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Rules & Regulations of the Medical Staff

As recently amended and approved by the Board of Trustees of Hunterdon Medical Center on:

3/26/2020

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I. GENERAL

- 1.1 Patients may be admitted and treated in the Medical Center only by licensed physicians, oral and maxillofacial surgeons and podiatrists who have been granted privileges under Medical Staff Bylaws Article 5 by appointment to the Medical Staff by the Board of Trustees. A physician, oral and maxillofacial surgeon, or podiatrist may delegate such care to their Advanced Practice Professional holding appropriate scope of practice.
- 1.2 The Medical Staff shall observe the Patient's Bill of Rights and adhere to the Agreement of Professional Responsibility as appended hereto.

No differentiation in personnel, procedures or quality of care shall be experienced by any patient in the Medical Center by reason of race, creed, religion, ability to pay, or other circumstances.

- 1.3 Every member of the Medical Staff shall assist in the training of medical students and residents.
 - 1.3(a) Patients have the right to be informed that a participant in a qualified medical education program is involved in their care. It is the responsibility of the attending practitioner to so inform the patient who has the right to refuse without prejudice to his care. Such refusal shall be recorded in the patient's chart.
- 1.4 All staff members shall be expected to participate in the event of any in- or out-of hospital multiple casualty incidents. Assignment of responsibility in such an event is outlined in the "Hunterdon Medical Center Multi-Casualty Incident Plan."
- 1.5 The Medical Executive Committee will establish policy for the framework for the decision-making process in determining levels of care.
- 1.6 Judgment as to the serious nature of the (patient's) illness and any question of doubt as to the diagnosis and treatment rests with the practitioner responsible for the care of the patient and the department chairperson or designee.
- 1.7 All members of the Medical Staff shall attend to emergencies within a timeframe appropriate to the particular emergency. Response times to emergencies specific to individual departments or services may be established by those departments or services with the approval of the Medical Executive Committee. *(This does not apply to consultations called by the Emergency Department physician – see Consultations 3.2(e).)*

II. ADMISSIONS / DISCHARGES

- 2.1 The care of all patients in the Medical Center shall be managed and coordinated by a physician, oral and maxillofacial surgeon or podiatrist holding appropriate privileges, subject to the standards of care as maintained by the Chairperson of each department and within limitations imposed by the Board of Trustees after consideration by the Medical Executive Committee.
 - 2.1(a) Exceptions to the attendance by the patient's physician, oral and maxillofacial surgeon or podiatrist may occur under the following circumstances.
 - (1) When the physician, oral and maxillofacial surgeon or podiatrist delegates responsibility to another in writing on the patient's chart;
 - (2) When the physician, oral and maxillofacial surgeon or podiatrist is regularly associated in practice with one or more other physicians, such other physicians may attend the patient during the primary admitting physician's absence.
 - (3) When the physician is temporarily unavailable due to an emergency.
 - (4) Until or unless their own practitioner is present, Emergency Department patients are the responsibility of the Emergency Department attending physician.
 - (5) In rare and exceptional situations where professional administrative decisions dictate otherwise.

- 2.2 Physicians, oral and maxillofacial surgeons and podiatrists requesting admission of any patient shall provide a provisional diagnosis, which is consistent with a need for care in an acute care hospital. The practitioner shall be given such other information as may be necessary to protect other patients already in the Medical Center from patients who are or may be a source of danger from whatever cause.
- 2.2(a) Emergency patients may be admitted without the above required data, but the attending staff member must finish said data within 24 hours after admission of the patient.
- (1) An emergency patient shall be defined as one whose condition is such that any delay in initiating care could compromise the well-being of the patient.
- 2.3 Hospitalized patients shall be seen by the attending or physician at least once daily or every other day if there is clinical justification, which is documented in the medical record. A chronological pertinent progress note shall accompany each visit.
- 2.4 A patient may be discharged only on written order of the attending physician, oral and maxillofacial surgeon or podiatrist, except when the patient or the patient's representative signs a legal release and leaves the hospital at his own request but against advice
- 2.5 The transferring physician will give a verbal report to the accepting physician prior to patient transfer, allowing time for questions. The transferring physician shall complete a transfer-of-care document prior to transfer.

III. CONSULTATIONS

- 3.1 Consultations shall be in conformity with defined medical staff privileges and shall be available for all patients when needed and requested.
- 3.2 It shall be the duty of the Vice President of Medical Affairs through the department chairperson and the Medical Executive Committee to see that other members call for appropriate consultations.
- 3.2(a) All consultations shall be performed as set forth in the Medical Staff Bylaws. A satisfactory consultation shall include an examination by the consultant who shall record it as part of the patient's record.
- 3.2(b) When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.
- 3.2(c) In circumstances of great urgency or where consultation is required by the rules of the hospital, the department chairperson shall have the right to call in a consultant.
- 3.2(d) Psychiatric consultation and treatment is recommended, and shall be made available to all patients who have attempted suicide or taken a chemical overdose. Documentation of this action shall appear in the medical record.
- 3.2(e) The Medical Staff shall maintain an on-call list of appropriate physicians for all patients who require emergency department treatment or admission to the hospital. Consult requests shall be considered either routine or emergent.
- (1) Consult requests are considered routine in those instances where the treating provider wishes to present a patient to the on-call physician, but where the patient's condition does not require emergency consultation. Telephone response time to routine consult requests shall be within twenty minutes. The in-person response time shall be mutually decided between the on-call physician and treating provider. The opinion of the treating provider shall prevail in the case of differing opinions as to appropriate in-person response time.
- (2) Emergency consult requests require the on-call physician's response by telephone within 20 minutes of receiving a call from the hospital's clinical staff. The treating provider and the on-call physician shall determine the appropriate in-person response time for the on-call physician. The opinion of the treating provider present in the hospital shall govern in the event of differing opinions as to appropriate in-person response time.
- (3) For patients 18 years old or less, the in-person response time of the on-call physician shall not exceed 60 minutes from the initial call to the on-call physician.
- (4) For the purpose of Sections (1) and (2) above, "provider" is defined as physician, physician's assistant, advanced practice nurse, nurse practitioner, registered nurse as set forth in New Jersey licensure standards.

- (5) There shall be a physician specialist on call to the emergency department for each major clinical service provided by the hospital, as determined from time to time by the Medical Executive Committee, including a physician who is credentialed to care for children and who is either board certified in pediatrics or has attained provider status in Advanced Pediatric Life Support or Pediatric Advanced Life Support. It shall be the responsibility of the treating provider to determine whether the responding on-call physician may be a resident or an attending physician.

- 3.1 Consultations shall be in conformity with defined medical staff privileges and shall be available for all patients when needed and requested.
- 3.2 It shall be the duty of the Vice President of Medical Affairs through the department chairperson and the Medical Executive Committee to see that other members call for appropriate consultations.

IV. CONSENTS / PERMITS

- 4.1 A properly executed informed consent must be obtained before any procedure involving special risks as defined by the Medical Executive Committee.
- 4.2 Every member of the Medical Staff shall be actively interested in securing legal permission for autopsies. Particular attention shall be directed to obtaining permission when the cause of death is unclear or the course of the disease was unusual, unanticipated or unexplained. No autopsy shall be performed without proper legal consent. All autopsies shall be performed by a member of the Department of Pathology or a physician delegated by the Chairperson of the Department of Pathology to perform that duty. Autopsies in progress shall be announced as Pathology Conferences via hospital-wide page.

V. MEDICAL RECORDS

The Medical Record is the responsibility of the attending physician, oral and maxillofacial surgeon or podiatrist, who shall prepare it to be a timely, accurate, legible and complete record of the patient's hospitalization.

- 5.1 The Medical Record shall include: identification data, reason for admission, history of present illness, review of systems, past history, personal-social history, family history, special reports when available, physical examination, laboratory and radiologic data, pathologic findings, blood components, progress notes, case summary, final diagnosis, condition on discharge and follow up treatment plans, medications, diet and activity directions or limitations, and a notation as to the existence of an Advance Directive Document, its inclusion in the chart, and the designation of a healthcare representative, if any.
- 5.2 All medical records are the property of the Medical Center and shall not be removed from the Medical Center unless a court order is obtained.
- 5.3 Abbreviations and symbols may be utilized, but they shall be only those approved by the Medical Staff and kept on file with Health Record Services.
- 5.4 In the case of a patient's readmission, all previous records shall be available for the use of the current attending physician.
- 5.5 Authentication by a licensed attending physician is required on those parts of the medical record written by unlicensed personnel in an approved medical education program.
- 5.6 Liberal access to medical records of all patients shall be afforded to a member in good standing of the Medical Staff for bona fide study and research, consistent with the rules established for the protection of human subjects and enforced by the Institutional Review Board and Medical Executive Committee to preserve the confidentiality of personal information.
- 5.7 Subject to the discretion of the Vice President of Medical Affairs, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering the period of time in which they attended these patients in the Medical Center.

- 5.8 The responsible physician, oral and maxillofacial surgeon, or podiatrist shall complete and sign the patient's record, including final diagnosis, within thirty days of discharge.
- 5.8(a) Medical records not completed within thirty days of discharge are considered delinquent.
- 5.8(b) Failure to complete delinquent records after reasonable notification will result in suspension of the practitioner's privileges.

VI. ORDERS

- 6.1 All orders for treatment and diagnostic tests shall be in writing, signed, dated, and timed by a licensed physician, oral and maxillofacial surgeon or podiatrist responsible for them.
- 6.2 Verbal Orders may be used only in urgent situations where, in the judgment of the physician, the benefit of a verbal order outweighs the possibility of risk of misinterpretation.
- 6.2(a) With the exception of time limited orders, i.e. restraints and level of care, which must be signed, dated and timed within 24 hours, all other verbal orders must be verified, signed, dated and signed within 48-hours. (See *Administrative Policy and Procedure III-98-35 "Restraints"*)
- 6.3 Orders written for a patient's care by an unlicensed resident in the Family Medicine Residency Program shall be countersigned within 24 hours by a physician possessing a current unrestricted license to practice medicine and surgery in New Jersey.
- 6.4 Registered Dietitians may initiate and/or change pharmaceutical oral supplements for patients on regular and modified diets with a physician's co-signature within 24 hours.
- 6.5 Telephone Orders from a licensed practitioner may be written, signed and labeled as a telephone order by the person receiving them whose own signature must be on the orders.
- 6.5(a) With the exception of time limited orders, i.e. restraints and level of care, which must be signed, dated and timed within 24 hours, all other telephone orders must be verified, signed, dated and timed promptly but no later than 30 days. (See *Administrative Policy and Procedure III-98-35 "Restraints"*)
- 6.6 Personnel authorized to accept and transcribe orders shall be registered nurses, resident physicians in a qualified educational program, licensed respiratory therapists, pharmacists or registered dietitians within their scope of practice.
- 6.7 Orders which are illegible or improperly written will not be carried out until rewritten.
- 6.8 Standing Orders, when felt necessary, may be formulated only by joint action of the Medical Executive Committee and department chairperson. They shall be followed insofar as proper treatment of the patient will allow, and shall constitute the orders of treatment until specific orders are written and signed by a physician, oral and maxillofacial surgeon or podiatrist.
- 6.9 Members of the Medical Staff who prescribe drugs for inpatients shall do so in accordance with the rules and policies of the Pharmacy and Therapeutics Committee, which has the responsibility to maintain the Formulary in agreement with the best available information regarding new drugs, sources of supply, and safety.
- 6.9(a) Medication orders will include the name of the drug, dosage, route of administration and frequency.
- 6.9(b) PRN orders shall include indications for administration.
- 6.9(c) Medical orders for medicine and treatment shall be prescribed by a licensed practitioner.
- 6.9(d) When prescribing investigational drugs, members of the Medical Staff shall abide by the rules and regulations of the Pharmacy and Therapeutics Committee and the Institutional Review Board, as approved by the Medical Executive Committee.
- 6.10 Orders and progress notes shall include any revisions, revocations, or other alterations to a patient's Advance Directive, the date thereof, and reasons therefor; the nature, cause, extent and probable duration of the patient's loss of decision making capacity, should that occur; and documentation that the patient and/or proxy has been notified of the patient's loss of decision-making ability.

- 6.11 A Doctor of Pharmacy may write and/or amend orders for dosing of medication with a physician's co-signature within 24 hours.

VII. SURGICAL PATIENTS

Surgical patients shall have a history and physical examination recorded before any surgical operation is undertaken, unless the surgeon certified in writing that any delay incurred for this purpose would constitute a hazard to the patient. When such history and physical examinations are not recorded at the time surgery is scheduled, the operation shall be canceled, unless the surgeon records that cancellation of the surgery would jeopardize the patient.

- 7.1 The provisional diagnosis shall be recorded by the surgeon before operation.
- 7.2 The surgeon shall be responsible for securing a properly signed operative consent.
- 7.3 The attending physician shall arrange to have all testing of elective surgery patients performed on pre-admission basis when practical.
- 7.4 Pre-operative assessment of surgical patients shall be performed by an anesthesiologist who shall write a pertinent record of the patient's condition, anesthesia risk (using American Society of Anesthesiology terminology) and the anesthesia selection. The anesthesiologist shall maintain a complete anesthesia record of the pre-anesthetic evaluation and the post-anesthetic follow-up of the patient's condition.
- 7.5 Surgeons shall be in the operating room ready to begin surgery at the time scheduled.
- 7.6 Each operating room surgeon shall be assisted on major operations by a duly qualified assistant which can include any one of the following as specified by the Operating Room Committee regulations.
- 7.6(a) New Jersey licensed physician
 - 7.6(b) Resident in a surgical training program approved by the Educational Council of the American Medical Association or the American Osteopathic Association
 - 7.6(c) Family Medicine Resident in a training program approved by the Educational Council of the American Medical Association or the American Osteopathic Association
 - 7.6(d) RNFA or Physician's Assistant
 - 7.6(e) Certified nurse midwives with first assist privilege for C-sections on MNCC only
 - 7.6(f) Podiatrists
- 7.7 Prior to performing any surgical procedure, the physician shall inform the surgical patient of the opportunity to receive an autologous, designated or homologous blood transfusion if a transfusion becomes necessary, and of the positive and negative aspects of each, unless such communication is medically contraindicated or the surgery is performed on an emergent basis. This communication will be noted on the medical record and will occur so as to allow adequate time, prior to surgery, for the pre-donation to occur.
- 7.8 Operative Reports
The following shall apply:
- 7.8(a) Procedures in the operating room with general anesthesia, monitored anesthesia or conscious sedation require a dictated operative report and an operative note;
 - 7.8(b) Endoscopy, ERCP and bronchoscopy procedures require a completed operative form;
 - 7.8(c) Procedures under local or no anesthesia require an operative note;
 - 7.8(d) All other procedures require an operative note form or progress note.
- 7.9 All tissues or specimens removed at the time of surgery shall be sent to the attending pathologist accompanied by a clinical history and pre- and post-operative clinical diagnoses which the surgeon must ascertain have been incorporated into the medical record.
- 7.9(a) Specimens need not be sent for pathologist analysis if:
 - (1) The quality of care will not be compromised by the exception.
 - (2) Another suitable means for verifying the removal can be routinely employed.
 - (3) There is an authenticated operative or other official report that documents the removal.
 - (4) Specific exceptions may include:

- i. cataracts
- ii. orthopedic appliances
- iii. portion of rib removed to enhance operative exposure
- iv. foreign bodies (e.g. bullets that for legal reasons are given directly in the chain of custody to law enforcement personnel)
- v. teeth, provided the number, including fragments, is recorded in the medical record.

VIII. DENTAL AND PODIATRIC PATIENTS

Patients admitted for dental or podiatric care shall be under the care of the admitting oral and maxillofacial surgeon or podiatrist. All podiatric and dental surgical procedures shall be under the overall supervision of the Chairperson of the Department of Surgery.

The following conditions shall apply:

- A. A physician who is a staff member shall perform a history, physical examination, and evaluation of overall medical risks for the proposed surgery and anesthesia, recording the findings and assessment in the medical record. When significant medical problems are present, it shall be the responsibility of the staff physician to care for the patient's medical problems during hospitalization.
- B. The responsible oral and maxillofacial surgeon or podiatrist shall take into account any medical recommendations in his or her care of the patient. The oral and maxillofacial surgeon or podiatrist shall record:
 - 1. A dental or podiatric history justifying the hospital admission.
 - 2. A detailed description of the treatment area together with a pre-operative diagnosis.
 - 3. A complete operative report.
 - 4. Progress notes that are timely, accurate and pertinent.
 - 5. A discharge summary.

IX. ADVANCED PRACTICE PROFESSIONALS

Advanced Practice Professionals (APPs) are individuals not otherwise eligible for membership on the Medical Staff of Hunterdon Medical Center, who, by education, training or experience, are qualified to provide patient care services needed or desired by the Hospital, its Medical Staff, or the Community, as determined by the Board of Trustees. APPs may be Hospital employees, independent contractors, or employees of members of the Medical Staff. They are not members of the Medical Staff and do not have procedural rights under the Medical Staff Bylaws or hold clinical privileges.

Categories of APPs permitted to provide services in the hospital, and the process for appointment, reappointment and evaluation of APPs are set forth in the Hunterdon Medical Center Procedures and Guidelines for the Practice of Advanced Practice Professionals.

X. MEETINGS

- 10.1 Regular meetings of the Medical Staff will be held quarterly. These shall be business meetings at which reports from the Executive Committee shall be heard.
- 10.2 Active Staff and Community Active Staff members must attend at least 50% of the meetings biennially.
- 10.3 Robert's Rules of Parliamentary Procedure (latest current edition) shall guide the proceeding of the Medical Staff meetings.

XI. RESIGNATIONS

Medical Staff members who are planning to terminate their staff appointment shall notify the Departmental Chairperson, President of the Medical Staff, Vice President of Medical Affairs, and President of Hunterdon Medical Center of this intent and the anticipated date of termination. All medical records are to be completed and all other duties satisfactorily discharged before the practitioner shall be considered as having his or her personal file closed in good standing.

XII. AMENDMENTS

These Rules and Regulations shall be subject to amendment or repeal by a two-thirds vote of the members of the Active and Community Staffs. This vote shall be by an electronic, email, fax or mail ballot only after discussion of the proposed changes at a regular or special business meeting, provided that a two-week notice of such meeting has been made in writing to each member. The notice shall specify the proposed amendment or deletion. When new or amended Rules and Regulations are proposed for the purpose of complying with State and/or Federal law or standards mandated by the Joint Commission on Accreditation of Healthcare Organizations or other accrediting organizations, the Medical Executive Committee is authorized to approve, at a regular meeting, such amendments upon recommendation of the Bylaws Committee so long as the proposed amendment is circulated for comment to all members of the Active and Community Staffs in advance of the meeting of the Medical Executive Committee. Passage of such amendments shall be announced in writing to all members of the Medical Staff and also at the next quarterly meeting of the Active and Community Active Staffs. Such amendments will be binding only upon subsequent approval of the Board of Trustees.

XIII. APPROVALS

**HUNTERDON MEDICAL CENTER
RULES AND REGULATIONS
OF THE MEDICAL STAFF**

ADOPTED & APPROVED:

By: Signature on File 3/26/2020
Andrew Rudnick, MD Date
President of the Medical Staff

By: Signature on File 3/26/2020
Patrick J. Gavin Date
President and Chief Executive Officer

By: Signature on File 3/26/2020
Robert Cody, MD Date
Chairperson, Board of Trustees

Approved by the Medical Staff: May 1993
Approved by the Board of Trustees: June 1993

Amended: February 1994
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