RULES AND REGULATIONS

for

THE MEDICAL AND DENTAL STAFF

of

JERSEY SHORE UNIVERSITY MEDICAL CENTER

A Division of
Hackensack Meridian Health Hospitals Corporation

Adopted by the Medical and Dental Staff of Jersey Shore Medical Center
11/19/2018

Amended by the Medical Executive Committee 5/7/2019

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DEFINITIONS

The following definitions apply to the provisions of these Rules and Regulations for the Medical and Dental Staff. The definitions are in alphabetical order.

1. **ALLIED HEALTH PROFESSIONAL** means an individual other than a licensed Physician, Dentist, Podiatrist or Psychologist whose patient care activities require that his/her authority to perform patient care services be processed through the usual Medical and Dental Staff channels.This definition includes psychologists, advanced practice nurses, physician assistants, certified nurse midwives who are not members of the Medical and Dental Staff.

2. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted by the Medical Center director to a practitioner to provide those diagnostic, therapeutic, medical, or surgical services specifically delineated to him/her.

3. **DENTIST** means a person holding the degree of D.D.S. or D.M.D. from an American Dental Association Commission on Dental Accreditation (CODA) accredited dental school and a New Jersey state dental license..

4. **DIVISION** means Jersey Shore University Medical Center.

5. **EX OFFICIO** means service as a member of a body by virtue of the office or position held. When an individual is appointed ex officio to a committee or other group, the provision or resolution designating the membership must indicate whether it is with or without vote.

6. **MEDICAL AND DENTAL STAFF** or **STAFF** means the formal organization of the organized Medical and Dental Staff.

7. **MEDICAL AND DENTAL STAFF MEMBER IN GOOD STANDING** or **MEMBER IN GOOD STANDING** means a practitioner who has been appointed to the Medical and Dental Staff or to a particular category of the staff, as the context requires, and who is not under either a full appointment suspension, on a full or partial suspension of voting, office-holding or other prerogatives imposed by operation of any section of the Bylaws and related manuals or any other policies of the Medical and Dental Staff of the Division.

8. **PHYSICIAN** means a person holding the degree of M.D. or D.O. from an approved medical or osteopathic school.

9. **PODIATRIST** means a person holding the degree of D.P.M. from an approved podiatric school.

10. **PRACTITIONER** means any appropriately licensed Physician, Dentist, orPodiatrist applying for or exercising clinical privileges in the Division.

11. **PREROGATIVE** means a right granted, by virtue of Staff category, to a Staff Member or affiliate.

12. **PSYCHOLOGIST** means a person licensed to practice Psychology by the New Jersey Board of Psychological Examiners.

13. **SPECIAL NOTICE** means written notification sent by certified mail, return receipt requested or by personal delivery service with signed acknowledgment of receipt.

PATIENT RIGHTS

Jersey Shore University 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 health care needs. Therefore, in order to affirm the rights of the patients, the Medical and Dental Staff will implement policies and procedures to address the following rights of patients:

- To receive reasonable access to care including the Division's reasonable response to his/her requests and needs for treatment or service, within the Division's capacity, its stated mission, and applicable laws and regulations.
- To receive considerate and respectful care that includes consideration of his/her psychosocial, spiritual, and cultural variables that influence his/her perception of illness and his/her personal value and belief systems.
- To participate in an informed manner in decisions regarding his/her care.
- To participate in the consideration of ethical issues that may arise in the provision of his/her care.
- To be afforded personal privacy and confidentiality of information.
- To have a designated representative decision-maker in the event he/she is incapable of understanding a proposed treatment or procedure or is unable to communicate his/her wishes regarding care.
- To accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
- To formulate advance directives and to appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law.
- To be granted access to information necessary to enable him/her to make treatment decisions that reflect his/her wishes.
- To be given information at the time of admission about the Division's patient rights policy and the mechanism for the initiation, review and resolution of patient complaints.
- To be informed of any human experimentation or other research/educational projects affecting his/her care or treatment.
- To have access to his/her medical record within the limits of law.
- To decide on the withholding of resuscitative services and the foregoing or withdrawing of life sustaining treatment.
- To allow action by legally authorized person to exercise patient's rights if patient is judged incompetent in accordance with law or is found by a physician to be medically incapable of understanding treatment or is unable to communicate wishes.
- To have freedom from physical and mental abuse. To have freedom from restraints, unless they are authorized by a physician for a limited period of time to protect the safety of the patient or others.
- To receive appropriate assessment and management of pain and related symptoms.

PART ONE: ADMISSION OF PATIENTS

1.1 TYPES OF PATIENTS

Patients are admitted without regard to race, creed, color, sex, sexual preferences, national origin, or source of payment. Admission of any patient is contingent on adequate facilities and personnel being available to care for the patient, as determined by the Regional President or designee after consultation with the applicable Department Chair.

The Medical Center shall admit eligible patients suffering from any type of disease which, in the opinion of the admitting physician, can be adequately cared for at this medical center and shall admit and treat any person for humanitarian purposes until such time as the patient may be safely transferred to another hospital.

1.2 ADMITTING PREROGATIVES

1.2-1 Generally

Only a member in good standing of the category of the Medical and Dental Staff may admit patients to the hospital, subject to the conditions provided below and to all other official admitting policies of the Division as may be in effect from time to time. Names of members not in good standing are submitted to the Admitting Office by the Medical and Dental Staff Office and other applicable areas.

1.2-2 Staff Priorities When Resources Strained

At times of full hospital occupancy or of shortage of hospital beds or other facilities, as determined by the Regional President or designee, priorities among the members of the various staff categories for access to beds, services or facilities for patients of similar status (i.e., elective, urgent, emergency) are as follows:

- Active Staff members in good standing.
- Regional Staff members in good standing.

When two or more practitioners with the same priority status have made a reservation for an elective admission and all such reservations cannot be accommodated, priority is determined by the order in which the reservations were received.

1.2-3 Limitations for Dentists and Podiatrists

1. Definition

A Podiatrist is a graduate of Podiatric Medicine approved by the Council of Education of the American Podiatric Medical Association, and who is licensed to practice in New Jersey. The practice of Podiatry is limited to the examination, diagnosis, treatment, and care of the condition and functions of the human foot and ankle as prescribed by the laws of the State of New Jersey.

The Podiatry Staff, through its Section Chief, shall be directly responsible to the Chair of the Department of Orthopedics. The Podiatrist may assume the responsibility for the management of a case consistent with the Standards of theThe Joint Commission, the Rules and Regulations of the Division of Podiatry, and the Bylaws of Hackensack Meridian Health Hospitals Corporation and the Rules and Regulations of the Medical and Dental Staff of Jersey Shore University Medical Center.

The responsibility for the general medical care of the patient, including History and Physical, will remain with the staff physician, and in accordance with the standards of the Joint Commission.

2. Membership

Members of the Podiatry and Dental Staff shall meet all the requirements of the Medical and Dental Staff and Surgical Staff that are applicable. Active membership is defined as fulfilling all Rules and Regulations of the Jersey Shore University Medical Center, Medical and Surgical Staff, as well as the Podiatry and/or Dental Staff. (See the Hackensack Meridian Health Hospitals Corporation Bylaws regarding Active Medical and Dental Staff.)

Members must make an active effort in upgrading his/her surgical credentials with the American Board of Foot and Ankle Surgery or the American Board of Podiatric Medicine or attaining eligibility of Board Certification in accordance with the Medical and Dental Staff Bylaws.

All Rules and Regulations will be enforced by the Section Chief of the Podiatry and/or Dental Staff. Dental patients admitted for care shall have a comprehensive History and Physical examination performed by a licensed physician, who is a member of the Medical and Dental Staff with admitting privileges. Podiatric patients may be admitted for care by a residency trained podiatrist who is a member of the Medical and Dental Staff. The Podiatrists are authorized to perform the history and physical examination only on their podiatric patients but only in those situations where the patient has no known current medical problems. Dentists are responsible for that part of their patient's history and physical examination related to their specialty. A physician member of the staff must perform a basic medical appraisal (including history and physical examination) for each dental and podiatric patient at least 48 hours prior to admission and must perform an evaluation of the overall medical risk and effect of any planned operation or procedure on the patient's health.

An oral surgeon with the requisite qualifications may be granted the privilege of performing an admission history and physical examination and assessing the medical risks of the proposed procedure to the patient but only in those situations where the patient has no known current medical problems.

1.3 ADMISSION DOCUMENTATION

Before the assignment of daily admissions, available beds are assigned for the transfer of patients in the following priority:

1.3-1 Emergent Condition - First Priority

A case may be declared an emergency by the attending practitioner. Prior to referral of an emergency patient for admission to the hospital, the attending practitioner must, when possible, call the Admitting Office to determine bed availability.

For each patient admitted as an emergency, the attending practitioner must provide the following documentation or information within the time frames indicated:

- Within 4 hours of the patient's arrival at the hospital, an admission note which indicates involvement in the immediate care for the patients; and
- Within 24 hours of the admission, sufficient documentation on the chart to justify the emergency admission.

Failure to furnish this documentation or information, or evidence of willful or continued misuse of this category, is grounds for such disciplinary action as the Medical Executive Committee or the Medical and Dental Staff President deems appropriate. The Quality Improvement and Outcomes Committee will periodically review claimed "emergency" admissions to identify patterns of possible noncompliance or misuse and report its findings to the Medical Executive Committee.

1.3-2 The attending practitioner must document, as part of his request for an urgent admission, the specific reason for admission supportive of the request and the degree of urgency involved. When all such admissions for a specific day are not possible, the applicable Department Chair will review urgent cases listed in the Admitting Office and determine the priority of the admissions. Failure to furnish the required documentation, or evidence of willful or continued misuse of this category, is grounds for such disciplinary action as the Medical Executive Committee deem appropriate. The Quality Improvement and Outcomes Committee will periodically review claimed "urgent" admissions to identify patterns of possible noncompliance or misuse and report its findings to the Medical Executive Committee.

1.4 ADMISSIONS DURING PEAK CENSUS

To ensure the appropriate and timely admission of patients during peak census and to ensure the availability of emergency beds.

Jersey Shore University Medical Center will provide a mechanism through which emergency patients are admitted when high census exists.

Medical/Surgical elective admissions will cease when the hospital's medical/surgical occupancy reaches capacity in accordance with the hospital's Admitting Policies.

.1.5 ADMISSION OF NEWBORNS BORN IN AND OUT OF THE MEDICAL CENTER

Babies Born in the Medical Center

1. Babies born within the building are considered hospital births, although the birth may not have occurred in the delivery room or on the single room maternity nursing unit. Babies not born in the delivery room or single room maternity nursing unit are admitted to the normal newborn nursery or the neonatal intensive care unit, as appropriate. Mothers are admitted to the maternity floor.
2. Babies are registered as a newborn admission and assigned a separate financial number. An admission chart is prepared by the registrar and a patient's signature is obtained on the general admission consent form.

Babies Born Outside the Medical Center or in a Septic Environment

1. Babies are registered as separate, direct admissions. Babies are admitted to the neonatal intensive care unit or to the normal newborn nursery, as ordered.
2. Cultures are obtained. The infant is to be kept in isolation until negative cultures are obtained.

Other Applicable Policies

Other policies as outlined in Department of Nursing, Division of Maternal Child Health Nursing Policy on care of newborns delivered outside of the labor and delivery area are to be followed.

1.6 TIME OF ADMISSION

Except in emergency cases, the attending practitioner shall arrange for a patient to be admitted during routine admission hours. In cases of outpatient or same day surgery, the attending practitioner must comply with hospital policies concerning pre-surgical laboratory tests, documentation and scheduling. Except in cases of emergency, patients for surgery should be admitted no later than 3:00 p.m. of the day prior to surgery.

1.7 RESTRICTED BED USE AREAS

Areas of restricted bed utilization and assignment for patients are as follows:

- Coronary Care Unit
- Medical Intensive Care Unit
- Neonatal intensive Care Unit
- Pediatric Critical Care
- Surgical Intensive Care Unit
- Neuro ICU
- Cardiovascular ICU

Questions regarding admission to or discharge from any of the above areas shall be referred to the physician director, or his designee, of the unit. When deviations are made from assigned areas, the admitting clerk will correct these assignments at the earliest possible moment, in keeping with the transfer priorities set forth in these rules and regulations.

1.8 ADMISSION INFORMATION

Except in an emergency, a patient will not be admitted to the hospital until a provisional diagnosis or valid reason for admission is provided by the practitioner requesting admission. Other required documentation or information specific to the type of admission involved is detailed in Section 1.3. The admitting practitioner is also responsible for providing the following information concerning a patient to be admitted: any source of communicable or significant infection; behavioral characteristics that would disturb or endanger others; need for protecting the patient from self-harm.

1.9 TIMELY VISITATION AFTER PATIENT ADMITTED

The attending practitioner or his designee must see the patient within the time frames provided below or within any shorter time frame if the patient's condition requires it:

- Patients designated as emergency cases and those admitted directly to or transferred into an intensive or critical care area from the Admitting Office, emergency department, or general care area -- within 2 hours.
- Patients admitted via the emergency department to a general care area -- within 12 hours.
- Elective admissions -- within 24 hours.
- Telemetry and Observation – within 6 hours

PART TWO: ASSIGNMENT AND ATTENDANCE OF PATIENTS

2.1 ASSIGNMENT TO SERVICE

All patients are assigned to the service concerned with the treatment of the problem or disease which necessitated admission.

2.2 ATTENDANCE OF PATIENTS

2.2-1 Each private patient will be attended by the practitioner of his choice provided said practitioner is a member of the Medical and Dental Staff and has appropriate clinical privileges. When any patient is attended by two or more members of the staff, the name of each attending practitioner must be entered officially on the hospital records. A private patient applying for admission who has no personal practitioner may request any practitioner who is a member of the Medical and Dental Staff and who has appropriate clinical privileges. When no such request is made or when the requested practitioner chooses not to undertake the care of the patient, a member of the active staff with the requisite privileges will be assigned to the patient according to the on-call schedule of the applicable department.

2.3 PARTICIPATION IN THE ON-CALL ROSTER

Unless specifically exempted by the Medical Executive Committee and the Regional President for good cause shown, each member of the active staff agrees that, when he is the designated practitioner on call, he will accept responsibility during the time specified by the published schedule for providing care to any patient in any unit of the hospital referred to the service for which he is providing on-call coverage. If there is a conflict with the published schedule, it is the staff member's responsibility to notify the applicable department and the emergency room director at least 24 hours prior to the scheduled rotation and supply a suitable replacement.

In the event that any assigned call creates an unreasonable burden on a specific member or members of a department, section or clinical division, the Department Chair may require all Active staff members, including those with a status of Senior Attending, to participate in the on call schedule unless otherwise specified in Department Rules and Regulations..

PART THREE: MEDICALLY INDIGENT COVERAGE

3.1 MEDICALLY INDIGENT PATIENTS

All members of the Medical and Dental Staff shall provide appropriate care, , to all in-patients and out-patients at Jersey Shore University Medical Center who have been designated to be "medically indigent" by Jersey Shore University Medical Center by application of objective criteria established and administered at the sole discretion of Jersey Shore University Medical Center.

PART FOUR: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

4.1 GENERALLY

A member of the Medical and Dental Staff shall be responsible for the medical care and treatment of each patient in the hospital for the prompt completeness and accuracy of those portions of the medical record for which he is responsible, for necessary special instructions, and for transmitting same, if any, to the patient and to relatives of the patient. Primary practitioner responsibility for these matters belongs to the admitting practitioner except when transfer of responsibility is affected pursuant to Section 4.2.

1. All patients will receive the same quality of patient care by all individuals with delineated clinical privileges, within Medical and Dental Staff departments, across departments/services, and between members and nonmembers of the Medical and Dental Staff who have delineated clinical privileges.
2. When acting in the capacity of supervisor of practitioners of medical students and students in Allied Health Programs, the Medical and Dental Staff member shall be responsible for assuring that these delegated

responsibilities are performed in an adequate and timely manner, when applicable, and in accordance with these Rules and Regulations and Medical Center Policy.

4.2 TRANSFER OF RESPONSIBILITY

When primary responsibility for a patient's care is transferred from the admitting or current attending practitioner to another staff member, a note covering the transfer of responsibility and acceptance of the same must be entered on the order sheet and progress notes.

All patients going to surgery must be transferred to the attending surgeon at the time of surgery.

4.3 ALTERNATE COVERAGE

Each practitioner must assure timely, adequate professional care for his patients in the hospital by being available or designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this hospital to care for the patient. Each member of the staff who will be out of town or unavailable in case of emergency must indicate in writing on the order sheet the name of the practitioner who will be assuming responsibility for the care of the patient during his absence. In the absence of such designation, the Medical Staff President or his designee, or the applicable Department Chair or Section Chief has the authority to call any member of the staff with the requisite clinical privileges. Failure of an attending practitioner to meet these requirements may result in loss of staff membership or such other disciplinary action as the Medical Executive Committee deem appropriate.

4.4 DENTISTS AND ALLIED HEALTH PROFESSIONALS

The services of certain Allied Health Professionals which are necessary and proper to the hospital function and treatments therein may be available within the limits of their technical skills and the scope of their lawful practice. Such appropriate departments or sections are charged with the responsibility for the maintenance of these types of services. The Allied Health Professionals may not admit patients directly. They may participate in the care of patients only under the direct supervision of a physician on the Active Medical and Dental Staff.

All applicants to the Allied Health Professionals Staff must conform to the same procedures that are used to process the applications of physicians or dentists seeking staff privileges (Article III of the Meridian Hospitals Bylaws). Documentation of education and licensure by the State of New Jersey must be submitted. Every Allied Health Professional shall be individually assigned to an appropriate clinical department/service and shall carry out his/her activities subject to departmental policies and procedures and in conformity with the applicable provisions of the Medical and Dental Staff Bylaws and these Rules and Regulations.

Dentists and Allied Health Professionals may treat patients under the conditions provided in the Hackensack Meridian Health Hospitals Corporation Bylaws and in these Rules and Regulations. Each Dentist and Allied Health Professional is responsible for documenting in the medical record, in timely fashion, a complete and accurate description of the services he provides to the patient.

More specifically, Dentist and Podiatrist members of the staff are responsible for the following:

1. A detailed dental/podiatric history and description of the dental/podiatric problem documenting the need for hospitalization and any surgery. The responsibility for the general medical care of the patient including the History and Physical will begin with the staff physician or podiatrist assigned to an appropriate clinical department/service.

2. A detailed description of the examination of the area of expertise and a preoperative diagnosis.
3. A complete operative report, describing the findings, technique, specimens removed and postoperative diagnosis.
4. Progress notes as are pertinent to the dental/podiatric condition.
5. Pertinent instructions relative to the dental/podiatric condition for the patient and/or significant other at the time of discharge.
6. Clinical resume or final summary note.

4.5 POLICY CONCERNING IMMEDIATE QUESTIONS OF CARE

If a nurse or other health care professional involved in the care of a patient has any reason to doubt or question the care provided to that patient or feels that appropriate consultation is needed and has not been obtained, such individual shall bring the matter to the attention of the individual's supervisor who, in turn, may refer the matter to the attention of the director of the hospital department. If warranted, said director may bring matter to the attention of the Medical and Dental Staff President wherein the practitioner has clinical privilege. Where circumstances are such as to justify such action, the Department Chair and/or the Medical and Dental Staff President may request a consultation.

4.6 CONSULTATIONS

4.6-1 The good conduct of medical practice includes the proper and timely use of consultation. The attending practitioner is primarily responsible for calling a consultation from a qualified staff member when indicated or required pursuant to the guidelines in Section 4.6-2 below. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending practitioner.

It is the duty of the hospital staff, through its Medical and Dental Staff President and Medical Executive Committee to make certain that members of the staff do not fail in the matter of requesting consultations as needed.

When a consultation is required under these Rules or when the best interests of the patient will be served, any of the following may direct that a consultation be held and, if necessary, arrange for it: the applicable Department Chair; Section Chief, the physician director of a special unit; or the Medical and Dental Staff President.

4.6-2 Guidelines for Calling Consultations

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

1. Any patient known or suspected to be suicidal or homicidal.
2. When these Rules or the rules of any clinical unit, including any intensive or special care units, of the staff require it.
3. When the patient requires mechanical ventilation.
4. Problems of critical illness in which any significant question exists of appropriate procedure or therapy.
5. When the patient is not a good risk for operation or treatment.
6. Cases of difficult or equivocal diagnosis or therapy.
7. When requested by the patient or family.
8. .
8. All patients where there is a question of criminal action.

4.6-3 Qualifications of Consultants

Any qualified practitioner may be called as a consultant regardless of his staff category assignment. A consultant must be a recognized specialist in the applicable area as evidence by certification by the appropriate specialty or sub-specialty board or by a comparable degree of competence based on equivalent training and experience. In either case, a consultant must have demonstrated the skill and judgment requisite for evaluation and treatment of the condition or problem presented and have been granted the appropriate level of clinical privileges.

A practitioner who requests consultation by a practitioner not on the staff of the hospital must make such a request to the Department Chair,. Such consultant may be granted temporary consulting privileges upon the recommendation of the Medical and Dental Staff President and in accordance with the Medical and Dental Staff Bylaws.

4.6-4 Documentation

1. Consultation Request

When requesting consultation, the attending practitioner must indicate in writing on the consultation record, the date, the reason for the request, and the extent of involvement in the care of the patient expected from the consultation.

Specifically, the consultation request shall indicate:

a. The specific purpose of the consultation and why specific questions are being directed to the consultant; and/or
b. Request for a general evaluation of the case and recommendation for diagnosis and treatment; and/or
c. A request by the attending physician for the consultant to render concurrent care to the patient until further notice by the primary attending physician; and/or
d. A request for direct transfer of the patient from the present attending to the consultant's service.

All members of the Staff are urged to engage in verbal contact with their Consultants and (visa versa) as it is recognized that such communication enhances patient care and satisfies the requirements of high-level professional etiquette.

2. Consultant's Report

The consultant must make, date and sign a report of his findings, opinions and recommendations that reflects an actual examination of the patient and the medical record, including the review of laboratory data, which supports his opinion and recommendation for treatment. When operative procedures are involved, the consultation note, except in emergencies, shall be recorded prior to the operation.

Such report shall be made upon the forms designated for this purpose and shall be incorporated into and be made a part of the patient's medical record.

3. Attending Practitioner's Response to Consultant's Opinion

In cases of elective consultation when the attending practitioner elects not to follow the advice of the consultant, he shall either seek the opinion of a second consultant or record in the progress notes his reasons for electing not to follow the consultant's advice. In cases of required consultation when the attending

practitioner does not agree with the consultant, he shall either seek the opinion of a second consultant or refer the matter to the applicable Department Chair for final advice. If the attending practitioner obtains the opinion of a second consultant and does not agree with it either, he shall again refer the matter to the applicable Department Chair.

4.7 TREATING OF FAMILY MEMBERS – see Medical and Dental Staff policy and procedure "Caring for Family Members in the Hospital"

PART FIVE: TRANSFER OF PATIENTS

5.1 INTERNAL TRANSFER

1. Internal patient transfer priorities are as follows:

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   a. Emergency patient to an available and appropriate patient bed;
   b. From Surgical Intensive Care Unit and Medical Cardiac Care Unit to any general care room;
   c. From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

2. No patient will be transferred without such transfer being approved by the practitioner responsible for the patient except in the case of transfers from the Special Care Unit to the general care area. Selection of such patients for transfer is the responsibility of the attending in charge of the Special Care Unit who must also inform the attending directly responsible for the care of the patient.
3. With the exception of emergencies, transfers from one service to another shall be done only by documented or verbal consent of both practitioner (i.e., the practitioner of the section to which the patient should be transferred). This consent of both parties shall be incorporated in the medical record.

5.2 TRANSFER TO ANOTHER FACILITY

5.2-1 A patient shall be transferred to another medical care facility only upon the order of the attending practitioner, only after arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to insure continuity of care must accompany the patient. If such transfer is considered to be in the patient's best interest despite the potential hazard to movement, then such transfer shall be made only after explaining the need for same to the patient and to the patient's family or significant other.

5.2-2 Demanded by Emergency or Critically Ill Patient

A transfer demanded by an emergency or critically ill patient or his family or significant other should not occur until a physician has explained to the patient or his family or significant other the seriousness of the condition and generally not until a physician has determined that the condition is sufficiently stabilized for safe transport. In each such case, the appropriate release form is to be executed. If the patient or agent refuses to sign a release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

5.3 SOCIAL TRANSFERS

All reservations made for patients transferred to the Medical Center for the convenience of family members, change of physician, or any reason other than a medical necessity constitutes a "Social Transfer". Social transfers are non-emergent. Refer to Administrative Policy

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5.4 INTER-FACILITY TRANSFERS FOR SPECIALIZED TREATMENT

This rule relates to transfers into the Medical Center for special treatment not provided by referring hospitals.

Upon agreement for transfer of the sending and receiving physician, the request for transfer will be made to the Transfer Center.

The Transfer Center will obtain financial information from the referring hospital and obtain pre-certification, if needed. Urgent and emergent admissions will be accepted and pre-certification will be obtained within 24 hours. If applicable, the referring hospital will send Jersey Shore University Medical Center copies of their charity care applications and documentation.

If the required treatment/procedure can be done as an outpatient, the patient will be registered as an outpatient and returned to the referring hospital following the treatment/procedure.

Patients transferred to JSUMC should arrive on the day of the scheduled procedure. However, should the patient need to be transferred prior to the day of the procedure, they must be cleared through the Utilization Review Department.

Transfers not pre-certified by the commercial carrier will be referred to the Utilization Review Department. If it is determined that the transfer is not medically necessary, The Transfer Center will notify the referring physician, who will follow the Social Transfer Policy.

5.5 TRANSFERS FROM ANOTHER FACILITY

The medical center shall accept transfers from other facilities providing the patient is eligible for admission and that beds are available. All such transfers must be accepted by a physician on staff who agrees to provide the treatment necessary. The patient will not be accepted to this facility unless the sending and receiving physicians have discussed the case and the receiving physician agrees to accept the transfer to his service. The specific specialist who accepts the responsibility for specialized care must be the one who agrees to accept the patient. The receiving physician must assure that the required services and facilities are available. The transferring facility must ensure that the patient is sufficiently stabilized for transfer and must also assume responsibility for the patient during transfer. All pertinent medical information must also accompany the patient.

5.6 EMTALA POLICY

For the Emergency Medical Treatment, Active Labor (EMTALA) and Transfer Policy, please refer to the Administrative Policies & Procedures manual.

PART SIX: DISCHARGE OF PATIENTS

6.1 REQUIRED ORDER

A patient may be discharged only on the written order of the attending practitioner.

The discharge order shall be written and authenticated in the medical record prior to the patient discharge from the facility with the exception of patients who sign out against medical advice or expire. The attending physician is responsible for co-signing orders written by unlicensed physicians.

Any individual who cannot legally consent to his own care shall be discharged only to the custody of a spouse, parents, legal guardian, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he shall so state in writing; and the statement must be made a part of the patient's medical record.

6.2 TIME OF DISCHARGE

The attending practitioner is responsible for discharging his patients as early as possible on the day of discharge.

6.3 LEAVING AGAINST MEDICAL ADVICE

If a patient desires to leave the hospital against the advice of the attending practitioner or without proper discharge, the attending practitioner shall be notified and the patient will be requested to sign the appropriate release form, attested by the patient or his legal representative and witnessed by a competent third party. If a patient leaves the hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident must be made in the patient's medical record.

When it has been determined by the nurse that the patient will not remain in the hospital, the covering resident physician must be notified. He/she will speak to the patient. After speaking to the patient, the resident will notify the attending physician. If no resident is covering, the attending physician will be notified by the nurse.

After notifying the attending, the patient will be requested to sign the proper release. This must be dated and witnessed. If the patient refuses to sign the release, this fact shall be recorded on the Nursing Progress Notes. An incident report describing the circumstances shall be completed. The patient may then leave the hospital.

The above steps must be documented on the Nurses Notes.

If it is discovered that the patient has left the hospital premises without informing the hospital personnel, Security, Nursing Services, and the attending physician shall be notified. The circumstances shall be documented in the patient's medical record and an incident report shall be filled out and processed.

6.4 LEGAL HOLD STATUS

No patient on a legal hold status will be discharged or released/removed from this status, prior to its ordinary time lapse, unless authorized by the Chair of the Department of Psychiatry or his approved list of designees, the Medical and Dental Staff President or the Regional President or designee. Telephone consultation with any of these individuals will be deemed sufficient. However, documentation in the patient's medical record must indicate the time and date of the consultation, and must clearly state the name and title of the individual consulted. Release of a patient to any law enforcement agency is an exception to this rule.

6.5 DISCHARGE PLANNING

Discharge planning shall be initiated as early as a determination of need can be made. Discharge planning shall provide for continuity of care to meet the patient's needs. These plans should be documented in the medical record. Criteria for discharge must include the availability of appropriate services to meet the patient's needs.

PART SEVEN: ORDERS

7.1 GENERAL REQUIREMENTS

All orders for treatment and diagnostic tests must be written clearly, legibly and completely and signed by the practitioner responsible for them, or entered through the computerized order entry system. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. Orders for diagnostic tests which necessitate the administration of test substances or medications will be considered to include the order for this administration. All drugs and medication orders must be entered and signed in the order sheet with the dosage, route of administration and frequency clearly designated.

Written orders may be accepted from all Medical and Dental Staff members, house staff and other individuals within the scope of their practice privileges.

7.1-1 Dietary Orders

1. All patients must have an order for a diet entered upon admission; unless the dietician is immediately available, the initial diet will be ordered by the admitting physician or Allied Health Professional.
2. Dieticians who are registered and credentialed through the Commission on Dietetic Registration and employed by the Medical Center are authorized to enter orders in accordance with the following parameters:

a. The Registered Dietician (RD) may make the following diet order changes:
   i. Adjust carbohydrate levels for diabetic diets based on estimated energy needs.
   ii. Adjust calories, protein, and fat based on estimated needs for renal, hepatic, weight reduction, weight gain, and wounds.
      ii (a) adjust/modify therapeutic diet restrictions (sodium, potassium, gluten, lactose, fiber, etc. based on patient's assessed needs, medical diagnosis or per patient's request.
   iii. Downgrade diet consistencies/textures when PO intake is affected or a choking hazard may occur (i.e. regular consistency to soft, mechanical soft, pureed).
   iv. Upgrade diet consistencies/textures when information from testing or responsible clinicians insures that such change can be accomplished safely.
   v. Liberalize therapeutic diet restrictions for patients with inadequate intake.

b. RDs will not independently advance and/or change patient orders for NPO or clear liquids, or in patients who have recently undergone gastrointestinal or abdominal/pelvic surgery.

c. The RD may initiate oral supplements, including liquid protein supplements when estimated energy needs are not met due to condition or intake as evidenced by objective nursing documentation, calorie count, subjective information, clinical judgment, or patient preference.

d. The RD may change the current oral supplement order under the following conditions:
   i. Current supplement is inappropriate to meet nutritional needs.
   ii. Changes in clinical condition warrant (i.e. hyperglycemia, renal insufficiency, wound status).
   iii. Patient or family request changes (to optimize intake).

e. The RD, upon specific consult by the physician, may manage enteral feedings. The physician writes an order stating, "RD to manage enteral feed."

f. The RD may order vitamin and mineral supplementation when patient's oral and/or enteral feeding intake is less than 100% RDA or as indicated for disease state and/or wound care.
g. The RD may order nutrition specific labs when deemed appropriate to monitor interventions or better asses patient's nutritional status (e.g. albumin, pre-albumin, 24 hour urea nitrogen to assess nitrogen balance).
h. The RD may order calorie counts when deemed appropriate through nutritional evaluation.
i. The RD may order weights when needed to provide an accurate nutritional assessment.
j. A physician may discontinue RD orders at his/her discretion or may limit changes made by the RD by initiating an order to that effect in the chart.
k. Documentation of initiation and modification of medical nutrition therapy should be documented in the medical record under "Progress Notes".
l. Monitoring of the RD will be done via chart audits and yearly competencies to ensure that appropriateness of orders and appropriate nutrition therapy are maintained.
m. Orders written under this policy will require RD's name and credentials and will be co-signed by the physician.

7.2 STANDING ORDERS

Standing orders must be approved by the Medical Executive Committee . These orders shall be signed by the attending physician for each individual patient. The Medical Executive Committee will review Standing Orders.

7.2-1 Unacceptable Orders

Orders must be individually written or entered into the computerized order entry system. The use of "renew", "repeat", and "continue order" are unacceptable.

7.2-2 Acceptable Orders

Resuming previous orders on post procedure patients is acceptable upon approval of the primary attending physician.

7.3 ADMISSION ORDER

7.3-1 For patients to be formally admitted as inpatients into the hospital, an order for admission is required and must state the admission is for inpatient or observation services.

7.3-2 The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital, and is knowledgeable about the patient's hospital course, medical plan of care, and current condition. Admission orders may be written by Allied Health Professionals provided they are co-signed by the admitting physician.

7.3-3 A valid admission order must be completed, signed, dated, timed, and documented in the medical record prior to discharge.

7.4 VERBAL ORDERS

7.4-1 Telephone and verbal orders shall only be accepted by a Registered Nurse, Physician's Assistant or other authorized professional as described below.

All telephone or verbal orders shall be written in the physician's order section of the medical records or entered into the computerized order entry system (as a verbal or telephone order.) Each verbal order must include the date, time of entry, and name

signature and credentials of the professional taking and/or transcribing the order as well as the name and credentials of the physician, dentist, podiatrist or Allied Health Professional giving the order.

All telephone and verbal orders must be countersigned and dated by the responsible physician, dentist, podiatrist or ALLIED HEALTH PROFESSIONAL either manually or electronically, within the time frame of medical record completion. Verbal orders require repeat back by the RN or Allied Health Professional. Telephone orders require read back by RN or Allied Health Professional. Refer to Administrative Policy: Acceptance and Documentation of Verbal and Telephone Orders.

Telephone orders for restraints must be countersigned, timed and dated within 24 hours of the order. Verbal orders may only be given in an emergent situation or when it facilitates the smooth flow of patient care (i.e., during a procedure). Verbal orders for restraints must be cosigned, timed and dated as soon as possible but within 24 hours. Refer to Administrative Policy: Restraint & Seclusion.

7.4-2 Documentation

Telephone and verbal orders shall be accepted by a Registered Nurse, Physician's Assistant or other authorized person as described below.
All telephone and verbal orders shall be transcribed in the proper place in the medical record, shall include the date, time, name and signature of the person transcribing the order and the name of the practitioner and shall be countersigned by the responsible practitioner.

All telephone and verbal orders must be countersigned and dated by the responsible practitioner, either manually or electronically, within 72 hours. Verbal orders require repeat back by the RN or Allied Health Professional. Telephone orders require read back by RN or Allied Health Professional. Refer to Administrative Policy: Acceptance and Documentation of Verbal and Telephone Orders.

Telephone orders for restraints must be countersigned, timed and dated within 24 hours of the order. Verbal orders may only be given in an emergent situation or when it facilitates the smooth flow of patient care (i.e., during a procedure). Verbal orders for restraints must be cosigned, timed and dated as soon as possible but within 24 hours. Refer to Administrative Policy: Restraint & Seclusion.

7.4-3 Verbal Orders by Other Professionals

- Verbal Orders by Registered Dieticians:
  Registered dieticians may accept verbal orders for nutritional management of patients from physicians.

- Verbal Orders by Licensed Therapists:
  Licensed Therapists may accept verbal orders for physical therapy, occupational therapy, speech language pathology, or audiology services from physicians.

- Verbal Orders by Registered Pharmacists:
  Registered Pharmacists may accept verbal orders for medications from physicians or other practitioners authorized by the Medical Staff to order medications.

- Verbal Orders by Registered Respiratory Therapists:

Registered Respiratory Therapists may accept verbal orders for respiratory from physicians or other practitioners authorized by the Medical Staff to order respiratory therapy.

7.5 ORDERS BY HOUSE STAFF AND OTHER ALLIED HEALTH PROFESSIONALS

7.5-1 Orders by House Staff

When a PGY-1 resident or other resident without a state permit writes or enters orders on a patient, those orders must be co-signed and dated by the responsible physician, dentist, podiatrist or his/her designee upon discharge. Orders by residents or fellows who hold state permits or licenses do not require co-signature.

All telephone and verbal orders by residents must be countersigned and dated by the resident, either manually or electronically, within the time frame of medical records completion. In addition telephone or verbal orders by a resident without a permit or license must be co-signed by the responsible physician, dentist or podiatrist upon discharge. Verbal orders require repeat back by the RN or Allied Health Professional. Telephone orders require read back by RN or Allied Health Professional. Refer to Administrative Policy: Acceptance and Documentation of Verbal and Telephone Orders.

Telephone orders by residents for restraints must be countersigned, timed and dated within 24 hours of the order. Verbal orders may only be given in an emergent situation or when it facilitates the smooth flow of patient care (i.e., during a procedure). Verbal orders for restraints must be cosigned, timed and dated as soon as possible but within 24 hours. Refer to Administrative Policy: Restraint & Seclusion.

7.5-2 Orders by Allied Health Professionals

An Allied Health Professional may write orders only to the extent, if any, specified in the position description developed for that category of Allied Health Professional and consistent with the scope of services individually defined for that individual. Any authorized order by a Physician Assistant (PA) on an inpatient must be countersigned by the responsible physician, dentist, podiatrist or his/her designee within 24 hours. Outpatient orders by PAs must be co-signed by the responsible physician, dentist, podiatrist or his/her designee within 48 hours if for medication and within 7 days for all other orders. Orders by Nurse Practitioners (NPs) do not require co-signature.

All telephone and verbal orders entered on behalf of a NP or PA must be countersigned and dated by the Allied Health Professional, either manually or electronically, within the time frame of medical record completion. However, orders entered on behalf of a PA must also be co-signed by the responsible physician, dentist, podiatrist or his/her designee within 24 hours. Verbal orders require repeat back by the RN or Allied Health Professional. Telephone orders require read back by RN or Allied Health Professional. Refer to Administrative Policy: Acceptance and Documentation of Verbal and Telephone Orders.

Telephone orders for restraints must be countersigned, timed and dated within 24 hours of the order within the time frame of medical record completion. Any order entered by a PA must also be co-signed by the responsible physician, dentist, podiatrist or his/her designee within 24 hours. Verbal orders may only be given in an emergent situation or when it facilitates the smooth flow of patient care (i.e., during a procedure). Verbal orders for restraints must be cosigned, timed and dated as soon

as possible but within 24 hours. Refer to Administrative Policy: Restraint & Seclusion.

7.6 AUTOMATIC CANCELLATION OF ORDERS

All previous orders are automatically discontinued when a patient goes to surgery or is transferred into or out of an intensive care area. After review of the patient's medical record, new orders must be written by the attending physician or surgeon. The attending physician or surgeon may delegate this responsibility to another physician or other credentialed licensed independent practitioner but the attending will be responsible for confirming that the chart review and the new orders are completed.

7.7 STOP ORDERS

7.7-1 Drugs/Treatments Covered and Maximum Duration

When feasible, and in order to assure that the proper and complete therapeutic regimen intended by the prescribing practitioner is carried out, the exact total dosage or total period of time for the drugs or treatments listed shall be specified. When that has not been done, a stop order will be placed automatically, as specified in section 7.6-2 and a new order provided in accordance with section 7.7-2. In implementing the stop order, Nursing/Pharmacy/Respiratory Therapy will calculate the maximum duration permissible so as to cover the total number of hours indicated. In no event shall the drug or treatment be given for the maximum duration permissible if the last effective order specifies a shorter interval or particular dosage.

7.7-2 Schedule for the Rewriting of Medication Orders

The schedule for the rewriting of medication orders will be in accordance with the policies and procedures of the Pharmacy Department with the approval of the Medical Executive Committee and the Board of Trustees.

7.7-3 Exceptions

Exceptions to the stop order rule are made under the following conditions:

- The last effective order indicated an exact number of doses to be administered; or
- The last effective order specifies an exact period of time for the medication.

7.7-4 Notification of Stop

The physician order entry system notifies the prescribing within 12-36 hours that an order is approaching expiration

7.8 BLOOD TRANSFUSIONS AND INTRAVENOUS INFUSIONS

Blood transfusions and intravenous infusions must be started by a practitioner, an Allied Health Professional who is so credentialed, or by a Registered Nurse who has the requisite training. The order must specifically state the rate of infusion.

7.9 SPECIAL ORDERS

7.9-1 Patient's Own Drugs and Self-Administration

Drugs brought into the hospital by a patient may not be administered unless the drugs have been identified and there is a written order from the attending practitioner to administer the drugs. Self-administration of medications by a patient is permitted on a specific written order by the authorized prescribing practitioner and in accordance with established hospital policy.

7.9-2 Do Not Resuscitate (DNR)/Withdrawing of Life Sustaining Treatment

Do Not Resuscitate orders shall be in compliance with the Division's Administrative Policies and Procedures "Do Not Resuscitate Levels of Care".

7.9-3 Restraints and Seclusion

Restraints and Seclusion shall be in compliance with the Division's Administrative Policies and Procedures. Refer to Administrative Policy: Restraint & Seclusion.

7.9-4 Pain and Symptom Management

Patients are required to receive appropriate assessment and management of pain and related symptoms via hospital policy.

7.9-5 Multi-Disciplinary Treatment Plan

1. This Medical Center utilizes, to the extent possible, the multi-disciplinary treatment plan approach with psychiatric and substance abuse patients.
2. The multi-disciplinary plan must be approved by a Medical and Dental Staff member who has clinical authority/responsibility for the patient. At no time will the Medical and Dental Staff member relinquish responsibility, as a treating physician, to the multi-disciplinary team.

7.10 FORMULARY AND INVESTIGATIONAL DRUGS

General Requirements:

- Medication orders must include the administration route, dosage, and time or time intervals between doses.
- Use of terms "prn" and "on-call" must be qualified.

7.10-1 Formulary

The hospital formulary lists drugs available for ordering from stock. Each member of the Medical and Dental Staff assents to the use of the formulary as approved by the Medical Executive Committee. All drugs and medications administered to patients, with the exception of drugs for bonafide clinical investigations, shall be those listed in the latest edition: United States Pharmacopoeia; National Formulary; New and Non-Official Drugs; American Hospital Formulary Service; or AMA Drug Evaluations.

7.10-2 Investigational Drugs

Use of investigational drugs must be in full accordance with all Regulations of the Food and Drug Administration and must be approved by the Institutional Review Board (IRB) of the Medical and Dental Staff. Their use must also be in accordance with the Investigational Drug Policy of the Pharmacy and Therapeutics Committee.

PART EIGHT: INPATIENT MEDICAL RECORDS

8.1 UNIT RECORD SYSTEM

8.1-1 Medical Record Documentation is maintained for the following:

- In-patients
- Same day surgery patients
- Clinic patients
- Private patients
- ER patients - admitted and not admitted
- Home Care Program
- Outpatient chemotherapy
- Observation
- Hospice
- Family Health Center

8.1-2 A unit record is maintained which includes all in-patient, same day surgery and admitted ER patients.

1. Clinic records are stored within the treating department and pertinent results are readily available upon patient readmission via the Lifetime Clinical Record System (LCR). Copies of pertinent in-patient records are stored with clinic records. Microfilmed clinic records are stored at the off site storage facility.
2. Private outpatient records (lab, x-ray, PT, EKG, EEG) are maintained within the treating departments, but are readily located with the LCR
3. Outpatient chemotherapy records are kept in a locked, secured file in the treatment area. These records are reviewed quantitatively by the Cancer Registrar, who also maintains an index of these patients.
4. The clinical data system describes the type of encounter the patient had in order to discern where the record is maintained.

8.1-3 Authorized Entries

Authorized individuals who make entries into the medical record are limited to members of the Medical/Dental Staff and those individuals who provide patient care and are authorized to do so either through approved clinical privileges or job descriptions. The record's content shall be pertinent, accurate, legible, timely and current.

8.1-4 Required Content

The record shall include:

1. Face Sheet: Patient identification data shall include the patient's name, address, date of birth, age, sex, origin, next of kin or contact in case of emergency, financial information, billing and medical record number. When this information is unobtainable, the reason shall be documented in the medical record.
2. Patient Discharge Instruction Sheet
3. Emergency Room Record (if applicable) and any emergency care, treatment and services, related to his or her ER visit, provided to the patient before his or her arrival
4. Medical History of the Patient and Family
5. Description and history of present complaint and/or illness and Physical Examination.
6. Physician's Progress Notes and other clinical observations, including results of therapy.
7. Informed Consent (if applicable)
8. Operative Report (if applicable)
9. Anesthesia Record (if applicable)
10. Recovery Room Record (if applicable)
11. Pre- and Post Operative Check List (if applicable)
12. Consultation Report (if applicable)
13. Reports of Procedures, Tests, and Results
14. Reports of Radiology and Nuclear Medicine
15. Necropsy Reports (if applicable)
16. Ancillary Department Therapy Forms (if applicable)
17. Pulmonary Function Studies (if applicable)
18. Diagnostic and Therapeutic Orders
19. Provisional Diagnosis
20. The goals of treatment and the treatment plan
21. Treatment Provided
22. Final diagnosis without the use of symbols or abbreviations
23. Final Discharge Summary

24. Nursing Entries
25. Condition on discharge, including instructions, if any, to the patient or significant other on post-hospital care.
26. Birth certificate and autopsy report when appropriate and available
27. The patient's legal status
28. The record and findings of the patient's assessment
29. A statement of the conclusions or impressions drawn from the medical history and physical examination
30. Evidence of known advance directives
31. All reassessments, when necessary
32. The response to the care provided
33. Every medication ordered or prescribed for an inpatient
34. Every dose of medication administered and any adverse drug reactions
35. Every medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge
36. All relevant diagnoses established during the course of care
37. Any referrals and communication made to external or internal care providers and to community agencies
38. Pre and Postoperative Diagnosis
39. Any records of communication with the patient, such as telephone calls or email, as is related to advanced directives or Informed consents.
40. Any patient generated information

8.1-5 Use of English Language

All members of the Medical and Dental Staff shall record in the English language all hospital documents, including but not limited to histories, physicals, consultations, progress notes, orders.

8.1-6 Delinquent Medical Records

The medical record will be considered delinquent if not completed within 30 days after discharge. Medical records lacking a discharge summary, operative report, history and physical or consultations authenticated by the appropriate physician will be considered incomplete and subsequently delinquent if not completed within 30 days of discharge.

Operative and procedure reports not dictated within 24 hours will be considered delinquent. Physicians will be notified via the method outlined in the HIM policy that they will be automatically suspended if these reports are not completed within 7 days. Physicians placed on suspension three or more times in any 12 month period for undictated procedure and operative reports will be required to appear before the Credentials Committee, which may make recommendations to Medical Executive Committee regarding further action as outlined in the HIM policy.

Physicians will be notified of the existence of incomplete and delinquent records on a weekly basis. Letters will be faxed to the physicians' primary office as recorded in the Medical Staff Office. When a physician does not complete all presented and available records within 30 days post-discharge, the physician will be placed on restriction.

Upon restriction, a physician will NOT be allowed to admit elective patients or direct admissions, or schedule new procedures. They may perform procedures that were scheduled prior to the date the restriction was imposed. Physicians who intentionally ignore restriction may be subject to corrective action. Such restriction of a staff member's privileges shall not relieve the staff member from his obligation to cover the Emergency Room call or his/her duties on Ward and Clinic Service.

Physicians who do not complete their delinquent records within four weeks of being placed on restriction will be automatically suspended, in accordance with Article IX, Section 9.3 (e) of the Hackensack Meridian Health Hospitals Corporation Medical and Dental Staff Bylaws. Upon automatic suspension, physicians will not have active clinical privileges and their ID badges shall be deactivated.

A Medical and Dental Staff member who is automatically suspended shall not have a right of appeal under the Hackensack Meridian Health Hospitals Corporation Medical and Dental Staff Bylaws, but shall have the opportunity to demonstrate to the Medical and Dental Staff President and the Director of the member's department that there was not a factual basis for imposing the suspension under this rule, in which case, if all parties agree, the suspension shall be revoked.

Any request for a change in status or for letters of recommendation for any member of the Medical and Dental Staff will only be considered after all medical records have been completed and other obligations have been fulfilled, as defined in the Meridian Hospitals Medical and Dental Staff Bylaws.

8.2 HISTORY AND PHYSICAL EXAMINATION

8.2-1 Generally

A complete History & Physical examination shall be written legibly or dictated within no more than 24 hours of admission of the patient. The history and physical may be completed up to 30 days prior to admission but must be updated within 24 hours of admission or at the time of the outpatient surgery or service, and include the statement “I have examined the patient”.

A complete history and physical shall include:

- The chief complaint
- Reason for admission
- History of present illness
- Past medical history, family history, psychosocial and social history
- Medications
- Allergies
- Review of systems
- Physical examination by body systems
- Impression and statement of course
- Indications for all antibiotics used in treatment

The following non-inpatient services require a medical history and physical:

- Ambulatory Surgery
- Angioplasty
- Cardiac Cath
- Chemotherapy
- Endoscopy
- EPS
- Observation
- Outpatient Surgery
- Plasmapheresis
- Patients receiving regional anesthesia

New services, additions or deletions that may require history and physical must be approved by the Medical Executive Committee.

For patients receiving only local anesthesia, a brief clinical review that includes the following elements is required:

- Reason for the procedure
- Significant past medical history
- Current medications
- Allergies
- Plan for anesthesia
- Post-operative plan
- Recording of vital signs, examination of heart, lungs and relevant diagnostic or therapeutic region

Dental patients admitted for care shall have a comprehensive History & Physical examination performed by a licensed Medical Doctor or licensed Osteopathic Doctor or licensed Oral Surgeon who is a member of the Medical and Dental Staff with admitting privileges. Podiatric patients may be admitted for care by a residency trained podiatrist who is a member of the Medical and Dental Staff. The podiatrist is authorized to perform the history and physical examination only on their podiatric patients. Histories and physicals completed for outpatient services should be performed by either a qualified physician or podiatrist who is credentialed and privileged by the hospital, or when the histories and physicals are performed by a qualified physician who is not credentialed and privileged at the medical center, then the histories and physicals must be reviewed and signed by a physician or podiatrist who is privileged at the Medical Center.

8.2-2 Use of Reports Prepared Prior To Current Admission

All obstetrical records shall be updated to the time of admission to include all available information from the original office or clinic prenatal record.

8.3 PREOPERATIVE DOCUMENTATION

8.3-1 History and Physical Examination

A relevant history and physical examination is required on each patient having surgery. Except in an emergency so certified in writing by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed until after the pre-operative diagnosis, history, physical examination, and required laboratory tests have been recorded in the chart. If the history and physical examination have been dictated but are not on the chart at the time of surgery, a written note must be entered before surgery stating the basic nature of the proposed surgery/procedure and the condition for which it is to be done, the condition of the heart and lungs, allergies known to present, other pertinent pathology and information relating to the patient, and that the history and physical have been dictated. If not recorded, Nursing Administration or appropriate designee shall inform both the surgeon and anesthesiologist that the requirement has not been met and surgery should not proceed. In case of emergency, the responsible practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure, and the history and physical examination shall be recorded immediately after the emergency surgery has been completed. All cases in which the requirements of this section are not met shall be acted upon in accordance with Article VIII, Section 8.3 of the Meridian Hospitals Corporation Bylaws.

8.3-2 Laboratory and Diagnostic Testing

Pre-anesthetic laboratory and diagnostic testing is often essential; however, no routine laboratory or diagnostic screening test is necessary for the pre-anesthetic

evaluation of patients. Appropriate indications for ordering tests include the identification of specific clinical indicators or risk factors (e.g., age, pre-existing disease, magnitude of the surgical procedure). Individual surgeons and anesthesiologists should order test(s) when, in their judgment, the results may influence decisions regarding risks and management of the anesthesia and surgery. Legal requirements for laboratory testing where they exist should be observed.

8.3-3 Preoperative Anesthesia Evaluation

The anesthesiologist (or other licensed independent professional responsible for the patient's anesthesia care) must conduct and document in the record a pre-anesthesia evaluation of the patient, including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, ASA patient status classification, and orders for pre-op medication. Except in cases of emergency, this evaluation should be recorded prior to the induction of anesthesia and before preoperative medication has been administered.

8.4 PROGRESS NOTES

8.4-1 Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

Progress notes should be narrative in form and reflect condition from day to day; reflect the changes in the physical findings from day to day; contain direct references to laboratory tests, x- ray findings, ECG, and other special tests; address consultations, treatments, medical or surgical changes in diagnosis; and indication for all antibiotics used in treatment.

Progress notes by the attending practitioner must be written at least daily on acutely and critically ill patients and on those where there is difficulty in diagnosis or management of the clinical problem.

Progress notes written by a physician-directed allied health professional must be countersigned within 24 hours and supplemented every 48 hours by the responsible supervising practitioner. Each progress note must be dated, timed, and signed by the attending physician.

8.4-2 By Attending Practitioner When House Staff Involved

It is generally expected that at least every other day during hospitalization, the attending practitioner will personally write a note indicating involvement in the care of the patient. Countersigning a house staff member's note is acceptable but only if the house staff note specifically indicates that the attending practitioner examined the patient on that given day and his observations coincided with those of the house staff member. If the patient's condition warrants, more frequent notes by the attending practitioner are expected.

8.5 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS

8.5-1 Operative and Special Procedure Reports

A brief operative or procedural report must be entered into the medical record at the conclusion of the case and before the patient is transferred to the next level of care. This note shall contain at a minimum: pre-op diagnosis, post-op diagnosis, name of procedure, name of surgeon and assistant(s), a brief description of findings, the type of anesthesia employed, the estimated blood loss, specimens

removed/sent, and a description of any complications. If the practitioner performing the operation or procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or entered into the medical record in the new unit or area of care. In addition, a full operative or procedure report must be dictated within 24 hours of completion of the case. Operative and special procedure reports must contain, as applicable, the name of the procedure performed, the pre-operative diagnosis, a detailed account of the findings, the technical procedures used, estimated blood loss, the specimens removed, the post-operative diagnosis and the name of the primary performing practitioners and any assistants.

8.5-2 Tissue Examination and Reports

All tissues, foreign bodies, artifacts and prostheses removed during a procedure, except those specifically excluded by policy recommended by the Chair of Pathology and adopted by the Medical Executive Committee, shall be properly labeled, packaged in preservative, , if required, identified as to patient and source in the operating room at the time of removal, and sent to the Department of Pathology in the Laboratory. Laboratory personnel shall document specimen receipt and confirm that required documentation has been provided. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative diagnoses. The final pathology report shall be made a part of the medical record.

8.5-3 Possible Exempted Categories

The Chair of Pathology may recommend to the Medical Executive Committee limited types of specimens that may be exempted from the requirement to be examined by a pathologist. Such exclusions may include the following:

- Specimens that by their nature or condition do not permit productive examination, such as cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure.
- Therapeutic radioactive sources, the removal and disposal of which is guided by radiation safety regulatory requirements.
- Traumatically injured members that have been amputated and for which examination for either medical or legal reason is not deemed necessary.
- Foreign bodies (e.g. bullets) that, for legal reasons, are given directly in the chain of custody to law enforcement representatives.
- Teeth, provided the anatomic name or anatomic number of each tooth, or fragment of each tooth, is recorded in the medical record.

Whichever, if any, types of specimens are exempted will be reviewed periodically by the Chair of Pathology, with any recommended revisions being referred to the Clinical Medical Executive Committee for its consideration.

8.5-4 Pre-Procedure Review of External Histo-Pathologic Diagnosis

Before a patient is to be admitted to undergo a major ablative surgical, gynecological or other procedure based on a histopathologic diagnosis made elsewhere, the physician performing the procedure must arrange for diagnostic slides and reports to be sent to the Department of Pathology for pathologist review and confirmation of the diagnosis. Review of previous pathology slides is required by the American College of Surgeons National Accreditation Program for Breast Centers and is consistent with contemporary standards of prudent surgical and gynecological practice. Failure to follow this policy shall result in notification of the appropriate department chair and referral to the Peer Review Committee for corrective action.

8.6 ENTRIES AT CONCLUSION OF HOSPITALIZATION

8.6-1 Final Diagnoses

The principal diagnosis, any secondary diagnoses, co-morbidities, complications, hospital acquired infections, principal procedure and any additional procedures must be recorded in full and must be dated and signed by the attending practitioner. The following definitions are applicable to the terms used herein:

1. **Principal Diagnosis:** The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
2. **Secondary Diagnosis** (If applicable): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.
3. **Co-morbidities** (If applicable): a condition that coexisted at admission with a specific principal diagnosis, and is thought to increase the length of stay by at least one day (for about 75% of the patients).
4. **Complications** (If applicable): An additional diagnosis that describes a condition arising after the beginning of hospital observation and treatment and modifying the course of the patient's illness or the medical care required, and is thought to increase the length of stay by at least one day.
5. **Principal Procedure** (If applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.
6. **Additional Procedures** (If applicable): Any other procedures, other than the principal procedure, pertinent to the individual stay.

8.6-2 Discharge Summary

1. **In General:** A discharge summary must be dictated or written legibly for all patients and placed in the patient's medical record. The summary shall state concisely:
    - The reason(s) for hospitalization
    - Significant findings and complications
    - Procedures performed
    - The care, treatment and services provided
    - The condition of the patient on discharge
    - Information provided to the patient and family
    - Medications on discharge
    - Final diagnosis
    - In the case of death, the events leading to the death and the cause of the death.

2. **Exceptions:** A final progress note which is dictated or written legibly may be substituted for the discharge summary in the case:

    - Where the patient is discharged alive within 48 hours of admission and is not transferred to another facility;
    - of normal newborns; or
    - of uncomplicated deliveries

    The final progress note includes at least the patient's condition on discharge, medications on discharge and discharge instructions.

When a patient is transferred to a different level of care within the hospital and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.

8.6-3 Instructions to Patient

The Interdisciplinary Discharge Instructions or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet and follow-up care.

Follow-up care notations should indicate the disposition of the case, such as: return to physician's office; transfer to another hospital; transfer to an extended care facility; transfer to a nursing home. If no instructions were required, a record entry must be made to that effect.

8.7 AUTHENTICATION

All clinical entries in the patient's record must be accurately dated, timed and individually authenticated. Authentication means to establish authorship by written or electronic signature. In addition, orders by unlicensed residents who do not have a state permit and orders by PAs require co-signature by the supervising physician, dentist, podiatrist or his or her designee.

8.8 LATE ENTRIES

Late entries may be made into the record provided that they are labeled as such and reflect the date that the late entry is written.

8.9 CLOSING

No medical record shall be closed until it is complete and properly signed. In the event that a chart remains incomplete by reason of death, resignation or other inability or unavailability of the responsible practitioner to complete the record, Determination to close the medical record will be made by the Health Information Manager.

8.10 MEDICAL RECORD COMPLETION

All members are subject to, and must comply with, the Medical and Dental Staff policy on medical record completion.

PART NINE: CONSENTS

9.1 WRITTEN CONSENT FOR TREATMENT

The Medical Record shall contain evidence of the Informed Consent as well as the General Admission Consent of the patient or his legal representative for any procedures or treatment for which it is appropriate. Appropriateness for Informed Consent shall be judged according to the standards of the local medical community. The nature, purpose, benefits, medically significant alternatives and risks and consequences of the procedure or treatment shall be explained to the patient and/or his/her legal representatives in terms which same can reasonably be expected to be understood.

A physician may perform a surgical or medical procedure or treatment under emergency conditions without obtaining the consent of a patient or his legal representative when, in the physician's professional judgment, the performance of said procedure or treatment is required to preserve life or prevent serious impairment to health and when the patient is incapable of rendering a consent. In cases of emergency without proper authorization, the Regional President or his designee must be notified of the circumstances.

PART TEN: SPECIAL SERVICES, UNITS AND PROGRAMS

10.1 DESIGNATION

Special services units and programs include, but are not limited to, the following:

- Intensive care units of all types (ICUs, CCUs, etc.)
- Emergency Room
- Operating Room
- Recovery Room
- Day-surgery program

10.2 POLICIES

Appropriate officers, committees, and representatives of the Medical and Dental Staff and its departments will develop in coordination with applicable hospital departments, specific policies for the special services units and programs, covering, when applicable, such subjects as the responsibility for care of patients in the unit/program, criteria for patient admission to the unit/program, consultation requirements, admission/discharge/transfer protocols, direction/organization of the unit/program, authority of the physician director of the unit/program, special record-keeping requirements, and scheduling of patients. The policies of the various units and programs will be coordinated by, and are subject to, the approval of the Medical Executive Committee

PART ELEVEN: HOSPITAL DEATHS AND AUTOPSIES

11.1 HOSPITAL DEATHS Reference Administrative policy 3376674 "death Pronouncement"

11.2 AUTOPSIES Reference Medical and Dental Staff Policy and Procedure "Autopsy"

PART TWELVE: INFECTION CONTROL

The Infection Control Committee has the authority to institute any appropriate control measure or study when it is reasonably felt to be a danger to patients or personnel from an infectious source.

12.1 PATIENTS WITH INFECTIOUS/COMMUNICABLE DISEASES

Any patient with a suspected infectious or communicable disease will be treated using appropriate isolation techniques, as ordered by the attending physician and consistent with the principles outlined in the Infection Control Manual of Jersey Shore University Medical Center. The Infection Control practitioner or any registered nurse may institute isolation precautions until the attending physician can be contacted to make a final decision regarding the need for isolation. If there is a disagreement between the attending physician and the infection control practitioner or nurse, the matter shall be referred to the Chair of the Infection Control Committee who will consult with the attending physician and then make a final decision regarding the need for isolation for the protection of the hospital employees and other patients.

12.2 REPORTING OF INFECTIOUS/COMMUNICABLE DISEASES

All cases of infection and communicable disease must be reported to the Infection Control Committee in accordance with the Infection Control Manual.

12.3 All practitioners must comply with the Sepsis State Education requirement. Reference Medical and Dentals Staff Policy and Procedure on "Sepsis Guidelines".

PART THIRTEEN: COMMITTEES

13.1 GENERAL

Committees shall be Standing and Special. Members of all committees, except as otherwise provided below, shall be appointed by the Medical and Dental Staff President annually. Committees shall be chaired by an Attending physician. All committee meetings shall be open to members of the Medical and Dental Staff upon request. Members of the Board of Trustees, Administration or other guests may be invited at the discretion of the Medical and Dental Staff President or the committee. House Staff appointments to Medical and Dental Staff committees may be made by the Medical and Dental Staff President in cooperation with the Department of Academic Affairs. The Vice President of Academic Affairs shall make recommendations for appointment only following discussion with the Program Directors in the appropriate departments. Non-physicians, non-dentists, and members of the House Staff shall have no vote on Medical and Dental Staff committees; the only exception is that the medical house staff can vote on the GME Committee. As per Section 13.1 of the Bylaws, all Standing Committees shall report to the Medical Executive Committee.

13.2 OTHER COMMITTEES

Supplements to Standing Committees are listed in Article XIII, Section 13.3.1 of the Medical and Dental Staff Bylaws of the Hackensack Meridian Health Hospitals Corporation are as follows:

- Blood Use Evaluation Committee
- Cancer Committee
- Credentials Committee
- Graduate Medical Education Committee
- Medical Executive Committee
- Investigating Committee
- Medical Equipment Committee
- Medical and Dental Staff Peer Review Committee
- Nominating Committee
- Physician Health Committee
- Radiation Safety Committee
- Research Committee
- Rules and Regulations Committee
- Search Committee
- Trauma Committee

13.3 BLOOD USE EVALUATION COMMITTEE

13.3-1 Composition

Members shall be appointed by the Medical and Dental Staff President and shall include representatives from the Departments of Pathology, Surgery, Pediatrics, Orthopedics, Section of Hematology (Department of Medicine), and Section of Cardiac/Thoracic Surgery (Department of Surgery).

13.3-2 Duties

The Blood Use Evaluation Committee shall be responsible for evaluating the appropriateness of all cases in which patients were administered transfusions, including the use of whole blood and blood components; evaluating all confirmed transfusion reactions; developing or approving policies and procedures relating to the distribution, handling, use and administration of blood and blood components;

reviewing the adequacy of transfusion services to meet the needs of patients; and reviewing the ordering practices for blood and blood products.

13.3-3 Meetings

The Blood Use Evaluation Committee shall meet quarterly and report in writing to the Quality Improvement and Outcomes committee.

13.4 CANCER COMMITTEE

13.4-1 Composition

The Cancer Committee shall be a multidisciplinary standing committee and composed of Representatives of the various disciplines concerned with cancer care, with membership and duties as delineated in Standard 2.2.0 of "The American College of Surgeon's Commission on Cancer Registry Operations and Data Standards" and the Cancer Program's Quality Improvement Plan.

13.4-2 Duties

1. To insure that patients have access to consultative services in all disciplines through weekly Tumor Conferences.
2. To be responsible for assuring that education programs, Tumor Conferences and other clinical activities cover the entire spectrum of cancer.
3. To audit data concerning the care of patients with cancer, and make recommendations where appropriate.
4. To actively supervise the Tumor Registry for quality control of abstracting, staging and reporting.

13.4-3 Meetings

The Committee shall meet at least quarterly as an entity separate from Tumor Conferences and document its activities and attendance as delineated in its Quality Improvement Plan guidelines to the Medical Executive Committee.

13.5 CREDENTIALS COMMITTEE

13.5-1 Composition

The Chair or designee of each of the Medical and Dental Staff departments shall serve in the committee. The Chair of the Committee shall be the Secretary of the Medical Executive Committee. The President of the Medical and Dental Staff and the Regional President may serve (or appoint) representatives to the Committee, who shall be non-voting participants.

13.5-2 Duties

1. Review and evaluate the qualifications and credentials of each applicant for initial appointment, reappointment (if requested by the Department Chair), or modification of appointment or clinical privileges (if requested by Department Chair), and in connection therewith, obtain and consider the recommendations of the appropriate departments.
2. Review and evaluate qualification of each Allied Health Professional applying for permission to perform specific services, and in connection therewith, obtain and consider the recommendations of the appropriate department.
3. Submit reports required under Articles VI, VII, and VIII of the Medical and Dental Staff Bylaws to the Medical Executive Committee on the qualifications of each applicant for Staff membership and of each Allied Health Professional for permission to perform specified services. Such reports shall include recommendations with respect to appointment, staff

category, department and section affiliation, clinical privileges or specified services, and special conditions attached thereto.

4. Submit monthly reports to the Medical Executive Committee on the status of pending applications, including specific reasons for any undue delay in processing an application.
5. The Committee shall treat all the discussion and the materials as confidential. Members of the Committee will recuse themselves when a conflict of interest arises.

13.6 GRADUATE MEDICAL EDUCATION COMMITTEE

13.6-1 Composition

1. The membership of the Education Committee will include the Program/Site Directors of the residency programs entered immediately after Medical or Dental School, namely, General Dentistry, General Surgery, Medicine, Obstetrics and Gynecology, and Pediatrics. The Vice President, Academic Affairs, will serve as an Ex Officio member of the Graduate Medical Education Committee.
2. The Chair will be appointed by the President of the Medical and Dental Staff from among the Graduate Medical Education Committee voting members and rotate annually amongst the Program/Site Directors.

13.6-2 Duties

1. Establishment of policies and monitoring compliance with the Special Requirements and the Institutional Requirements for graduate medical education as specified by the Accreditation Council for Graduate Medical Education.
2. Establishment of policies and monitoring compliance with respect to continuing medical education programs as specified by the Accreditation Council for Continuing Education.
3. Establishment of policies and monitoring compliance with respect to undergraduate medical education programs.
4. Establishment of policies and monitoring compliance with respect to the Health Sciences Library.
5. Advise and recommend to the Medical Executive Committee and Administration regarding the allocation of resources for educational activities.

13.6-3 Meetings

The Graduate Medical Education Committee shall meet at least six times per year and will report to the Medical Executive Committee, which will receive copies of all minutes.

13.7 MEDICAL EXECUTIVE COMMITTEE

Composition of the Medical Executive Committee as stated in Article XIII, Section 13.2.1 of the Hackensack Meridian Health Hospitals Corporation Bylaws will be supplemented with the chairs of each of the Departments and elected representatives of at least Attending Rank as follows:

- Department of Medicine (2 Members)
- Department of Obstetrics & Gynecology (1 Member)
- Department of Surgery (2 Members)
- Department of Pediatrics (1 Member)

- The Vice Chairs of the Departments of Medicine, Obstetrics & Gynecology, Pediatrics and Surgery
- The Regional President or designee, ex-officio, with a vote.
- A member of the House Staff, without a vote.
- In their absence, members elected or appointed ex-officio from Departments of the Medical and Dental Staff, may assign a designee to attend in his/her place.

13.7-1 At-Large Members

1. Term limits shall apply to those representatives to the Medical Executive Committee
   who are elected as at-large members.
2. The duration of time on the Medical Executive Committee for an at-large representative cannot exceed six consecutive years.
3. The frequency of elections for an at-large member will be defined by the representative's primary Departmental Rules and Regulations.
4. When a term limit is reached, that representative would be eligible to serve again on Medical Executive Committee as an at-large member after one year.
5. For an at-large representative leaving the Medical Executive Committee then returning again after a year or more as an at-large member, the term limit clock starts over for that individual.

13.8 INVESTIGATING COMMITTEE

13.8-1 Composition

The Investigating Committee shall consist of a panel of members of the Active Medical and Dental Staff who shall be chosen by the Medical and Dental Staff President.

13.98-2 Duties

The Committee's duties shall be to investigate allegations contained in requests for corrective action referred to this Committee by the Medical Executive Committee pursuant to Article IX, Section 9.1 of the Hackensack Meridian Health Hospitals Corporation Bylaws.

13.8-3 Meetings

The Committee shall meet as needed and shall report to the Medical Executive Committee.

13.9 MEDICAL EQUIPMENT COMMITTEE

13.9-1 Composition

The members shall be appointed by the Medical and Dental Staff President and shall include the Chair and representatives of each clinical department, which shall include, but not be limited to, the Chair (or his representative) of Medicine, Surgery, Anesthesia, Dentistry, Family Practice, Cardiology, Pulmonary, Obstetrics & Gynecology, Orthopedics, Pathology, Pediatrics, Neonatology, Radiology, Psychiatry, Emergency Room. A representative of the Hospital Administration and Nursing Service shall also be included.

13.9-2 Duties

The Committee shall prepare the annual Medical Equipment Budget, in conjunction with Administration, as well as recommend and advise Administration regarding medical equipment priorities.

13.9-3 Meetings

The Committee shall meet regularly, document its activities, and report to the Medical Executive Committee.

13.10 MEDICAL AND DENTAL STAFF PEER REVIEW COMMITTEE

13.10-1 Composition

The members shall be appointed by the Medical and Dental Staff President and shall include the Chair and representatives from the Departments of Surgery, Medicine, Orthopedics, Obstetrics & Gynecology, Emergency Medicine, Pediatrics, and Psychiatry,a Nurse Practitioner and the Chief Medical Officer . The Manager of Quality Improvement and Outcomes will also be included as a non-voting member.

13.10-2 Duties

The committee shall make recommendations to the Medical Executive Committee on cases that do not meet the standard of care as determined by the committee.

13.10-3 Meetings

The Committee shall meet at least every other month (or more frequently if necessary), document its activities and report to the Medical Executive Committee.

13.11 NOMINATING COMMITTEE:

13.11-1 Composition. This Committee shall be composed of elected member(s) from each Department. The Committee shall elect its own Chair. Members of this committee shall be ineligible for nomination by the Committee to the Medical Staff Office. Nominating Committee members shall be required to provide financial disclosure. This financial disclosure shall be limited to the percentage of income that the particular individual derives from any contract with the Health System or other health care organization.

13.11-2 Duties. The Committee shall:

i. Consult with Members of the Organized Medical and Dental Staff concerning the qualifications and acceptability of prospective nominees.

ii. Nominate and submit, at the appropriate times as provided in the Medical and Dental Staff Bylaws one or more qualified candidates for each elective office of the Organized Medical and Dental Staff to be filled and such other elective positions or to fill vacancies in any office or position as may be required.

13.11-3 If all persons nominated for an office by the Nominating Committee and by petition are unable to unwilling to serve, then substitute nominees may be accepted at the annual meeting from the Nominating Committee.

13.12 PHYSICIAN HEALTH COMMITTEE

13.12-1 Composition

The Physician Health Committee shall consist of a panel of members of the Active Medical and Dental Staff who shall be chosen by the Medical and Dental Staff President.

13.12-2 Meetings

The Committee shall meet at as needed and shall report to the Medical Executive Committee.

13.12-3 Duties/Policy Statement

1. The hospital and its Medical and Dental Staff are committed to providing patients with quality care. The delivery of quality care can be compromised if a member of the Medical and Dental Staff is suffering from an impairment. Impairment may result from a physical, psychiatric or emotional condition.

2. The Physician Health Committee shall recommend to the Department Chairs, the Credentials Committee, the Medical Executive Committee, the Chief Medical Officer, and the Regional President additional educational materials beyond this Policy that address physician health and emphasize prevention, diagnosis and treatment of physical, psychiatric and emotional illness. Materials will be utilized to educate licensed independent practitioners and staff at least twice per year. Educational materials will also be included in orientation packets for new staff. Additional educational programs may be developed as identified by committee. Physicians who are dealing with an impairment that affects their ability to practice are encouraged to voluntarily bring the issue to the Physician Health Committee so that appropriate steps can be taken to protect patients and to help the physician practice safely and competently.

3. To the extent possible, and consistent with quality of care concerns, the Physician Health Committee will handle impairment matters in a confidential fashion. The Physician Health Committee shall keep the Regional President, the Chief Medical Officer, the President of the Medical and Dental Staff, the Chairperson of the Credentials Committee, and the Department Chair apprised of matters under review.

MECHANISM FOR REPORTING AND REVIEWING POTENTIAL IMPAIRMENT

4. If any individual has a concern that a member of the Medical and Dental Staff may be impaired in any way that may affect his or her practice at the hospital, a written report shall be given to the Regional President, the, Chief Medical Officer the President of the Medical and Dental Staff, the Chairperson of the Credentials Committee, the Department Chair, or any member of the Physician Health Committee. The report shall include a factual description of the incident(s) that led to the concern.

5. If after discussing the incident(s) with the individual who filed the report, the Regional President, the Chief Medical Officer, the President of the Medical and Dental Staff, the Chairperson of the Credentials Committee, the Department Chair, and/or any member of the Physician Health Committee believes there is enough information to warrant a review, the matter shall be referred to the Physician Health Committee.

6. The Physician Health Committee shall act expeditiously in reviewing concerns of potential impairment that are brought to its attention.

7. As part of its review, the Physician Health Committee may meet with the individual(s) who prepared the report.

8. If the Physician Health Committee has reason to believe that the physician is or might be impaired, it shall meet with the physician. At this meeting, the physician should be told that there is a concern that he or she might be suffering from an impairment that affects his or her practice. The physician should not be told who filed the initial report, but should be advised of the nature of the concern.

9. As part of its review, the Physician Health Committee may request that the physician be evaluated by an outside practitioner/organization and have the results of the evaluation provided to it. A consent for the release of information to the Physician Health Committee is attached as Appendix A.

10. Depending upon the severity of the problem and the nature of the impairment, the Physician Health Committee will recommend to the Department Chair of one of the following options:
    a. recommend that the physician voluntarily take a leave of absence, during which time he or she would participate in a rehabilitation or treatment program to address and resolve the impairment;
    b. recommend that appropriate conditions or limitations be placed on the physician's practice;
    c. recommend that the physician voluntarily agree to refrain from exercising some or all privileges in the hospital until rehabilitation or treatment has been completed or an accommodation has been made to ensure that the physician is able to practice safely and competently;
    d. recommend that some or all of the physician's privileges are suspended if the physician does not voluntarily agree to refrain from practicing in the hospital.

11. If the Physician Health Committee recommends that the physician participate in a rehabilitation or treatment program, it should assist the physician in locating a suitable program.

12. If the physician agrees to abide by the recommendation of the Physician Health Committee, then a confidential report will be made to the Regional President, the Chief Medical Officer, the President of the Medical and Dental Staff, the Chairperson of the Credentials Committee, and the Department Chair. In the event there is concern by the Regional President, the Chief Medical Officer, the President of the Medical and Dental Staff, the Chairperson of the Credentials Committee, and/or the Department Chair that the action of the Physician Health Committee is not sufficient to protect patients, the matter will be referred back to the Physician Health Committee with specific recommendations on how to revise the action or it will be referred to the Medical Executive Committee for corrective action.

13. Prior to reinstatement, the Physician Health Committee must obtain a letter from the physician overseeing the rehabilitation or treatment program. (A copy of a release from the physician authorizing this letter is attached as Appendix B.) This letter must address the following:
    a. the nature of the physician's condition;
    b. whether physician is participating in a rehabilitation or treatment program and a description of the program;

c. whether the physician is in compliance with all of the terms of the program;
d. to what extent the physician's behavior and conduct need to be monitored;
e. whether the physician is rehabilitated;
f. whether an after-care program has been recommended to the physician and, if so, a description of the after-care program; and
g. whether the physician is capable of resuming medical practice and providing continuous, competent care to patients.

14. Before recommending reinstatement, the Physician Health Committee may request a second opinion of the above issues from a physician of its choice.

15. Assuming that all of the information received indicates that the physician is capable of resuming care of patients, the following additional precautions shall be taken before the physician's clinical privileges are reinstated:
a. the physician must identify at least one practitioner who is willing to assume responsibility for the care of his or her patients in the event of the physician's inability or unavailability; and
b. the physician shall be required to provide periodic reports to the Physician Health Committee from his or her attending physician, for a period of time specified by the Committee, stating that the physician is continuing rehabilitation or treatment, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired. Additional conditions may also be recommended for the physician's reinstatement.

16. The final decision to reinstate a physician's clinical privileges must be approved by the Regional President in consultation with the Chief Medical Officer, the President of the Medical and Dental Staff, the Chairperson of the Credentials Committee., and/or the Department Chair, and a recommendation will be made to the Board of Trustees.

17. The physician's exercise of clinical privileges in the hospital shall be monitored by the Department Chair or by a physician appointed by the Department Chair. The nature of that monitoring shall be recommended by the Physician Health Committee in consultation with Chief Medical Officer, the President of the Medical and Dental Staff and/or the Chairperson of the Credentials Committee.

18. If the physician has an impairment relating to substance abuse the physician must, as a condition of reinstatement, agree to submit to random alcohol or drug screening tests at the request of the Regional President, Chief Medical Officer, the President of the Medical and Dental Staff, the Chairperson of the Credentials Committee, the Department Chair, or by the Physician Health Committee.

COMMENCEMENT OF AN INVESTIGATION

19. The hospital and the Medical and Dental Staff believe that issues of impairment can best be dealt with by the Physician Health Committee to the extent possible. If, however, the Physician Health Committee makes a recommendation, including a recommendation for an

evaluation or a restriction or limitation on privileges, and the physician refuses to abide by the recommendation, the matter shall be referred to the Medical Executive Committee for possible corrective action.

DOCUMENTATION AND CONFIDENTIALITY

20. Information related to any individual shall be maintained by the Physician Health Committee in a confidential file. Information maybe received from or shared with the Professional Assistance Program of NJ. The physician shall have an opportunity to provide a written response to any concern presented to that individual about potential impairment, which response shall be included in this confidential file.

21. The Regional President, the Chief Medical Officer or the President of the Medical and Dental Staff shall inform the individual who filed the report that follow-up action was taken.

22. Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone other than those described in this Policy.

23. If at any time it becomes apparent that the matter cannot be handled internally, or jeopardizes the safety of the physician or others, the Regional President, the Chief Medical Officer, the President of the Medical and Dental Staff, the Chairperson of the Credentials Committee, and/or the Department Chair, may contact law enforcement authorities or other governmental agencies.

24. All requests for information concerning the impaired physician shall be forwarded to the President of the Medical and Dental Staff or the Chief Medical Officer for response.

25. In the case of a physician who applies for appointment to the Medical and Dental Staff who has a history of impairment, the Credentials Committee may request the Physician Health Committee to interview that individual. The applicant shall be interviewed by either the Committee or a member designated by the Committee. If the applicant is interviewed by a member of the Committee, the Committee shall review the information gathered by such member. After its interview or review the Committee shall then issue a report and recommendation to the Credentials Committee.

APPENDIX A

CONSENT FOR RELEASE OF INFORMATION PERTAINING TO EVALUATION

I hereby request that_____ {the Facility/Physician Evaluator} provide _____ Hospital {"the Hospital"} and its Physician Health Committee with all information relevant to your evaluation of my ability to care for patient safely, to competently fulfill the responsibilities of medical and dental staff appointment and to relate cooperatively to others in the Hospital.

I also request that the hospital and the Physician Health Committee provide _____ {the Facility/Physician Evaluator} with a copy of any information which it believes supports the need for the evaluation and any other information that _____ {the Facility/Physician Evaluator} might request.

I release from liability and grant absolute immunity to, and agree not to sue, _____ {the Facility/Physician Evaluator} and the Hospital and its Physician Health Committee (and any physician on the Hospital's medical and dental staff who is involved in reviewing my practice) for providing the information set forth above.

_____ _____

Date Signature of Physician

APPENDIX B

CONSENT FOR RELEASE OF INFORMATION

I hereby request the Dr._____ {physician overseeing treatment} provide_____ Hospital {"the Hospital"} and its Physician Health Committee with information pertaining to my rehabilitation or treatment program. Specifically, this information should include:

(a) the nature of my condition;
(b) whether I am participating in a rehabilitation or treatment program;
(c) whether I am in compliance with all of the terms of the program;
(d) to what extent my behavior and/or conduct needs to be monitored;
(e) whether I am rehabilitated;
(f) whether an after-care program has been recommended for me, and, if so, a description of the after care program; and
(g) whether I am capable of resuming medical practice and providing continuous competent care to patients.

I also request the Dr._____ provide the Hospital and its Physician Health Committee with periodic reports relating to my ongoing rehabilitation or treatment and my ability to treat and care for patients in the Hospital.

I release from liability, grant absolute immunity to and agree not to sue Dr._____ for providing the information set forth above.

_____ _____

Date Signature of Physician

13.13 RADIATION SAFETY COMMITTEE

13.13-1 Composition

The Radiation Safety Committee shall be composed of representatives from the Departments of Radiology, Medicine, Surgery, Pediatrics, Obstetrics/Gynecology, and such subspecialties as appointed by the Medical and Dental Staff President; plus, the Radiation Safety Officer, the Radiation Physicist, a Nursing representative, an Employee Health representative, and an Administrative Officer responsible for radio diagnosis and radiation therapy. A radiologist shall be chair.

13.13-2 Duties

The Committee shall be responsible for maintaining proper radiation safety standards for patients as well as professional and nonprofessional medical personnel. The Committee shall also address aspects of continuing medical education and all other matters relative to potential or actual radiation hazards and abuses.

13.13-3 Meetings

The Radiation Safety Committee shall meet quarterly and report in writing to the Medical Executive Committee.

13.14 RESEARCH COMMITTEE

13.14-1 Composition

Members of the Research Committee shall work cooperatively with the IRB and the Chair of the Research Committee or his/her designee shall be a member of the IRB.

13.14-2 Duties

The duties of the Research Committee shall be to:

1. Report and encourage clinical research activities within Jersey Shore University Medical Center.
2. Provide consultative resource to the IRB regarding research proposals.
3. Provide consultative resources for authors of research publications.
4. Conduct other academically oriented activities, such as but not limited to, the Publication Award Program.

13.14-3 Meetings

The Committee shall meet no less than 3 times a year, document its activities, and report to the Medical Executive Committee.

13.15 RULES AND REGULATIONS COMMITTEE

13.15-1 Composition

This committee shall be composed of a member of the Medical Executive Committee as Chair and at least five other Active Medical and Dental Staff members, appointed by the President of the Medical and Dental Staff.

13.15-2 Duties

The duties of this committee shall be to:

1. Review and make recommendations to the Medical Executive Committee on amendments to these Rules and Regulations of the Medical and Dental Staff. It shall review and make recommendations on procedures and forms of the Medical and Dental Staff or of its Departments and Sections as may be proposed by or submitted to the Committee from time to time.
2. Conduct periodic review of the Rules and Regulations of the Medical and Dental Staff, to better assure their conformity with current requirements and

practices.

3. Submit any recommendations for amendments to the Medical Executive Committee together with the text of each proposed amendment.
4. Serve as a liaison, when required, between on the one hand, the body responsible for evaluating and/or maintaining the Medical and Dental Staff Bylaws and on the other hand, the Medical and Dental Staff members and its Medical Executive Committee.

13.16 SEARCH COMMITTEE

13.16-1 Composition

The Search Committee shall consist of equal representation from the Organized Medical and Dental Staff (appointed by the Medical and Dental Staff President) and Administration or Board of Trustees (appointed by the Regional President). Sixty percent (60%) of the Organized Medical and Dental Staff members shall be from the involved Department.

13.16-2 Duties.

A search committee will be authorized by the Medical Executive Committee and Division Administration for the purpose of recommending at least two (2) candidates to the Regional President who will make the selection subject to the approval of the Board of Trustees

13.16-3 Meetings

The Committee shall meet as needed.

13.17 TRAUMA COMMITTEE

13.17-1 Composition

The Trauma Committee shall be a multi-disciplinary committee chaired by the Director or Associate Director of the Trauma Section, Department of Surgery. Members shall include representatives from the following Medical and Dental Staff Departments: Surgery, Pediatric Surgery, Anesthesia, Orthopedics, Radiology, the Oral and Maxillofacial Section of Dentistry, Emergency Medicine, and Neurosurgery. In addition, members shall include other trauma surgeons, the Trauma Nurse Coordinator, the Director of Critical Care Nursing, and representatives from Administration, Pediatric Intensive Care, Social Services, Rehabilitation Medicine, Quality Assurance, Mobile Intensive Care, Blood Bank, and Medical Records.

13.17-2 Duties

The Committee shall oversee the development of policies, procedures, and protocols for the Trauma Service. It shall be responsible for written policies and protocols to support a comprehensive approach to the care of the trauma patient, including triage protocols, trauma team response policies, trauma patient resuscitation and stabilization protocols, operating room policies for support of the trauma patient, trauma patient transport protocols; monthly audit of trauma patient deaths, morbidity review, and cost of care review.

13.17-3 Meetings

The Committee shall meet at least bi-monthly and report in writing to the Medical Executive Committee.

PART FOURTEEN: DEPARTMENTS

14. 1 DEPARTMENTS. The academic departments of the Medical and Dental Staff of Jersey Shore University Medical Center are as follows:

Department of Anesthesiology
Department of Dentistry
Department of Emergency Medicine
Department of Family Practice
Department of Medicine
Department of Neurosurgery
Department of Obstetrics and Gynecology
Department of Orthopedic Surgery
Department of Pathology
Department of Pediatrics
Department of Psychiatry
Department of Radiology
Department of Surgery

14.2 DEPARTMENT CHAIRS

The Department Chair shall be responsible to the Medical and Dental Staff through the Medical Executive Committee for the functioning of their Department and shall have general supervision over the clinical work within that Department. The Chair shall also be responsible for the education and training of the House Staff appointed to his department and shall cooperate with the Vice President of Academic Affairs.

14.2-1 Department Vice-Chairs

In addition to the elected Vice-Chair provided for in the Medical and Dental Staff Bylaws, the Chair may appoint additional Vice-Chairs to assist the Chair and fulfill specific departmental goals and objectives. The provisions of Section 12.3.1 of the Medical and Dental Staff Bylaws shall not be applicable to the additional Vice-Chairs, nor shall any of them assume the duties of the Chair as provided for in Section 12.3.2 of the Medical and Dental Staff Bylaws.

14.3 SECTION CHIEFS

Each Section shall be organized as a subdivision of a particular department of the Medical and Dental Staff and shall have a Chief, appointed by the Board of Trustees. The Section Chief shall have attained the rank of Attending and shall have been recommended by the Chair of the Department and the Medical Executive Committee.

14.4 DEPARTMENTS WITH APPROVED RESIDENCY PROGRAMS

14.4-1 Participation in Teaching

1. Jersey Shore University Medical Center, a division of Hackensack Meridian Health Hospitals Corporation, is an academic hospital, and as such, physicians on the Medical and Dental Staff should participate and supervise the Resident Staff in the curriculum of the program and in the care of patients. All patients should generally be available for instruction of the Resident Staff, unless excluded in accordance with the provisions of Section 14.3-2, Item 2.

2. Job descriptions for residents at each level of training are the responsibility of each Department Chair (and may be delegated to the Residency Program Director or Sit Director) and will be reviewed and approved annually by the

Graduate Medical Education Committee and placed on file with the president of the Medical & Dental Staff.

3. The Department Chair is responsible for specifying (in the Rules and Regulations of the Department) how the medical and dental staff member responsible for the care of each patient on the teaching service is designated. The Department Rules and Regulations must also outline the supervisory responsibilities of the Medical and Dental Staff with respect to medical students and residents, including policies delineating house staff and medical student participation in writing orders. These responsibilities must not prohibit medical staff members from writing orders.

14.4-2 Patient Admissions

1. Medical and Dental Staff members admitting patients to departments in which a Residency Training Program exists shall advise their patients prior to or upon admission that they will be involved in the teaching program for the Hospital House Staff and medical students.

2. A patient may be excluded from participation in the training program if:
   a. The attending physician/dentist determines that such participation might be harmful to that patient; or
   b. The patient declines to participate.

3. Professional responsibility for the care and management of all patients shall remain with the attending of the Medical and Dental Staff.

4. Any patient excluded from the training program may also be excluded from receiving services of House Staff members at the discretion of the Chair of the Department, except in medical emergencies.

14.4-3 Program Director

In departments with approved educational Residency Programs, wherein the department and the Hospital have agreed that a Program Director is beneficial, such person may be employed by the board of trustees, at its pleasure. The Graduate Medical Education Committee reviews and approves program directors and makes recommendations to the Medical Executive Committee Should the Department select the Program Director to be its Director, a later termination of a directorship does not imply termination of the employed position.

14.4-4 Implementing a Training Program

Specific policies for implementing a training program shall be at the discretion of the Department Chair. Whenever university affiliation exists, the contract governing the affiliation shall be consistent with departmental regulations.

14.4-5 Non-Teaching Service

1. A department with an approved Residency Program may create a non-teaching service as well as a teaching service. This division into two separate services will depend on:
   a. The number of residents available.
   b. The number of Attending Staff members that desire teaching status.
   c. The needs of the Residency Program.
   d. The number of patients available to the residents for teaching purposes.
   e. The Rules and Regulations of the Residency Review Committee in

that specialty, as specified by the A.C.G.M.E. or comparable governing body.

2. The initial decision to have both teaching and non-teaching services shall be made by the Department Chair, with input from the department's Program Director and attending physicians, the Vice President of Academic Affairs and Department Chair (of similar department) at affiliated institutions. The decision shall be final upon approval of both the Medical Executive Committee and the Board of Trustees.

3. The Department Chair and Program Director shall determine which physicians shall be on the teaching service and which are not. This selection shall be based on:
    a. Teaching experience and desire to teach.
    b. Number of teaching physicians needed.
    c. Evaluations by residents and faculty members.

PART FIFTEEN: DISRUPTIVE BEHAVIOR - MEDICAL/DENTAL STAFF MEMBERS

15.1 DISRUPTIVE BEHAVIOR

Please refer to the Medical and Dental Staff Policy and Procedure "Disruptive Behavior Policy".

15.2 RECORDING ON HOSPITAL PREMISES

It is the policy of the Medical Center to prohibit the unauthorized use of any recording devices, including tape recorders, video recorders, and cameras between and among any Medical Center personnel (employees, physicians, volunteers, and any other affiliated individuals) except under the following circumstances:

1. Medical Center and Medical and Dental Staff committee meetings wherein the recording is used for the express purpose of documenting the meeting. In all such cases, the use of a recording device shall be approved by the Committee Chair and displayed in a visible manner.

2. Medical Center and Medical and Dental Staff educational meetings wherein the meetings are recorded for subsequent use as educational materials. In all such cases, the recording shall be approved by the speaker and the Medical Center or Medical and Dental Staff representative in charge of the educational session or meeting, and the participants should be informed that the meeting is being recorded.

3. Specific departments within the Medical Center may be authorized by the Regional President or his designee in writing to utilize recording devices in the normal course of their day-to-day operation or under special or exceptional circumstances. Specifically, any videotaping or photography conducted on hospital premises must be cleared in advance with the Director of Corporate Communications. If any recording is to be conducted under this section, notice shall be posted in the areas affected or recorded, stating (1) that the area is under surveillance; (2) that such surveillance is being conducted for security purposes only and (3) that the contents of the recording shall not be made public to preserve confidentiality.

4. The use of a tape recording device by an individual person for dictation or similar purposes.

The above prohibition applies to all facilities and grounds of the Medical Center both on and off the main campus. Violation of this policy will result in disciplinary action in accordance with the Medical and Dental Staff's Bylaws and Rules and Regulations.

To protect the privacy and confidentiality of patients, the use of any recording device is strictly prohibited in patient care areas.

Patients or families who wish to utilize video recorders within the Medical Center must obtain the written consent of the patient, physician, and administration through the office of Risk Management. Videotaping must be discontinued immediately at the direction of the physician.

15.3 POSSESSION AND USE OF WEAPONS BY MEMBERS OF THE MEDICAL AND DENTAL STAFF

1. The Medical and Dental Staff of Jersey Shore University Medical Center is concerned and committed to promoting a safe working environment within the Medical Center for Members of the Medical and Dental Staff and all Medical Center employees, residents and volunteers.

2. The possession and use of any weapon on Medical Center property undermines the effective and safe delivery of care within the Medical Center and is contrary to an atmosphere of collaboration by and among physicians, employees, residents and volunteers.

3. It is therefore the policy of the Medical and Dental Staff to prohibit the possession and use of weapons within the Medical Center and on the grounds of the Medical Center by Members of the Medical and Dental Staff, whether or not a duly authorized carrying license or permit exists. Weapons shall be defined consistent with N.J.S.A. 2C:39-1 as anything readily capable of lethal use or of inflicting serious bodily injury, including but not limited to firearms/guns, knives and stun guns.

4. Violation of this Rule and Regulation by a Member of the Medical and Dental Staff shall be considered a violation of the Egregious Behavior section of the Disruptive Behavior Policy, which permits immediate corrective action in accordance with the Medical and Dental Staff Bylaws.

PART SIXTEEN: PHYSICIAN PERFORMANCE FILES

16.1 PRACTITIONER PERFORMANCE

Practitioner performance is evaluated through the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) processes in accordance with the Medical and Dental Staff FPPE and OPPE Policies and Procedures which are maintained in the Medical Staff Office.

PART SEVENTEEN: ALLIED HEALTH PROFESSIONALS

17.1 Job descriptions, duties, qualifications, responsibilities, and competency of a given Allied Health Professional shall be defined by the department responsible for the supervision of that individual and the Medical and Dental Staff Bylaws. Rules and Regulations for specified Allied Health Professional personnel are delineated in the appropriate Departmental Rules and Regulations.

17.2 Categories of Allied Health Professionals that may be authorized to provide care without being appointed to the medical and dental staff include:

1. Dental Assistant
2. Nurse Physician Liaison
3. R.N. First Assistant
4. Surgical Assistant
5. Others as indicated in the approved staffing plans for the institution

Categories of Allied Health Professionals who must be appointed to the Medical and Dental Staff and granted clinical privileges in order to practice include:

1. Advanced Practice Nurse (APN)
2. Physician Assistant (PA)
3. Certified Nurse Midwives

PART EIGHTEEN: APPOINTMENT AND REAPPOINTMENT PROCESS - SCHEDULE FOR REAPPOINTMENT - MEDICAL/DENTAL STAFF MEMBERS & ALLIED HEALTH PROFESSIONALS

18.1 APPOINTMENT AND REAPPOINTMENT PROCESS

The Medical and Dental Staff through its designated Departments, Sections, committees, and officers shall investigate and evaluate each application for appointment or reappointment to the Staff, each request for modification of Staff membership status, and each request for clinical privileges or their modification and shall adopt and transmit recommendations thereon to the Board of Trustees. The Medical and Dental Staff shall perform these same functions in connection with any Independent Allied Health Professional or other individual who seeks to provide specific services or exercise clinical privileges in any Department or Section of the Division, whether or not such Affiliate or individual is eligible for Medical and Dental Staff membership. For a detailed explanation of the Appointment and Reappointment Process, refer to Article VII, Section 7.3, Application for Initial Appointment, and Section 7.5, Reappointment Process of the Medical and Dental Staff Bylaws.

18.1-1 ANNUAL EDUCATION

All members of the medical and dental staff and the Allied Health Profession staff must participate in ongoing mandatory education in accordance with the Medical and Dental Staff Policy and Procedure “Annual Education”

18.2 PRE-APPLICATION FOR INITIAL APPOINTMENT

18.2-1 Criteria. Pre-application criteria shall be adopted by the Board of Trustees. In consideration of the information and recommendations provided by the Medical Executive Committee and the Medical Council Committee. Such information, recommendations and criteria shall address the Hospital, the Division and the community’s service needs, available resources and service arrangements deemed appropriate to best match services, needs and resources and to maintain the quality and efficient of patient care. Once adopted, such pre-application criteria shall be implemented by the Board of Trustees through the Medical Executive Committee.

18.2-2 Form. The Medical Council shall review the pre-application form developed from the pre-application criteria. A practitioner who requests a regular application form shall be sent such pre-application form.

18.2-3 Submission of Pre-Application. The applicant shall submit the completed pre-application for to the Division's Medical Staff Office.
Pre-qualification. If the completed pre-application form shows that criteria are met, the Medical Staff Office shall then send the practitioner a regular application form. If such criteria are not met, the individual shall be notified thereof, including the reason the criteria are not met, and shall not be eligible to apply for membership. Prequalification to apply for appointment shall not preclude a later rejection of the applicant on ground relating to the pre-application criteria, due to a later change in the criteria, or otherwise.

18.3 LEAVE OF ABSENCE OR RESIGNATION REQUIREMENTS

It is the policy of the Medical and Dental Staff that, except in unusual circumstances, a Leave of Absence or a Resignation request be submitted in writing no later than 30 days in advance of the effective date. Forms are available in the Medical Staff Office.

1. A request for Leave of Absence or Reinstatement Form must be completed and submitted to the Department Chair 30 days prior to the effective date requested. The amount of time requested must be included on the form (which shall not exceed one year) and the reason.
2. The Department Chair will review the request submitted, and determine if membership obligations (i.e. Call Schedule, Medical Records) have been met. If obligations have been met, the Department Chair will make recommendation for approval to the Medical Executive Committee.

18.4 PHYSICIAN COVERAGE REQUIREMENT

Upon submitting an application to Jersey Shore University Medical Center, names and contact information of covering physicians must be supplied.

18.5 NPI/MEDICARE/MEDICAID NUMBERS

NPI, Medicare and Medicaid numbers must be supplied at the time of application, or proof provided that an application has been submitted.

18.6 MALPRACTICE INSURANCE POLICY STATEMENT FOR JERSEY SHOREUNIVERSITY MEDICAL CENTER

1. All malpractice insurance coverage at Jersey Shore University Medical Center must be of the "Occurrence" or "Claims Made" type of policy with prepaid tail coverage.
2. All members of the Active Medical and Dental Staff must carry limits of at least $1,000,000/$3,000,000 of liability coverage.
3. The Senior Attending Medical and Dental Staff can admit and see patients, and therefore, must also carry limits of at least $1,000,000/$3,000,000 of liability coverage.
4. The Regional Medical and Dental Staff can admit an occasional patient to our institution, and therefore, they must also carry limits of at least $1,000,000/$3,000,000 of liability coverage.
5. The Emeritus Medical and Dental Staff cannot admit, cannot treat and cannot consult patients at Jersey Shore University Medical Center, so there is no requirement that they have any medical liability insurance coverage whatsoever.
6. Oral surgeons must carry limits of at least $1,000,000/$3,000,000 of liability coverage.
7. Dentists must carry limits of at least $1,000,000/$3,000,000 of liability coverage.
8. Surgical Podiatrists must carry limits of at least $1,000,000/$3,000,000 of liability coverage.
9. Allied Health Professionals must carry limits of at least $1,000,000 each medical incident and $3,000,000 annual aggregate written on an occurrence basis or claims made with prepaid tail.

PART NINETEEN: APPOINTMENT OF FELLOWS TO ACCREDITED FELLOWSHIPS

19.1 APPOINTMENT OF FELLOWS TO ACCREDITED FELLOWSHIPS

Applicants shall be solicited, reviewed, and interviewed by the Departmental Chair and Fellowship Director.

The applications and Curriculum Vitae of candidates selected by the Fellowship Director shall be submitted to the Vice President of Academic Affairs for approval. The Vice President of Academic Affairs may request review of the candidate's credentials at regularly scheduled meetings of the Graduate Medical Education Committee. Fellows shall be selected and appointed as House Staff by the Fellowship Director and Departmental Program Director and shall not require review by the Credentials Committee.

Contractual contracts are similar to other Resident contracts.

19.2 PROTOCOL FOR CREDENTIALING NONACCREDITED FELLOWSHIPS

Approval Process For Nonaccredited Fellowships

No individual shall be hired or employed as a "Fellow" until the fellowship program has received full and final approval by the Board of Trustees.

The proposed Fellowship Director must submit the essentials, goals, and objectives of the Fellowship to the Chair and Residency Program Director of the Department for their approval.

With the endorsement of the Chair and Residency Program Director, the proposed Fellowship Director must submit the essentials, goals, and objectives of the Fellowship to the Department of Medical Education for approval. After reviewing the document, the Director of Medical Education will submit the proposal at a scheduled meeting of the Department of Medical Education.

If the proposal is approved by vote at the Medical Education Committee, the Fellowship approval is forwarded to the Medical Executive Committee for its approval.

PART TWENTY: MEDICAL/DENTAL STAFF HOME PHONE NUMBERS AND TELEPHONE NUMBERS

20.1 MEDICAL/DENTAL STAFF HOME PHONE NUMBERS

All members of the Medical and Dental Staff must provide their personnel phone numbers to the Medical and Dental Staff Office of Jersey Shore University Medical Center.

PART TWENTY- ONE: RECORDING OF MEETINGS

21.1 RECORDING OF MEETINGS

Except as otherwise provided in the Medical and Dental Staff Bylaws, Rules and Regulations, or as required by law, any meetings of the Medical and Dental Staff or body thereof may be recorded with the prior knowledge and consent of the Chair, subject to majority vote of the committee.

PART TWENTY-TWO: MEDIA INQUIRIES AND DISSEMINATION OF INFORMATION

22.1 Media inquiries, dissemination of information and release of information will be handled according to the Administrative Policies and Procedures Manual of Jersey Shore University Medical Center.

PART TWENTY-THREE: DISASTER EMERGENCY ASSIGNMENTS

23.1 DISASTER EMERGENCY ASSIGNMENTS – Refer to the Medical and Dental Staff Bylaws Article 8.6

PART TWENTY-FOUR: ANNUAL DUES & BUDGET

24.1 ANNUAL DUES OF THE MEDICAL AND DENTAL STAFF

1. Medical and Dental Staff dues are in the amounts listed below:

ACTIVE MEDICAL AND DENTAL STAFF	$200.00
PODIATRY & PSYCHOLOGY STAFF	$200.00
ORAL & MAXILLOFACIAL SURGERY	$200.00
REGIONAL MEDICAL AND DENTAL STAFF	$135.00
DENTAL AMBULATORY CARE	$ 50.00
ACTIVE DUTY MILITARY STAFF	$100.00
TELEMEDICINE STAFF	$100.00
AFFILIATE STAFF	$100.00
ALLIED HEALTH PROFESSIONALS	$50.00

A late fee of $100.00 will be assessed if dues are not paid within thirty (30) days of the due date.

2. The dues shall be set by the Medical Executive Committee. To insure that Medical and Dental Staff dues remain just and equitable, any increase in staff dues of $200.00 or more shall be passed by a majority of the voting members of the Medical and Dental Staff present at the General Staff meeting immediately following the vote of the Medical Executive Committee.
3. The Medical Executive Committee may authorize a discount of the dues for early payment.
4. Officers of the Medical and Dental Staff shall be exempt from the requirement for payment of dues during their terms of office.
5. All members of the Medical and Dental Staff, except Honorary, Emeritus, Senior Attending and Consulting Staff members, shall be required to pay annual dues.
6. New staff members shall not be required to pay dues until the beginning of the next calendar year.
7. Statements for the coming year shall be mailed in October; Medical and Dental Staff dues shall be paid by January 31. Failure to pay dues by the designated date shall result in automatic suspension. The Medical and Dental Staff Member will be notified by certified letter of the suspension.
8. Notification of the suspension will be provided to:
    - The physician – by certified mail
    - Department Chair(s)
    - CMO and Regional President
    - Medical and Dental Staff President
    - Medical and Dental Staff Treasurer

9. If the suspension for nonpayment of dues is for thirty (30) days or less, the suspension will be removed immediately upon payment and those listed above will be notified.
10. If the suspension is for thirty (30) days or more, the practitioner may be required to appear before the Credentials Committee and/or Executive Committee prior to reinstatement.
11. If after sixty (60) days the dues remain unpaid, the practitioner will be sent a certified letter indicating that they have been deemed to have voluntarily resigned his/her membership and privileges effective ten (10) business days after the date of the letter. Such termination shall not entitle the practitioner to appeal under the fair hearing process. Thereafter, should the practitioner wish to reapply for staff membership and privileges, the request will be treated as an initial application and processed in the same manner as an initial appointment upon payment of the dues and any late fees that have remained unpaid.

24.2 BUDGET OF THE MEDICAL AND DENTAL STAFF

1. The Medical and Dental Staff budget will be reviewed and approved by the Medical Executive Committee at each December meeting. The adopted budget will be distributed to the Medical and Dental Staff.
2. A Certified Public Accountant (CPA) will periodically review the books. His report will be submitted to the Treasurer and the Medical Executive Committee.

PART TWENTY-FIVE: MEETING ATTENDANCE

25.1 GENERAL MEDICAL AND DENTAL STAFF MEETING ABSENCES

All members of the Medical and Dental Staff are encouraged to attend 50% of the General Staff meeting, See Medical and Dental Staff Bylaws , Article 14.7.1

25.2 DEPARTMENT MEDICAL AND DENTAL STAFF MEETING ABSENCES

Refer to the Departmental Rules and Regulations

PART TWENTY-SIX: MEDICAL AND DENTAL STAFF POLICIES AND PROCEDURES

26.1 The Medical and Dental Staff may develop and implement policies as a means to accomplish the business of the Medical and Dental Staff and to ensure good patient care. Policies and procedures must be consistent with Medical and Dental Staff Bylaws, Rules and Regulations, and Hospital Policies.

PART TWENTY-SEVEN: TERM OF OFFICE OF MEDICAL & DENTAL STAFF OFFICERS

27.1 The term of office of Officers of the Medical and Dental Staff shall commence on the first day of January and shall continue for two years and until a successor is elected and assumes office, provided that an officer who has served for two years is eligible to be re-elected for one additional term of one year. The Medical and Dental Staff President shall not be eligible to serve more than three consecutive years.

PART TWENTY-EIGHT: AMENDMENT

28.1 Amendments to these Rules and Regulations require majority approval of the Medical Executive Committee prior to the approval of the Board of Trustees of Hackensack Meridian Health Hospitals Corporation (Article XVI, Section 16.1).

PART TWENTY-NINE: ADOPTION

29.1 MEDICAL AND DENTAL STAFF

These Rules and Regulations were adopted by the Medical Executive Committee on _____.

29.2 BOARD OF TRUSTEES

These Rules and Regulations were approved and adopted by the Board of Trustees of Meridian Hospitals Corporation on _____after considering the Medical Executive Committee recommendation.

APPENDIX C

The Medical and Dental Staff Policies and Procedures can be found on the Jersey Shore University Medical Center physician extranet located at www.jsumcdoctor.com

The following policies and procedures are in effect and must be followed:

- Abbreviations Policy
- Annual Education
- Appraisal of Emergencies
- Autopsy Policy
- Caring for Family Members in the Hospital
- Communication to the Medical and Dental Staff
- Computer Access for Emeritus Staff
- Credentialing Criteria for Privileges to Administer Sedation
- Credentialing and Privileging
- Criteria for Initiating and Maintaining Telemetry Monitoring
- Disaster Privileges
- Disruptive Behavior
- EMTALA Policy
- EMTALA for OB Patients
- Expedited Credentialing
- Guidelines for Incorporating Surgeon Specific Volume
- Guidelines for Institutional Minimal Procedure Volumes
- Influenza Vaccination Policy
- IOM Electrodiagnostic Testing in the Operating Room
- Licensed Independent Practitioners – Health Policy
- Legibility of Medical Record Documentation
- Medicaid Number Policy
- Medical Staff Conflict of Interest Policy
- Midlevel Providers (HPA) FPPE policy
- No Order Transfers from Emergency Department
- Patient Satisfaction Policy
- Site Identification and Patient/Procedure Verification Policy for Surgical and Other Invasive Procedures
- "Hand-off" Communication Policy
- Focused Professional Practice Evaluation (FPPE) Policy & Procedure
- Ongoing Professional Practice Evaluation (OPPE) Policy & Procedure
- Medication Reconciliation Policy
- NJ Board of Medical Examiners Reporting Requirements
- Pediatric Cardiology
- Pediatric Gastroenterology
- Pediatric Hematology Oncology
- Pediatric Neurology
- Pediatric Pulmonology
- Peer Review Policy
- Process to Disseminate Practitioner Privilege Information
- Restraint/Seclusion
- Sepsis Guidelines
- Stat LTM/Video EEG On Call Protocol for Adult patients
- Stat LTM/Video EEG On Call Protocol for K. Hovnanian Hospital Pediatric patients
- Stat Routine EEG On Call Protocol for Adult patients

- Stat Routine EEG On Call Protocol for K. Hovnanian Hospital Pediatric patients
- Surgical Necessity
- Temporary Privileges
- National Practitioner Data Bank
- Verification of Practitioner Identity
- Confidentiality of Credentials