5.6 Late entries and addenda may be entered into the medical record, provided that they are labeled as such and reflect the date and time that they were entered.

5.6 **Informed Consent**

5.6.1 Written, signed, and dated informed consent is obtained prior to any significantly invasive procedure except in those situations where the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient.

5.6.2 It is the obligation of the physician/surgeon who will perform the procedure to obtain informed consent by discussing the risks, benefits, and alternatives to the patient or legal proxy.

5.6.3 The policy for witnessing and completing the HMH consent form is contained in the HMH Universal Protocol / Patient Identification, Procedure Verification, and Site Verification Policy.

5.6.4 In all cases in which the patient is presumed to be mentally competent, every effort should be made to obtain his/her signature or mark after the patient has received the discussion of informed consent about his/her proposed procedure. Only if the patient is obviously temporarily or permanently mentally incompetent or a minor should a legal guardian or next of kin sign in place of the patient. The issue of incompetence of the patient must be documented on the chart by the physician.

5.6.5 If physical infirmity makes it impossible for a competent patient to sign a consent, verbal consent is obtained, witnessed, and documented on the consent form.

5.6.6 In emergencies involving a minor or unconscious patient in whom consent for surgery cannot be immediately obtained from the child's parents, guardian, or next of kin, these circumstances should be fully explained in the patient's medical record.

5.6.7 Alterations, additions, or changes on a signed informed consent form necessitate a new consent form. In the event a new surgical consent form has to be written and the

patient has received pre-medication, the case will be rescheduled to such a time when the patient is alert enough to sign the new consent form. In this circumstance, the physician shall document the mental alertness of the patient at the time of signature on the patient's chart.

5.6.8 The name of the person performing the procedure must be on the original surgical consent form. Group names are unacceptable.

5.6.9 A fax or electronic copy of the consent is acceptable if the consent is physically off-site and there is no time to obtain the original.

5.7 **Orders**

5.7.1 Orders must be entered by the computer.

5.7.2 All orders are dated, timed, and signed. Orders which are improperly entered will not be carried out until they are corrected by the ordering practitioner and are understood by the appropriate health care provider.

5.7.3 For all medication orders, the CPOE must document the drug to be given, date, dosage, route of administration, and frequency of administration.

5.7.4 Appropriate policies regarding automatic stop orders on dangerous drugs, recommended by the Pharmacy and Therapeutics Committee, and approved and adopted by the Medical Executive Committee will comply.

5.7.5 Dose ranges do not constitute a valid order. When dose ranges (e.g. Percocet 1-2 q3-4 hr. prn pain) are given, the order will not be transcribed and the practitioner will be contacted to clarify the order and correct the invalid order.

5.7.6 Symbols and abbreviations may be used only when they have been approved by the MEC. An official listing of approved abbreviations is kept on file in the Health Information Management Department. Those abbreviations and symbols which have been identified as "high risk" for medical errors by the MEC will constitute an invalid order. The order will not be transcribed and the practitioner will be contacted to clarify the order and correct the invalid order.

5.7.7 Orders for radiology studies must include the reason for the requested study.

5.7.8 All previous orders are canceled when patients go into surgery, with the exceptions of minor procedures that, in the opinion of the physician who is to perform the procedure, will not alter the patient's treatment plan or significantly affect the stability of the patient's condition. The physician is required to reenter all orders post-operatively. Orders must be rewritten at the time of transfer from a medical/surgical unit to the ICU or PACU/other special unit.

5.7.9 The use of "blanket" orders, such as "resume pre-op medications," is prohibited.

5.7.10 POLST/Advance Directive/End-of-Life/DNR

It is the attending physician's responsibility to determine, as is feasible, any patient wishes or documentation regarding End-of-Life determinations.

It is the attending physician's responsibility to work collegially with the Nursing and Case Management staff to determine and respect the patient's and family's wishes in these matters.

5.7.11 Medication Reconciliation: It is the attending physician's responsibility to perform Medication Reconciliation upon admission, discharge, and changes of levels of care. It is the responsibility of the attending physician to abide by the HMH Policy on Medication Reconciliation.

Article VI

Discharge

6.1 General

6.1.1 Medical Staff members are required to provide their patients with sufficient time before discharge to have arrangements made for health care needs after hospitalization. Medical Staff members are also required to inform patients and provide assistance to other providers of health care services about any continuing health care requirements after the patients' hospital discharge and in arranging for required follow-up care after discharge. Criteria to be used in making the evaluation include the patient's functional status, cognitive ability, and family support.

6.1.2 Patients will be discharged only on an order of the attending physician or designee. If the patient leaves the hospital against the advice of the attending physician or without proper discharge, a notation of the incident is made in the patient's medical record, such patient, upon subsequent return, is considered a new admission.

6.1.2.1 **Conditional Discharge Orders**: It is the attending physician's responsibility to discharge the patient. Conditional orders (i.e. pending review and concurrence by a consultant) are not acceptable. If there are any issues regarding a consultant, it is the attending physician's responsibility to directly contact the consultant and resolve all issues.

6.1.3 In the event of a hospital death, the deceased is pronounced dead by the attending physician or his/her designee 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 the deceased shall conform to local law.

6.1.4 **Electronic Death Record**: The New Jersey Electronic Death Registration System (NJ-ERDS) has 3 components. The NJ-ERDS will be initiated by the Nursing Supervisor or the Nurse Manager on the floor. The patient demographics will be completed. The physician who pronounces the patient (*pronouncer or medical certifier*) shall complete that portion of the NJ-ERDS. The attending physician shall complete the *medical certifier* portion of the NJ-ERDS. The NJ-ERDS must be completed within 24 hours of patient expiration.

6.2 Autopsies

6.2.1 It is the duty of all Medical Staff Members to secure permission for meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies are performed by a hospital pathologist or by a practitioner delegated with this responsibility.

6.2.2 Provisional anatomic diagnoses are recorded in the medical record within 48 hours and the complete protocol should be made part of the record within one month.

6.2.3 Criteria for identifying deaths in which an autopsy should be performed are the following:

6.2.3.1 No diagnosis before death

6.2.3.2 Intra-operative death

6.2.3.3 Post-operative death as defined by the New Jersey Department of Health

6.2.3.4 Death incident to pregnancy

6.3 **Documentation at Discharge**

6.3.1 At the time of discharge, the physician shall enter or dictate a note indicating diagnoses at the time of discharge.

6.3.2 A discharge order or transfer order must be performed by a credentialed practitioner on all patient records with the exception of patients who sign out against medical advice or expire.

6.3.3 A **discharge summary** is entered or dictated on all medical records of patients hospitalized who remain in the hospital for 24 hours or longer or expire during the hospitalization. Normal newborns do not require a discharge summary. In all instances, the content of the medical record is sufficient to justify the diagnosis, warrant the treatment, and document the end result. All summaries are authenticated by the responsible practitioner's original signature or electronic signature. If the discharge summary is performed by a designee, that designee must be licensed and credentialed at HMH-RMC for the appropriate privileges to perform this task. If the discharge summary is performed by a designee, the discharge summary remains the attending physician's responsibility and he/she must sign, date and time the discharge summary after his/her review.

6.3.3.1 For same day surgery patients, completion of operative note forms will suffice.

6.3.3.2 The discharge summary must include the following elements: a brief summary of the admission diagnosis, final diagnosis, procedures performed, significant findings, description of the patient's course in the hospital, treatment rendered, discharge instructions regarding diet, medications, and activity limitations, the condition of the patient upon discharge from the hospital, discharge medication reconciliation, and follow-up with the attending physician and/or consultants.

6.3.3.3 A **transfer form** is required for all patients transferred to another acute care facility, skilled nursing facility, or extended care facility. The physician must sign, date, and time this form.

6.3.4 A **transfer consent form** must be signed, dated, and timed on all non-emergency transfers to another facility. The process for providing appropriate care for a patient, during and after transfer from HMH Riverview Medical Center to another facility, includes: assessing the reason(s) for transfer, establishing the conditions under which transfer can occur, evaluating the mode of transfer/transport to assure the patient's

safety, and ensuring that the organization receiving the patient assumes responsibility for the patient's care after arrival at the facility. Whenever a patient is transferred to another facility, the attending physician will explain the reason for transfer, the risks and benefits of the transfer, and any available alternatives to the patient.

6.3.5 A **discharge summary at the time of transfer** is required for all patients transferred to another acute care facility, skilled nursing facility, or extended care facility. In addition, a transfer record containing at least the following information must be completed and must accompany the patient at the time of transfer:

6.3.5.1 A diagnosis, including history of any serious physical conditions unrelated to the proposed treatment which might require special attention to keep the patient safe.

6.3.5.2 Physician orders in effect at the time of discharge and the last time each medication was administered.

6.3.5.3 The patient's nursing needs, hazardous behavior problems, and drug or other allergies.

6.3.6 All patients, upon discharge from the hospital, same-day surgery unit, and delivery suite, will be given instructions about their post-discharge care. If the patient or representative cannot read and understand the discharge instructions, reasonable efforts will be made to provide appropriate language resources to permit him or her to understand.

6.3.7 With the exception of the Medical Examiner's autopsies, the report of autopsy is included as a permanent part of the medical record. The responsible pathologist shall record the provisional anatomic diagnoses in the medical record within three days of death. The autopsy protocol is completed 90% of the time and filed in the medical record within 60 working days of death. The 90% threshold is used in recognition of the fact that occasional unusual cases may require more than 60 working days for completion, particularly when external consultation is required. If the case is going to exceed 60 working days, there should be documentation of the reason for delay and of ongoing review of information.

6.3.8 **Telephone/Verbal Orders**: Telephone/Verbal Orders are governed by the HMH Policy on Telephone/Verbal Orders. All telephone/verbal orders must be signed, dated, and timed prior to discharge.

Article VII

Medical Records

7.1 General

7.1.1 The attending physician is responsible for the complete medical record for each patient. Its contents are pertinent and current and contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

7.1.2 All clinical entries in the patient's medical record are accurately dated, timed, and authenticated by the responsible practitioner. Late entries and addenda may be entered into the medical record, provided that they are labeled as such and reflect the date and time that they were transcribed. Authentication must be via original or electronic signature of the practitioner. All entries in the medical record must be in either blue or black ink, and symbols and abbreviations may be used only when they have been approved by the Medical Executive Committee. The use of rubber-stamp signatures is prohibited. Corrections to any entry are made by computer editing or an addendum. A practitioner may make corrections only to those entries that were made by him/her. Amendments and additions may be entered and must be signed, dated, and timed at the time of entry.

7.1.3 All diagnoses that are present at the time of admission or that developed subsequently and that affected either management or length of stay are recorded in full, without the use of symbols or abbreviations in the medical record at the time of discharge. This is the responsibility of the discharging physician and will be deemed equally as important as the discharge order. All final diagnoses/procedures shall conform to the current version of the International Classification of Disease (ICD-10).

7.1.3.1 In the event that a final diagnosis cannot be established until a laboratory or pathology report has been returned and filed into the medical record, the attending physician shall complete the record as soon as possible after discharge.

7.1.4 Practitioners who are credentialed and privileged by HMH Riverview Medical Center are subject to the medical records policies of the Medical Staff.

7.1.4.1 **Physician Assistants**: The responsible attending physician shall authenticate and co-sign the following documents:

a. History and physical, discharge summary, consultation report

b. Orders given by physician assistants within 24 hours

7.1.4.2 **Advanced Practice Nurses**: The following items of medical record documentation **must be co-signed** by the collaborating physician:

a. History and physical, discharge summary, consultation report

b. The following documentation **does not require co-signature** by the collaborating physician when completed by NP/CNS/CNM:

i. Prescriptive rights

ii. Antepartum record

iii. Admission/labor record

iv. Delivery record

v. Birth certificate

vi. Orders

vii. Narcotic order

7.2 **Access and Retention of Record**

7.2.1 Information about patients will be handled according to applicable HMH HIPAA policies.

7.2.2 Written consent of the patient is required for the release of medical information to persons not otherwise authorized to receive this information.

7.2.3 Access to medical records of all patients is afforded members of the Medical Staff for bona fide impersonal study, research, and audit consistent with preserving the confidentiality of the patient and in accordance with Institutional Review Board oversight.

7.2.4 All medical records are the property of the hospital. Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with subpoena, court order, or state statute. Unauthorized removal of charts by a practitioner is grounds for action by the Medical Executive Committee.

7.2.5 In the case of readmission of a patient, the current attending physician is given timely access to all previous medical records for the patient.

7.2.6 The medical record shall not be permanently filed until it is completed by all reasonable practitioners or is ordered filed by the CMO. If, in spite of all reasonable measures, a record remains incomplete and cannot be completed, the chart is reviewed by the CMO and, at his/her discretion, the chart may be reassigned for completion and signature or ordered filed in its incomplete form.

7.3 **Delinquent Medical Records**

7.3.1 Each Medical Staff member is obligated to complete the physician portion of the medical record within 30 days of notification. Any Medical Staff member who fails to meet this deadline will be considered delinquent. Medical Staff members with delinquent medical records will be reviewed at the Credentials Committee and then the Medical Executive Committee for appropriate corrective action.

7.3.2 The Health Information Management Department (HIM) electronically notifies the physician each week by email of any assigned medical record deficiencies that are

incomplete. The physician will receive 2 email notifications for deficiencies considered "incomplete."

7.3.3 If the medical record deficiencies are not completed within 15 days, the deficiency is considered delinquent and the matter will be referred to the Credentials Committee for appropriate corrective action and then referred to the Medical Executive Committee. Corrective action may include:

- Admitting clinical privileges
- Consulting privileges
- Voting eligibility
- Committee membership
- Access to CIS (Clinical Information System) temporarily suspended until delinquent deficiency completion
- Possible cancellation of elective surgical cases

7.3.3.1 Such relinquishment is effective until medical records are completed in accordance with the Rules and Regulations and this policy, unless the period of relinquishment exceeds 45 days. Relinquishments in excess of 45 days will be considered an automatic relinquishment of staff appointment. No procedural fair hearing rights shall apply. The practitioner may be eligible to reapply for staff appointments. Such reapplication is processed in the same manner as if it were an initial application for staff appointment.

7.3.3.2 The President of the Medical Staff, the Chief Medical Officer, or their designees may override a relinquishment in the case of emergencies or other justified reasons.

7.3.3.3 Justified reasons for delay in completing medical records: The attending physician or any other practitioner contributing to the record is ill, on vacation, or otherwise unavailable for a period of time and has acted in accordance with the **HMH/RMC Medical Staff Bylaws**.

7.3.3.4 The Health Information Management Department will distribute copies of the list of suspended Medical Staff members to department and section chiefs on a timely basis, as determined by the Medical Executive Committee. The Health Information Management Department will also prepare trend reports regarding chart delinquency.

7.3.4 Medical Staff members who are delinquent will be reviewed at the Credentials Committee and the Medical Executive Committee for appropriate corrective action, as outlined in 7.2.3 of these Rules and Regulations.

Article VIII

Emergency Services

8.1 **General**

8.1.1 A physician on-call list will be provided to the Emergency Department by the head of each department or section for each major clinical service.

8.1.2 This list will be provided through the RMC Medical Staff Office.

8.1.3 The list will be provided at least 1 week before the end of each month.

8.1.3.1 For any changes in the posted schedule, it is the responsibility of the individual requesting the change to seek coverage and notify his/her section chief or department chair, as appropriate, and to notify the Medical Staff Office and the Emergency Department. The request must be approved by the section chief/department chair before the request is granted except in the case of a dire emergency.

8.1.4 Response times by on-call physicians for the Emergency Department are in accordance with the requirements set forth in this section:

8.1.4.1 The on-call physician must respond by telephone within thirty (30) minutes of consultation request being made.

8.1.4.2 The Emergency physician and the on-call physician shall confer about the appropriate in-person response time, with the emergency physician having final determination in the appropriate in-person response time.

8.1.4.3 For any patient under the age of 18, the in-person response time shall not be longer than sixty (60) minutes after the initial call to the on-call member.

8.1.4.4 Failure to respond as set forth above shall be referred to the relevant department chief or section chief for review and reported to the Credentials Committee and the Medical Executive Committee.

8.1.4.5 Any physician on-call for an unassigned patient or a private patient shall forfeit the care of that patient for failure to respond in 30 minutes after he/she has been personally contacted or cannot be contacted.

8.1.4.6 For patients being admitted to Critical Care, there must be a physician-to-physician communication with the tele-intensivist prior to the patient being sent to the unit.

8.1.4.6.1 It is the responsibility of the admitting physician to notify the tele-intensivist prior to the patient being transferred to the ICU.

8.1.4.6.2 If the attending physician does not see the patient in the ED prior to admission to the ICU, it is the responsibility of the emergency physician to contact the tele-intensivist and “hand off” care prior to transfer.

8.1.5 Physicians who have treated patients as a result of providing on-call coverage or by accepting unassigned patients must provide appropriate follow-up care, for the duration of the acute illness, when the patient presents for such. Such care should be provided regardless of the patient's insurance status.

8.1.5.1 Appropriate follow up care includes, at a minimum, 2 post-acute care office visits if clinically appropriate.

8.1.5.2 Failure to provide appropriate follow up care will be reported to the department chair and will result in loss of unassigned coverage rotations.

8.1.6 The duties and responsibilities of all personnel serving patients within the emergency area are defined in the Departmental Rules and Regulations. Each department's Rules and Regulations will be developed by the respective department chair and approved by the Medical Executive Committee.

8.2 **Medical Screening Examinations**

For purposes of providing an appropriate medical screening examination to any person who presents to the Emergency Department, the initial triage is performed by a registered professional nurse or "qualified medical personnel" as defined below. The medical screening examination itself is performed by any of the following persons ("qualified medical personnel"): a physician who meets the requirements at N.J.A.C. 8:43G-12.3, or an advanced practice nurse certified by the New Jersey State Board of Nursing or a physician assistant licensed by the New Jersey State Board of Medical Examiners. The advance practice nurse or licensed physician assistant shall have training and experience in emergency care. "Medical Screening Examination" means an examination within the capability of the hospital's Emergency Department, including ancillary services routinely available in the emergency department performed to determine whether an emergency medical condition exists.

8.3 **Medical Orders and Records**

8.3.1 All orders for hospital care entered by an Emergency Department physician must be reviewed by the attending physician within 8 hours.

8.3.2 "Bridging Orders" written by the emergency physician will expire in 8 hours.

8.3.3 An appropriate medical record is established and maintained for each patient receiving emergency services and is to be incorporated into the patient's hospital record, if such exists. The record shall include at least:

8.3.3.1 Mode, date, and time of arrival

8.3.3.1 Allergies

8.3.3.3 Medications used before admission to the Emergency Department

8.3.3.4 Immunizations when relevant

8.3.3.5 Timed vital signs

8.3.3.6 Chief complaint

8.3.3.7 Physician assessment

8.3.3.8 Nursing assessment

8.3.3.9 Treatment rendered, time-stamped, and signed by the person who rendered treatment

8.3.3.10 Medications prescribed and administered while in the Emergency Department, time-stamped and signed by the person who prescribed and the person who administered the medications

8.3.3.11 Discharge instructions

8.3.3.12 Last menstrual period, if relevant

8.3.3.13 Provisional diagnosis for visit

8.3.4 For patients admitted or placed in observation at RMC, the care of that patient becomes the responsibility of the attending physician once the attending physician acknowledges acceptance of the patient's admission to the hospital, regardless of the patient's location in the hospital (i.e., including patients boarded in the Emergency Department).

8.3.5 Each patient's Emergency Services medical record is signed by the practitioner in attendance in the Emergency Department, who is responsible for clinical accuracy.

8.3.6 There is a monthly review of Emergency Department medical records by the Emergency Medicine Department and, where indicated, by appropriate clinical departments to evaluate quality of emergency medical care. Reports are submitted to the Executive Committee via the meeting minutes of the Emergency Department on a quarterly basis.

8.4 **Additional Policies**

8.4.1 The Emergency Department will have policies to address:

i. the ability of family members and significant others to remain with patients during treatment; and

ii. the special needs of patients who are unable to communicate for reasons of language, disability, age, or level of consciousness.

8.4.2 A patient can be transferred to another health care facility only for a valid medical reason or by patient choice. The receiving physician and the receiving hospital must approve the transfer prior to the patient being transferred. The documentation requirements of the state licensure code must be completed and accompany the patient on transfer. Documentation of an explanation of the reasons for transfer, alternatives for transfer, verification of acceptance by the receiving facility, and risks associated with transfer must be provided by the attending physician to the patient and/or patient's next of kin or guardian.

8.4.3 The Emergency Department shall perform functions described in the HMH Riverview Medical Center Health Disaster Plan in the event of mass casualties at the time of any major disaster.

Article IX

Anesthesia Services

9.1 **General**

9.1.1 Anesthesia may only be administered by the following qualified practitioners:

9.1.1.1 A qualified anesthesiologist

9.1.1.2 A CRNA who is supervised by an anesthesiologist who is immediately available

9.1.2 An anesthesiologist is considered "immediately available" when needed by a CRNA under the anesthesiologist's supervision only if he or she is physically located within the same area as the CRNA (e.g., in the same operative suite, in the same labor and delivery unit, or in the same procedure room, and not otherwise occupied in a way that prevents him or her from immediately conducting hands-on intervention, if needed).

9.1.3 "Anesthesia" means general or regional anesthesia, monitored anesthesia care or deep sedation. "Anesthesia" does not include topical or local anesthesia. Policies regarding minimal, moderate, or conscious sedation are described in Article X of these Rules and Regulations.

9.1.4 Because it is not always possible to predict how an individual patient will respond to minimal, moderate, or conscious sedation, a qualified practitioner must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than originally intended.

9.1.5 General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

9.2 **Pre-Anesthesia Procedures**

9.2.1 A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 48 hours prior to an inpatient or outpatient procedure requiring anesthesia services.

9.2.2 The evaluation will be recorded in the medical record and will include:

9.2.2.1 a review of the medical history, including anesthesia, drug, and allergy history;

9.2.2.2 an interview and examination of the patient;

9.2.2.3 notation of any anesthesia risks in accordance with ASA classifications;

9.2.2.4 identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway);

9.2.2.5 development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits; and

9.2.2.6 any additional pre-anesthesia evaluations that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

9.2.3 The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

9.3 **Monitoring During Procedure**

9.3.1 All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.

9.3.2 All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:

9.3.2.1 the name and hospital identification number of the patient;

9.3.2.2 the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;

9.3.2.3 the name, dosage, route, and duration of all anesthetic agents;

9.3.2.4 the techniques used and patient positions, including the insertion or use of any intravascular or airway devices;

9.3.2.5 the name and amounts of IV fluids, including blood or blood products, if applicable;

9.3.2.6 time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

9.3.2.7 any complications, adverse reactions, or problems occurring during anesthesia.

9.4 **Post-Anesthesia Evaluations**

9.4.1 A post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 24 hours after the patient has been moved into the designated recovery area. Where post-operative sedation is necessary for the optimum care of the patient, the evaluation can occur in the PACU/ICU or other designated recovery area. For outpatients, the post-anesthesia evaluation must be completed prior to the patient's discharge.

9.4.2 The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

9.4.2.1 respiratory function;

9.4.2.2 cardiovascular function;

9.4.2.3 mental status;

9.4.2.4 temperature;

9.4.2.5 nausea and vomiting; and

9.4.2.6 postoperative hydrations.

The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition.

9.4.3 Patients will be discharged from the PACU by a qualified practitioner or according to pre-approved criteria. Post-operative documentation will record the patient's discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

9.4.4 Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.

9.4.5 When anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

9.5 **Minimal, Moderate or Conscious Sedation**

All patients receiving minimal, moderate, or conscious sedation or analgesia will be monitored and evaluated before, during, and after the procedure by a trained practitioner in accordance with Article X of these Rules and Regulations.

Article X

Minimal, Moderate, and Conscious Sedation

10.1 **General**

10.1.1 The purpose of this article is to establish guidelines whereby the administration of minimal, moderate, and conscious sedation will conform to professional standards and regulations and establish guidelines for pre-procedural, procedural, and post-procedure care for patients receiving sedation.

10.1.2 "Sedation and analgesia" describes a state that allows patients to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal command and/or tactile stimulation. (This definition derives from the American Society of Anesthesiologists Task Force on Sedation and Analgesia by Non-Anesthesiologists.)

10.1.3 Minimal, moderate, and conscious sedation is administered to facilitate performance of an anxiety-provoking and/or painful procedure, including but not limited to laceration repair, reduction of a fracture or dislocation, percutaneous aspiration, endoscopy, vascular catheterization, or trans-esophageal echocardiogram.

10.1.4 This Article is not intended to apply to the short-term management of anxiety and routine pain management (i.e., post-operative analgesia or ventilated patients).

10.2 **Policies and Protocols**

10.2.1 Minimal, moderate, and conscious sedation practices throughout the organization will be monitored and evaluated by the Department of Anesthesia and the QI&O Committee.

10.2.2 The physician must be credentialed to perform minimal, moderate, or conscious sedation and analgesia. In order to be eligible for the clinical privilege to administer minimal, moderate, or conscious sedation, practitioners must be able to demonstrate current competency in accordance with the Medical Staff policy on conscious sedation.

10.2.3 An individual different from the physician performing the procedure or individual assisting the physician must monitor the patient. The person may be an anesthesiologist, CRNA, credentialed physician, or qualified registered professional nurse. In accordance with HMH Nursing Administration Policies, the qualified RN must be ACLS/PALS-certified and/or able to demonstrate current experience with monitoring devices used and have documented competency in the ability to anticipate and recognize potential complications of sedation and analgesia in relation to the type of medication administered.

10.2.4 All patients will be reassessed by the physician immediately prior to the procedure.

10.2.5 Documentation of a pre-anesthesia assessment will be recorded on each patient's chart. The planned procedure, a plan for anesthesia administration, and the options,

alternatives, and risks will be discussed with the patient and/or responsible person prior to administration of sedation and documented in the clinical record.

10.2.6 The assessment will include, but is not limited to:

10.2.6.1 verification of correct patient;

10.2.6.2 history and physical (including age and review of symptoms with specific attention to cardiopulmonary and/or renal, hepatic, or metabolic disease);

10.2.6.3 determination of current medications and assessment of any previous adverse or allergic drug reactions to anesthesia or sedation;

10.2.6.4 vital signs: heart rate, blood pressure, respiratory rate, and oxygen saturation;

10.2.6.5 assessment of neurological status and level of consciousness;

10.2.6.6 assessment of NPO status;

10.2.6.7 assessment of potential pregnancy;

10.2.6.8 assessment of airway (Mallampati classification);

10.2.6.9 ASA determination; and

10.2.6.10 verification of signed consent for the procedure.

10.3 **Pre-Procedure**

10.3.1 The patient will have an intravenous access secured prior to the administration of minimal, moderate, or conscious sedation and maintained throughout the procedure.

10.3.2 The physician must administer the initial dose of sedation and analgesia.

10.3.3 All patients will be monitored throughout the procedure. At NO time may the patient be left unattended and/or without monitoring by a qualified clinician during the procedure.

10.3.4 The monitoring clinician will assess and record, prior to the beginning of the procedure, the baseline pulse rate and cardiac rhythm, respiration, blood pressure, and oxygen saturation.

10.3.5 Monitoring consists of noting and recording in the clinical record the following:

- assessment of the level of consciousness (baseline and every 15 minutes during the procedure);
- vital signs: heart rate, pulse, blood pressure, and respiratory rate. Signs are reassessed at a minimum of every five minutes throughout the procedure;
- continuous monitoring of the EKG;

- assessment of the baseline pulse oximetry and continuous monitoring of the oxygen saturation;
- all medications (name, dose, and route) administered during the procedure; and
- any hypersensitivity or unusual patient reaction.

Article XI

Operating Room Procedures

11.1 **General**

11.1.1 Procedures may be performed in the Operating Room only in accordance with the privileges delineated in compliance with the RMC/HMH Medical Staff Bylaws.

11.1.2 For members of surgical departments, privileges for procedures follow granted clinical privileges.

11.1.3 The scope and extent of surgical privileges for dentists and podiatrists shall follow granted clinical privileges and be in accordance with the RMC/HMH Medical Staff Bylaws.

11.1.4 Non-surgical Medical Staff members such as radiologists and cardiologists who have been granted the appropriate privileges may also schedule and perform procedures in the Operating Room.

11.1.5 A roster of physicians with delineation of current surgical privileges, including those with temporary privileges, is maintained in the Operating Room.

11.2 **Operating Room Committee**

11.2.1 The oversight of the Operating Room will be the responsibility of the Operating Room Committee as outlined in the HMH-RMC By Laws 13.4.5 (b) i through xi. Day to day operation and enforcing the policies and duties of the Operating Room Committee are the responsibility of the Chairman of the Department of Surgery, the Medical Director of Surgical Services, and/or the Chairman of the Department of Anesthesiology, or their designee, the anesthesiologist on call. The Chairman of the Department of Surgery, the Medical Director of Surgical Services, and the Chairman of the Department of Anesthesiology are the acting Physician Directors of Surgical Services.

11.2.2 The composition of this Committee is defined in the HMH-RMC By Laws 13.4.5 (a) and 3.5.3 of these Rules and Regulations.

11.2.3 The Committee will report to the Medical Executive Committee.

11.2.4 This Committee will have authority to make decisions regarding:

11.2.4.1 allocation of Operating Room time (blocks);

11.2.4.2 determination of policies regarding timeliness of surgeons and penalties for tardiness; and

11.2.4.3 determination of qualifications of the various levels of surgical assistants.

11.2.5 This Committee will advise and recommend regarding other matters:

11.2.5.1 Determination of allocation of resources for equipment, etc. The committee will work in close dialogue with the HMH Riverview Medical Center administration to establish strategic vision, define priorities, and formulate budgets.

11.2.5.2 Efforts to monitor and improve the efficiency and cost of the Operating Room.

11.3 **Delivery of Services**

11.3.1 The determination of requirements for each type of case requiring a surgical assistant will be made by each section (or department in the absence of section). A list will be maintained in the Operating Room.

11.3.2 All patients undergoing surgery must have an appropriate history and physical performed and documented on the chart at the time of surgery. In a life-threatening emergency, the physician shall make at least a comprehensive note on the patient's chart regarding the patient's condition prior to the induction of anesthesia at the start of surgery.

11.3.3 In the event the history and physical has been performed and dictated, but the document is lost or otherwise fails to reach the chart, the surgeon shall dictate the history and physical. The patient will not be permitted to go to the Operating Room suite until the history and physical is completed.

11.3.4 If the above process will cause an undue delay in the Operating Room schedule, the patient may be rescheduled for a time later in the day at the discretion of the Physician Director of Surgical Services or designee.

11.3.5 The medical record of a postpartum maternity patient scheduled for a tubal ligation must contain an update following delivery of the patient's condition and document the physician's discussion with the patient regarding the proposed procedure.

11.3.6 Laterality must be documented as left or right on the history and physical and OR consent.

11.3.7 For inpatients and surgical outpatients (including patients expected to stay 24 hours or more post-surgery), a history and physical examination must be performed within 30 days prior to the procedure and must be updated within 24 hours of the procedure. The medical record must contain the following:

11.3.7.1 A current history and physical;

11.3.7.2 An updated H&P addressing the patient's current status and/or changes to the patient's status, regardless of whether there were any changes in the patient's condition. The update must be performed within 24 hours of the procedure. The updated H&P must be signed, dated, and timed.

11.3.8 In emergency cases, a comprehensive note is required regarding the patient's condition prior to the induction and start of surgery whenever possible.

11.3.9 Informed consent is required for all surgical procedures consistent the HMH Universal Protocol / Patient Identification, Procedure Verification and Site Verification Policy and Article 5.6 of these Rules and Regulations. The anesthesiologist will obtain informed consent from the patient for the anesthesia portion of a procedure. It is the anesthesiologist's responsibility to obtain the appropriate signatures on the appropriate consent from.

11.3.10 The following will also occur before all surgical procedures:

11.3.10.1 The practitioner who will perform the procedure will thoroughly document the provisional diagnosis and the results of any indicated diagnostic tests in the medical record.

11.3.10.2 The anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care.

11.3.10.3 Pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services.

11.3.10.4 The procedure site is marked and a "time out" is conducted immediately before starting the procedure, as described in the HMH Universal Protocol / Patient Identification, Procedure Verification, and Site Verification Policy.

11.4 **Post-Procedure Protocol**

11.4.1 An operative procedure report must be dictated immediately after an operative procedure and entered into the record. The operative procedure report shall include:

11.4.1.1 the patient's name and hospital identification number;

11.4.1.2 pre- and post-operative diagnoses;

11.4.1.3 date and time of the procedure;

11.4.1.4 the name of the surgeon(s) and assistant surgeon(s) responsible for the patient's operation;

11.4.1.5 procedure(s) performed and description of the procedure(s);

11.4.1.6 description of the specific surgical tasks that were conducted by practitioners other than the primary attending physician;

11.4.1.7 findings;

11.4.1.8 estimated blood loss;

11.4.1.9 any unusual events or complications, including blood transfusion reactions and the management of those events;

11.4.1.10 the type of anesthesia/sedation used and name of the practitioner providing anesthesia;

11.4.1.11 specimen(s) removed, if any; and

11.4.1.12 prosthetic devices, grafts, tissues, transplants, or devices implanted (if any).

11.4.2 If a dictated report cannot be entered into the record immediately after the operation or procedure, a progress note containing the information below must be entered in the medical record immediately after the procedure and authenticated by the surgeon. The note must record:

11.4.2.1 the name of the physician(s) responsible for the patient's care and physician assistants;

11.4.2.2 procedure(s) performed;

11.4.2.3 findings;

11.4.2.4 estimated blood loss, when applicable or significant;

11.4.2.5 specimens removed; and

11.4.2.6 post-operative diagnosis.

11.5 **Surgical Services Operations**

11.5.1 The use of the Operating & Procedure Rooms is limited to members of the Medical Staff whose privileges include procedures which normally require the use of those rooms. Surgical procedures may be performed in the Operating Room only in accordance with the privileges delineated.

11.5.2 Minimum testing requirements for surgery as developed by the Department of Anesthesia and approved by the Medical Executive Committees.

11.5.3 It is strongly recommended that all preoperative testing be performed at HMH Riverview Medical Center.

11.5.4 It is the responsibility of the operative physician to provide all appropriate preoperative x-ray and laboratory test results which have been done outside of the HMH Riverview Medical Center system.

11.5.5 All reports/test results should be provided 2 days prior to procedure, but they must be on the chart 24 hours in advance. The procedure is subject to cancellation at the discretion of the Physician Director of Surgical Services or designee, the on call anesthesiologist, should test results not be available.

11.5.6 All patients undergoing surgery must have an **appropriate History and Physical** performed and documented on the chart prior to surgery. In a life-threatening emergency, the physician shall make at least a comprehensive note on the patient's chart regarding the patient's condition prior to the induction of anesthesia at the start of surgery.

11.5.6.1 In the event that a History and Physical has been performed and dictated, but the document is lost or otherwise fails to reach the chart, the surgeon shall re-dictate the History and Physical. The patient will

not be transported to the Operating Room Suite until the History and Physical is completed.

11.5.6.2 If the above process will cause an undue delay in the Operating Room schedule, the patient may be rescheduled for a time later in the day at the discretion of the Physician Director of Surgical Services or designee.

11.5.7 For inpatient or outpatient services (including patients expected to stay 24 hours or more post-surgery), a H&P must be performed. A H&P will be considered current if it was performed within 30 days prior to the procedure and updated within 24 hours of the procedure and must contain either the changes in medical history or physical exam, or a statement indicating that no changes have occurred.

11.5.8 The Medical Record of a **post-partum maternity patient** scheduled for a tubal ligation must contain an update following delivery of the patient's condition and document the physician's discussion with the patient regarding the proposed procedure.

11.5.9 Laterality must be written as Left or Right in the History and Physical and OR consent in cases requiring laterality.

11.5.10 No patient may be admitted to the Operating Room suite without a correct, proper, legible identification bracelet.

11.5.11 Consent: Written, signed, dated, timed, informed surgical consent is obtained prior to the operative procedure except in those situations where the patient's **life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient**. The following shall apply to this surgical consent policy:

- It is the obligation of the attending surgeon to obtain informed consent.
- The Policy for witnessing and completing the HMH Riverview Medical Center consent form are contained in the HMH Universal Protocol / Patient Identification, Procedure Verification, and Site Verification Policy.
- In all cases wherein the patient is presumed to be mentally competent, every effort should be made to obtain his/her signature or mark after the patient has received the discussion of informed consent about his/her proposed procedure. Only if the patient is obviously temporarily or permanently mentally incompetent or a minor should a legal guardian or next of kin sign in place of the patient. The fact of incompetence of the patient must be documented on the chart by the physician.
- If physical infirmity makes it impossible for a competent patient to sign a consent, verbal consent is obtained, witnessed, and documented on the consent form.
- In emergencies involving a minor or unconscious patient in whom consent for surgery cannot be immediately obtained from the child's parent, guardian, or next of kin, these circumstances should be fully explained on the patient's medical record.

- No alterations, additions, or changes are to be made on the surgical/procedure consent form. Any intended alterations necessitate a new consent form.
- The name of the operating physician/surgeon must be on the consent form. The name of a group is not valid.
- The anesthesiologist will obtain informed consent from the patient for the anesthesia portion of a procedure. It is the anesthesiologist's responsibility to obtain the appropriate consent form.

11.5.12 When an anesthesiologist decides that an elective case should be canceled, it is his/her responsibility to discuss the case with the attending physician/surgeon prior to the patient being informed of the cancellation.

11.5.13 It is the responsibility of the surgeon to initiate a call to anesthesia and to the operating room nursing personnel when "after-hours" surgery is contemplated.

11.5.14 Surgeons should be in the Operating Room and ready to commence surgery ten (10) minutes before the time scheduled. This means that the surgeon should be changed into scrub clothes, the pre-operative paperwork and labs completed, the operative consent signed and witnessed, and the appropriate verifications completed as detailed in the HMH Universal Protocol/Patient Identification, Procedure Verification and Site Verification Policy for Surgical and Invasive Procedures.

11.5.15 If a surgeon is unable to be present at the scheduled operating time, the surgeon should so notify the Operating Room no later than thirty (30) minutes prior to that scheduled time.

- When possible, attempts will be made to reschedule the case at a time mutually acceptable to the surgeon and the Operating Room. In the absence of such notification, the Operating Room is held no longer than fifteen (15) minutes past the scheduled time.
- Such a delayed case is rescheduled or cancelled at the prerogative of the Physician Director of Surgical Services or designee.
- The surgeon will be notified by the Physician Director of Surgical Services of the cancellation/rescheduling.
- Surgeons who do not comply will be subject to sanctions as approved by the appropriate Medical Staff committee.
- Should a case be delayed by the Operating Room, the surgeon will be notified thirty (30) minutes prior.

11.5.16 Surgeon lateness is defined as the surgeon's arrival in the OR suite at the scheduled case time or after.

11.5.17 When cases are scheduled, it is the responsibility of the surgeon to inform the Operating Room of special services or preparation needed for the patient.

- The surgeon must also notify the Surgical Services scheduling staff as to whether an x-ray technician and/or qualified surgical assistant are required for his/her surgery.
- It is the physician's responsibility to procure an assistant or notify the OR and inquire about the availability of a qualified assistant.
- Surgeons requiring private, non-physician technical assistants in the Operating Room must have these assistants approved consistent with the hospital policy for non-Medical Staff credentialing.

11.5.18 Immediately following each surgical procedure, the surgeon will complete a post-operative note to include:

- Name of surgeon and assistants
- Procedure(s)
- Pre- and post-op diagnosis
- Specimens removed
- Findings
- Blood loss

11.5.19 No unnecessary or unauthorized personnel are permitted in the Operating Room Suite. Family members, including those who are physicians, of patients who are being operated on should not be present in the actual operating room during the surgical procedure, except for obstetrical cases. Certain personnel may be permitted in the Operating Room Suite as follows:

- Physician-employed staff, provided that they are credentialed in accordance with the Credentialing Policy of HMH Riverview Medical Center
- Physicians, dentists, or podiatrists in training
    - If the training program has a formal affiliation with HMH Riverview Medical Center, then duties will be in accordance with the HMH Riverview Medical Center Policy. It is the prerogative of the surgeon and/or anesthesiologist in the room to approve or decline any trainee in his/her room
    - If the training program does <u>not</u> have a formal affiliation with HMH Riverview Medical Center, prior approval must be obtained through the Medical Director of Surgical Services and the OR Committee. It is the prerogative of the surgeon and/or anesthesiologist in the room to approve or decline any trainee in his/her room
- Surgical assistants if appropriately credentialed
- Product representatives, if approved by the surgeon or invasive procedure physician in the room and the anesthesiologist in the operating room.

11.5.20 The surgeon of record will be responsible for the acts of and adherence to all hospital and medical staff policies and procedures by his/her approved assistants or requested observers.

11.5.21 The Medical Staff shall maintain a list of those operative procedures requiring a physician as a first assistant. The physician first assistant must be a member of the Medical Staff and must hold unrestricted surgical privileges in a surgical specialty.

11.5.22 All specimens removed in the Operating Room or elsewhere in the hospital must be sent to Pathology for examination (gross and/or microscopic) and proper documentation of removal, unless there is an alternative mechanism in place for proper documentation of removal. The following specimens will be subject to a gross examination only:

- Orthopedic hardware (screws, nails, prosthetic devices, etc.)
- Foreign bodies
- Intrauterine devices
- Teeth
- Cardiac pacemakers
- Generators/batteries (i.e. dorsal stimulators)
- Port-a-catheters
- Grafts
- Portion of rib removed to enhance operative field (i.e. nephrectomy)
- Traumatic amputations (unless gross pathology identified)
- Nasal cartilage (unless gross pathology identified)
- Calculi (stones)
- Tonsils and adenoids 15 years of age and under (unless gross pathology identified)
- Foreskins 15 years of age and under (unless gross pathology identified) except neonates, which will not be submitted to pathology

All other specimens not listed will be subject to sampling and/or microscopic examination, unless determined unnecessary by the Pathologist on an individual case basis.

11.5.23 **Operating Room Scheduling**

11.5.23.1 The Physician Director of Surgical Services, in collaboration with the Chairman of the Department of Anesthesiology and his designee, the Anesthesiologist/Charge Physician on call, is in complete charge of the daily Operating Room schedule.

11.5.23.2 **Block time** is defined as OR time allocated to one physician or group of physicians who have exclusive rights to that time.

- Block time is allocated by the Medical Director of Surgical Services and approved by the Operating Room Committee. Block time is based upon requests, the surgeon's activity, and availability.
- Block time utilization will be evaluated quarterly by the Operating Room Committee to ensure full utilization of the time.
- Minimum utilization of block time is 50%, in accordance with the policy of the Operating Room Committee.

11.5.23.3 Practitioners given block time will be given 3 months before utilization is reviewed.

11.5.23.4 Emergency cases may be scheduled at any time, but will be governed by the Policy and Procedure established by the Operating Room Committee.

11.5.23.5 Patients upon whom an "emergency operation", as determined by the surgeon, is indicated, are operated on AS SOON AS the patient can be prepared for the Operating Room.

11.5.23.5.1 If more than one emergency should arise simultaneously, the determination of prioritization of cases will be the responsibility of the anesthesiologist as the designee of the Chairman of the Operating Room Committee, the Medical Director of Surgical Services, or the Chairman of the Department of Anesthesiology.

11.5.23.6 Emergency cases which require a surgeon to be "**bumped**".

- The surgeon requesting the emergency case will notify the OR Director
- The Nursing Director or charge nurse will notify the Chairman of the Department of Anesthesiology or his designee, the anesthesiologist on-call. They will determine if it is necessary to "bump" a case and which case will be bumped.
- The surgeon requesting the emergency case will be notified of the decision. If a case is to be "bumped", the requesting physician will be given the contact information of the surgeon to be bumped. The requesting physician MUST contact the physician to be bumped explaining the reason.

11.5.24 HMH-RMC OR Cases Requiring Assistants include but are not limited to:

General, Vascular, Thoracic Surgery; Whipple procedure, total pancreatectomy, major hepatic resection (lobectomy), open aortic surgery, pulmonary embolectomy

Spine Surgery; all cases require assistants except micro diseconomy, Kyphoplasty/Vertebroplasty, posterior lumbar I & D without removal or revision of instrumentation or revision decompression

Neurosurgery; Craniotomy for posterior fossa tumors, trans sphenoidal surgery

Otolaryngology and Head and Neck Surgery; extensive composite cancer resection of the head and neck, extensive reconstructive maxillofacial surgery

Oral and Maxillofacial Surgery; surgical correction of major maxillofacial deformities

Plastic and Reconstructive Surgery; composite resection of mandible and maxilla with neck dissection, surgical correction of major maxillofacial deformities

Urologic Surgery; open or robotic radical nephrectomy, radical cystectomy with urinary diversion, and radical prostatectomy

Gynecologic Surgery; open and robotic hysterectomies and myomectomies, radical vulvectomy

11.5.25 Surgical Service Definition of Terms

Case Status Definitions

Scheduled/Elective Case:	Any case scheduled before the schedule closes, M-F
Emergency Case:	Cases in which loss of life, limb, or bodily function may occur if not done expediently
Urgent Case:	Cases that should be done within 24 hours
Scheduled Time:	Case scheduled time as posted in the computer
Room Set-Up:	The set-up time before the case begins
Patient in the Room:	The time the patient enters the operating room
Anesthesia Start Time:	The time the anesthesiologist is in the room and begins to attend to the patient
Incision Time:	The time of surgical incision
Finish Time:	The time case is completed
Patient Out of Room:	The time the patient exits the operating room
Turn Over Time:	The time patient leaves the operating room to the time the next patient enters the room

Recovery Definitions

Recovery Room In:	Arrival time in the PACU
Anesthesia End:	The time anesthesia turns patient care over to another caregiver in the PACU

Article XII

Dues and Special Assessments

12.1 **Dues**

12.1.1 The amount of dues is determined annually by the Executive Committee.

12.1.1.1 Members practicing in more than one Division will pay full dues.

12.1.2 In accordance with the Medical Staff Bylaws, dues are paid as follows:

12.1.2.1	Active Staff	Full Dues
12.1.2.2	Consulting Staff	Full Dues
12.1.2.3	Affiliate Staff	Full Dues
12.1.2.4	Telemedicine Staff	Full Dues
12.1.2.5	Regional Staff	Full Dues

12.1.2.6 Honorary Staff members are not required to pay dues.

12.1.2.7 Emeritus Staff members are not required to pay dies.

12.1.2.8 The Medical Executive Committees shall retain the power to exempt or reduce dues for special circumstances.

12.1.3 Payment notices for dues will be sent electronically to each practitioner on the staff and his/her office manager in December of the preceding year. If dues payments are not received in full by January 15, a final notice will be sent. ALL DUES MUST BE PAID BY JANUARY 31, or the next business day when such occurs on a weekend.

12.1.4 **Dues will be prorated for new appointments** to the Medical Staff in accordance with the date upon which the Board approves the application.

- Those practitioners who are appointed by the Board after July 1 will be charged 50% of annual dues.

12.1.5 No refunds for Medical Staff dues will be made.

12.1.6 Non-payment of Medical Staff dues and/or special assessment will result in automatic suspension of staff membership until such time as dues are paid. Notice of such delinquency and suspension will be sent by certified mail, return receipt. All late payments are subject to a $50 late fee per month or any part thereof for each month of delinquency. If the involved physician's reappointment date occurs before payment, that will result in automatic termination from the Medical Staff. Those physicians terminated for failure to pay dues must pay the delinquent dues and late fees prior to reinstatement to the Medical Staff.

12.1.7 Allied Health Practitioners will be charged an annual assessment to be determined by the Medical Executive Committee.

12.2 **Special Assessments**

12.2.1 Special assessments can be approved by the Executive Committee at any time.

12.2.1.1 The amount and payment terms of any such assessments is determined by the Medical Executive Committee.

12.2.1.2 Deadlines for payment are in accordance with the special assessment deadline established by the Executive Committee.

12.2.2 Assessments shall apply to Active, Associate, and Affiliate members. The Medical Executive Committee will determine in what manner such assessments apply to Honorary, Consulting, and Adjunct physicians.

12.3 **Bank Transactions/Account Procedures**

12.3.1 All monies collected pursuant to these Rules and Regulations will be deposited in the Medical Staff Fund. The Medical Staff Office will assist in this process.

12.3.2 Transactions related to the Medical Staff Fund may only be carried out by the Treasurer of the Medical Staff. The Medical Staff Office will assist in carrying out transactions pursuant to these Rules and Regulations, but only the Treasurer has signatory authority for the funds. Proper authorization signatures are obtained when the Treasurer assumes office. At each monthly Medical Executive Committee meeting, the Treasurer of the Medical Staff will give a report of finances and offer a copy of all transactions to elected members of the Medical Executive Committee.

12.3.3 All checks received for deposit must be payable to the appropriate Medical Staff. Procedures for incoming checks shall include:

12.3.3.1 Stamp the check for deposit only to bank designated by the Medical Executive Committee on an annual basis.

12.3.3.2 Photocopy the check to retain for records.

12.3.3.3 Document the check in ledger.

12.3.3.4 Credit the appropriate amount.

12.3.3.5 List the check for deposit in the bank records.

12.3.4 A minimum balance, as determined by the Medical Executive Committee, is always to be maintained in the checking account.

12.3.5 Cash disbursement is documented in the ledger so that, at the end of each month, cash reconciliation of the balanced books to the bank statement can be conducted.

12.3.6 Disbursements greater than $5,000.00 must be approved by the Medical Executive Committee, and disbursements greater than $10,000 must be approved by the entire medical staff, both by majority vote.

12.3.7 An annual audit of the Fund will be conducted each year and approved by the President of the Medical Staff and the Medical Executive Committee.

12.3.8 Bank records will be retained for a six-year period.

Article XIII

Amendments

These Rules and Regulations may be amended by the process outlined in Article XVI of the HMH/RMC Bylaws.