VIRTUA MEDICAL STAFF RULES AND REGULATIONS

Approved by the Virtua Board of Trustees on: 11-24-2010
(Date)

TABLE OF CONTENTS

PAGE

I. GENERAL ... 1

1.1 Definitions ... 1
1.2 Delegation of Functions ... 1

II. ADMISSIONS ... 2

2.1 Admissions ... 2
2.2 Emergency Admissions ... 3
2.3 Specific Patient Circumstances ... 3
2.4 Documentation at the Time of Admission ... 4
2.5 Specific Admission Record Circumstances ... 7
2.6 Elective Admission Output Testing ... 7

III. INPATIENT HOSPITAL CARE, TREATMENT AND SERVICES ... 8

3.1 Responsibilities of Attending Physician ... 8
3.2 Consultations ... 9
3.3 Specialty Units ... 10
3.4 Treatment of Family Members ... 11
3.5 Progress Notes ... 12
3.6 Consultations ... 12
3.7 Informed Consent ... 12
3.8 Orders ... 13
3.9 Verbal Orders ... 14

IV. DISCHARGE ... 16

4.1 General ... 16
4.2 Autopsies ... 16
4.3 Documentation at Discharge ... 17

V. MEDICAL RECORDS ... 19

5.1 General ... 19
5.2 Access and Retention of Record ... 20
5.3 Delinquent Medical Records ... 21

PAGE

VI. EMERGENCY SERVICES 23

6.1 General 23
6.2 Medical Screening Examinations 23
6.3 Medical Orders and Records 23
6.4 Additional Policies 24

VII. ANESTHESIA SERVICES 26

7.1 General 26
7.2 Pre-Anesthesia Procedures 26
7.3 Monitoring During Procedure 27
7.4 Post-Anesthesia Evaluations 28
7.5 Minimal, Moderate or Conscious Sedation 29

VIII. MINIMAL, MODERATE AND CONSCIOUS SEDATION 30

8.1 General 30
8.2 Policies and Protocols 30
8.3 Equipment 31
8.4 Pre-Procedure 32
8.5 Intra-Procedure 33
8.6 Post-Procedure 33
8.7 Patient Discharge Instructions and Procedures 34
8.8 Discharge Criteria 34
8.9 Discharge Form Guidelines 35

IX. OPERATING ROOM PROCEDURES 38

9.1 General 38
9.2 Operating Room Committee 38
9.3 Delivery of Services 39
9.4 Post-Procedure Protocol 41

PAGE

X. GRADUATE MEDICAL EDUCATION AND RESIDENT SUPERVISION 43

10.1 General 43
10.2 Guidelines for Participation in a Virtua-Sponsored or Hosted GME Program 44
10.3 Responsibilities of Residents/Fellows/Students within Virtua 44
10.4 Supervising Physician's Responsibilities 46

XI. VIRTUA INSTITUTIONAL REVIEW BOARDS 49

XII. BOARD CERTIFICATION 50

12.1 Board Certification Exception 50
12.2 Board Recertification – Extension of Privileges Pending Recertification 52
12.3 Voluntary Relinquishment of Privileges 52

XIII. DUES AND SPECIAL ASSESSMENTS 53

13.1 Dues 53
13.2 Special Assessments 54
13.3 Bank Transaction/Account Procedures 54

XIV. AMENDMENTS 56

ARTICLE I

GENERAL

1.1. Definitions:

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

1.2. Delegation of Functions:

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

ARTICLE II

ADMISSIONS

2.1. Admissions:

2.1.1 Virtua shall accept all patients for care and treatment regardless of race, religion, national origin, sex, age or ability to pay.

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

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

2.1.3.1 Members of the Dental Staff may admit patients according to the rules set forth in the Policy on Appointment, Reappointment and Clinical Privileges, Section 2.2.2.3.

2.1.3.2 Oral surgeons who admit patients without medical problems may complete an admission history and physical and assess the medical risks of the procedure on ASA Class 1 and 2 patients with an age range from 12 to 65 years of age. All patients not fitting into this category must have a medical consultation pre-operatively.

2.1.3.3 Podiatrist members may perform the podiatric history and physical if credentialed to do so pursuant to the Policy on Appointment, Section 2.2.2.4.

2.1.4 Memorial ONLY

Admitted patients must be seen by the attending physician or designee and a progress note written on the chart within 24 hours from the time of admission. Critically ill patients must be seen within four hours. The responsibility for care of patients begins with the agreement to accept a patient, no matter where in the hospital that patient is located.

2.1.4 WJ ONLY

Admitted patients must be seen by the attending physician or designee and a progress note written on the chart within **12 hours** from the time of admission. There are two noted exceptions: 1) admissions to the Newborn Nursery; and 2) patients seen in the physician's office, who are directly admitted that same day, from the office, with history, physical, and admission orders already completed. Critically ill patients must be seen within four hours. The responsibility for care of

patients begins with the agreement to accept a patient, no matter where in the hospital that patient is located. [**Approved Virtua South MEC 1/24/2012**]

2.1.5 The Admissions Office will admit patients on the basis of the following order of priorities:

2.1.5.1 emergency admissions: patient requires immediate admission;

2.1.5.2 urgent admissions: patient requires admission within one to four days;

2.1.5.3 pre-operative admissions; and

2.1.5.4 elective admissions: patient requires admission at some future unassigned date. Priority shall be given to patients of members of the Active Staff.

The Chief Medical Officer will determine which patients will be admitted when conflicts arise regarding admission priority, especially in the event of insufficient beds.

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

2.2. Emergency Admissions:

2.2.1 Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

2.2.2 In an emergency case in which it appears the patient will have to be admitted to a hospital, the practitioner shall, when possible, first contact the Admissions Department to ascertain whether there is an available bed.

2.2.3 Practitioners admitting emergency cases shall be prepared to justify that the admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

2.2.4 A patient to be admitted on an emergency basis who does not have a private practitioner may request any practitioner in the applicable department or service to attend him. If (1) no request is made or (2) the requested practitioner is not on call for unassigned patients and chooses not to accept the patient, the Medical Staff member on duty in the department of service will be assigned to the patient according to Department/Section rules. Each Department/Section shall provide a written schedule for such assignments.

2.3. Specific Patient Circumstances:

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

2.3.2 Rules governing the admission of psychiatric patients to psychiatric units will be developed at each Division/hospital by the Psychiatry Department and ratified by the Medical Executive Committee.

2.3.3 Pregnant women and women up to four weeks' postpartum shall be admitted to the OB/GYN unit, unless their condition requires the services of another specialty unit.

2.3.4 Rules governing the admission of children will be developed at each Division/hospital by the Pediatrics Department and ratified by the Medical Executive Committee.

2.4. Documentation at the Time of Admission:

2.4.1 Complete History and Physical:

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

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

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

- If an assessment has been done within 30 days of outpatient surgery, the history and physical must be updated within 24 hours of registration for an outpatient surgical procedure, but in all cases prior to surgery or a procedure requiring anesthesia service, noting any changes in the patient's condition or physical findings. If no changes have occurred, the absence of change must be documented.

- When the history and physical examination and pertinent laboratory data are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure will be canceled.

- The history and physical requirement does not apply to emergency (immediately life-threatening) surgery. If the complete history and physical is not documented prior to this surgery, it must be done as soon as possible after surgery.

- An H&P performed by a physician who is not a member of the Virtua Medical Staff is not an acceptable document

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

2.4.1.1.1 History includes:

- presenting diagnosis/condition (chief complaint, reason for the visit);
- description of symptoms;
- current medications;
- allergies (drug, other);
- significant past medical or surgical history;
- review of systems;
- significant family history;
- psychosocial status; and
- nutritional evaluation (if GI, pediatrics, or elderly).

For surgery/invasive procedure requiring moderate sedation or anesthesia:

- indications;
- proposed procedures; and
- ASA classification (when anesthesia not providing care).

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

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

- vital signs;
- cardiovascular system;
- respiratory system;
- neurological system;
- gastrointestinal system;
- eyes;
- ear, nose, throat (ENT);
- genitourinary system;
- musculoskeletal system;
- skin;
- psychiatric; and
- hematologic/lymphatic/immunologic.

2.4.1.1.3 Assessment.

2.4.1.1.4 Treatment Plan.

2.4.2 Interval History and Physical:

An interval history and physical will be completed within 24 hours of admission or within 24 hours prior to a surgical procedure (but in all cases prior to surgery or a procedure requiring anesthesia service) for all cases in which the history and physical contained in the medical record is older than 24 hours. The interval history and physical will contain an update to the patient's current medical history that may have changed since the original history and physical or to address any areas where more current data is available. The patient's medical record will also reflect an update to the physical examination. The interval history and physical must contain either the changes in medical history or physical exam, or a statement indicating that no changes have occurred. For surgical cases, the history and physical will confirm that the indications for the procedure are still

present. In all cases, the interval history and physical will be written in sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status since the original history and physical. An interval history and physical is not valid in cases where the history and physical exceeds 30 days.

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

2.4.3 Focused History and Physical:

A focused history and physical is required for outpatient registrations (emergency department, observation, or any surgical or invasive procedure not requiring moderate sedation or anesthesia). The focused history and physical should provide an account of the chief complaint, the present illness (including an assessment of contributing factors), relevant past medical history, an appropriate review of body systems, a clinical impression, and a proposed initial plan of evaluation and treatment. The focused history and physical should, in all cases, be written in sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status.

2.4.3.1 The focused history and physical includes:

- history;
- history of present illness (including chief complaint);
- pertinent past medical and surgical history;
- pertinent family history;
- pertinent review of systems;
- current medication list;
- allergies (drug, other);
- indications and proposed procedures, if patient is in for surgery or invasive procedure;
- physical examination, as indicated;
- assessment; and
- treatment plan.

2.5. Specific Admission Record Circumstances:

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

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

2.6. Elective Admission Output Testing:

All patients electively admitted to the hospital (i.e., not emergent or urgent admissions), including same day surgery patients, shall have on admission those laboratory and diagnostic studies specifically ordered by the admitting physician (or a hospital staff physician having responsibility for the patient where there is no admitting physician) which are necessary or pertinent for the diagnosis or treatment of the condition for which the patient is admitted.

ARTICLE III

INPATIENT HOSPITAL CARE, TREATMENT AND SERVICES

3.1. Responsibilities of Attending Physician:

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

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

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

3.1.4 The attending physician shall be responsible for the appropriate oversight of the clinical services provided to the attending physician's patients by a resident physician or a house physician. Any issues regarding quality of care will be referred to and handled by the quality management process in place within the clinical department or residency program to which the house physician or resident in question is assigned. This is further described in the Resident Supervision Policy in Article X. All Virtua patient care policies and rules shall apply to members of the Medical Staff (e.g., Restraint Policy).

3.1.5 The attending physician is required to document the need for continued hospitalization after a specific period of stay, in accordance with the policies of the Case Management Department.

3.1.6 The attending physician will cooperate with the Case Management Department to expedite care of his/her patient. This will include, but is not limited to, returning

telephone calls in a timely manner, discussing care and discharge planning with family members, and assisting in overturning denied days.

3.2. Consultations:

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

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

3.2.2.1 when required by state law;

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

3.2.2.3 when any patient is known or suspected to be suicidal.

3.2.3 Consultation is strongly recommended in the following circumstances:

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

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

3.2.3.3 in cases of difficult or equivocal diagnosis or therapy; and

3.2.3.4 when requested by the patient or family.

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

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

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

Routine Requests: The Medical Staff member must respond within 24 hours of the request being made, unless a longer time is documented by the requesting physician.

Emergency Requests: If the consultation is urgent or needs to be completed sooner than 24 hours, the requesting physician must speak with the consultant directly in addition to the written request. Once a call is placed, the Medical Staff member, designee, or on-call practitioner must respond by telephone within 20 minutes of receiving a consultation request. Treating Medical Staff members and on-call Medical Staff members shall confer about the appropriate in-person response time, with the treating physician having final say in the appropriate in-person response time.

Members in the Departments of Anesthesia, Interventional Radiology, and Obstetrics and Gynecology must be able to arrive within 30 minutes of being summoned, under normal transportation conditions. For any patient under the age of 18, the in-person response time shall not be longer than 60 minutes after the initial call to the on-call Medical Staff member if required by the requesting physician, except as otherwise required by state, federal or other regulatory requirements.

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

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

3.2.9 In accordance with the Bylaws, Section 11.1.4(t), the department/section chairman may request a consultation regarding a patient if deemed appropriate for quality of care.

3.3. Specialty Units:

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

3.4. Treatment of Family Members:

3.4.1 Members of the Medical Staff are strongly discouraged from acting as physician to their immediate family members (first degree relatives, spouse, and children) who are treated at Virtua and its associated facilities and should do so only when no viable alternative treatment is available in the tri-state area. The complexities of acting as physician for family members are clearly expressed in AMA policy #E-8.19, entitled "Self Treatment or Treatment of Immediate Family Members."

3.4.2 The following circumstances are covered by this policy:

3.4.2.1 any procedure requiring written informed consent in any setting;

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

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

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

3.4.3 In the unusual event that a Medical Staff member desires to act as physician to a family member at Virtua facilities, the following steps must be taken:

3.4.3.1 The physician must notify the chief of the physician's department/section to review the situation prior to the initiation of the diagnostic/therapeutic plan, or as soon thereafter as can be reasonably performed, and attest to:

3.4.3.1.1 the necessity of the plan/procedure;

3.4.3.1.2 the lack of viable treatment alternatives in the tri-state area; and

3.4.3.1.3 the provision of informed consent by the patient, including demonstrated understanding of the risk of coercion, conflict of interest, the complexities that might arise in the face of poor outcomes, and an awareness of the issues surrounding reimbursement and insurance fraud. Consultation with the Ethics Committee is strongly encouraged to support the chief in the completion of this step.

3.4.3.2 The chief of the physician's department may review the case at the conclusion of the treatment episode to assure that appropriate technical and professional standards have been met.

3.5. Progress Notes:

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

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

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

3.5.4 Progress notes must be legible.

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

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

3.6. Consultations:

A consultation request must indicate the reason for the consultation. The completed consultation report will be included as part of the medical record, whether handwritten or dictated.

3.7. Informed Consent:

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

3.7.2 It is the obligation of the physician/surgeon who will perform the procedure to obtain informed consent.

3.7.3 The policy for witnessing and completing the Virtua consent form is contained in the Virtua Consent Policy.

3.7.4 In all cases in which the patient is presumed to be mentally competent, every effort should be made to obtain his/her signature or mark after the patient has received the discussion of informed consent about his/her proposed procedure. Only if the patient is obviously temporarily or permanently mentally incompetent or a minor

should a legal guardian or next of kin sign in place of the patient. The issue of incompetence of the patient must be documented on the chart by the physician.

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

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

3.7.7 Alterations, additions, or changes on a signed informed consent form necessitate a new consent form. In the event a new surgical consent form has to be written and the patient has received pre-medication, the case will be rescheduled at such a time after the patient is alert enough to sign the new consent form. In this circumstance, the physician shall document the mental alertness of the patient at the time of signature on the patient's chart.

3.7.8 The name of the person performing the procedure must be on the surgical consent form.

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

3.8. Orders:

3.8.1 Orders must be either entered by computerized orders or written with a ballpoint pen. Only authorized individuals may make entries in the medical record.

3.8.2 All orders shall be dated, timed and signed. All handwritten orders must be legible. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.

3.8.3 For all medication orders, the physician order sheet must document the drug to be given, date, dosage, route of administration and frequency of administration.

3.8.4 Appropriate policies regarding automatic stop orders on dangerous drugs, recommended by the Pharmacy and Therapeutics Committee, shall be adopted by the Medical Executive Committee and adhered to by the Medical Staff.

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

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

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

3.8.8 All orders written by resident house staff physicians who are participating in an approved educational program shall be countersigned by the attending physician or appropriate consultant within 24 hours.

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

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

3.9. Verbal Orders:

3.9.1 Verbal orders should be accepted only under circumstances when it is impractical for such order to be entered by the ordering physician. For a verbal order to be valid, the following four conditions must be met:

3.9.1.1 The order must be dictated by the ordering Medical Staff member or designee to a duly authorized person acting within the scope of his or her discipline (as described below), who will then legibly transcribe the verbal order into the patient's chart.

3.9.1.2 The entire verbal order will be documented in the medical record and the documentation will be read back to the prescriber and confirmed by the prescriber. Confirmation is to be noted on the order sheet by writing "RAV" (read back and verified).

3.9.1.3 The person transcribing the verbal order into the chart must date the order and sign his or her name and indicate the name of the Medical Staff member who dictated the verbal order.

3.9.1.4 The Medical Staff member who dictated the verbal order must authenticate the verbal order by signing his or her name to it within 48 hours.

3.9.1.4.1 The following are exceptions to the above:

a. Verbal orders for restraints must be authenticated in accordance with the Restraint policy;
b. Verbal orders for changes to a Heparin drip must be authenticated within 24 hours;
c. All verbal orders given by house physicians must be authenticated within 24 hours

3.9.2 Persons "duly authorized" to receive verbal orders are:

Physicians credentialed to work at Virtua.

Registered nurses duly authorized to work at Virtua may accept verbal orders only from licensed physicians.

Physician assistants duly authorized to work at Virtua may accept verbal orders from a supervising physician only.

Advance Practice Nurses duly authorized to work at Virtua may accept verbal orders from a supervising physician only.

Licensed physical therapists may accept orders for physical therapy, procedures and modalities.

Registered respiratory therapists or **certified respiratory therapy technicians** may accept verbal orders for inhalation or respiratory therapy, including orders for drugs used in inhalation or respiratory therapy and administered by the respiratory therapists.

Licensed pharmacists may accept verbal drug clarification orders.

Registered dietitians duly authorized to work at Virtua may accept verbal orders relating to dietary.

Licensed speech pathologists may accept verbal orders relating to speech pathology.

Dieticians may accept verbal orders for serum protein levels.

ARTICLE IV

DISCHARGE

4.1. General:

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

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

4.1.3 In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Policies with respect to release of the deceased shall conform to local law.

4.2. Autopsies:

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

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

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

4.2.3.1 no diagnosis before death;

4.2.3.2 intra-operative death;

4.2.3.3 post-operative death as defined by the New Jersey Department of Health; and

4.2.3.4 death incident to pregnancy.

4.3. Documentation at Discharge:

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

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

4.3.3 A **discharge summary** shall be legibly written, entered, or dictated on all medical records of patients hospitalized who remain in the hospital for 24 hours or longer or expire during the hospitalization**.** Normal newborns do not require a discharge summary. In all instances, the content of the medical record shall be sufficient to justify the diagnosis, warrant the treatment, and document the end result. All summaries shall be authenticated by the responsible practitioner's original signature or electronic signature.

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

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

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

4.3.4 A **transfer consent form** must be signed, dated, and timed on all non-emergency transfers to another facility. The process for providing appropriate care for a patient, during and after transfer from Virtua to another facility, includes: assessing the reason(s) for transfer, establishing the conditions under which

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

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

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

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

4.3.5.3 The patient's nursing needs, hazardous behavioral problems, and drug or other allergies

4.3.6 All patients, upon discharge from the hospital, same-day surgery unit, and delivery suite, will be given legible written instructions about their post-discharge care. The elements to be included in this document are: discharge diagnosis, procedures performed, discharge medications with dosages and frequency of administration, activity limitations, diet, attending physician's and consultant's names, and phone numbers and date for patient to make appointment for follow-up care. If the patient or representative cannot read and understand the discharge instructions, reasonable efforts will be made to provide appropriate language resources to permit him or her to understand.

ARTICLE V

MEDICAL RECORDS

5.1. General:

5.1.1 The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current and contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

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

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

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

5.1.4 Dependent practitioners who are credentialed by Virtua are subject to the medical records policies of the Medical Staff.

5.1.4.1 Resident Physicians, House Physicians, and Physician Assistants:

The responsible attending physician shall authenticate the following documents:

5.1.4.1.1 history and physical, discharge summary, consultation report, and/or

5.1.4.1.2 orders written/given by these physicians or physician assistants within 24 hours

5.1.4.2 Advanced Practice Nurses:

5.1.4.2.1 The following items of medical record documentation must be co-signed by the collaborating physician:

5.1.4.2.1.1 History and physical – when completed and signed by Nurse Practitioner (NP)/Clinical Nurse Specialist (CNS)/Certified Nurse Midwife (CNM);

5.1.4.2.1.2 Consultation – when completed and signed by NP/CNS/CNM;

5.1.4.2.1.3 Discharge summary – when completed and signed by NP/CNS/CNM;

5.1.4.2.2 The following documentation does not require co-signature by the collaborating physician:

5.1.4.2.2.1 Prescriptive rights – when completed and signed by NP/CNS/CNM;

5.1.4.2.2.2 Progress notes – when completed and signed by NP/CNS/CNM;

5.1.4.2.2.3 Antepartum record – when completed and signed by CNM;

5.1.4.2.2.4 Admission/labor record – when completed and signed by CNM;

5.1.4.2.2.5 Delivery record – when completed and signed by CNM; or

5.1.4.2.2.6 Birth certificate – when completed and signed by CNM.

5.1.4.2.2.7 Orders – when completed and signed by NP/CNS/CNM; and

5.1.4.2.2.8 Narcotic order – when completed and signed by NP/CNS/CNM.

5.2. Access and Retention of Record:

5.2.1 Information about patients will be handled according to applicable Virtua HIPAA policies. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information. Access to medical records of all patients shall be afforded members of the Medical Staff for bona fide impersonal study, research, and audit consistent with preserving the confidentiality of the patient and in accordance with Institutional Review Board oversight.

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

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

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

5.3. Delinquent Medical Records:

5.3.1 The hospital is obligated to complete each medical record within 30 days of the patient's discharge. Accordingly, each Medical Staff member is obliged to complete the physician's portion of the medical record within 15 days of receipt of the chart in order to allow sufficient time for the entire medical record to be completed within the 30-day time limit. Any Medical Staff member who fails to meet the applicable deadline set forth in this Paragraph shall be "delinquent" within the meaning of this Section of the Rules and Regulations.

5.3.2 The Health Information Management Department (HIM) electronically notifies the physician each week by email of any assigned medical record deficiencies that are incomplete. The physician will receive 2 email notifications for deficiencies considered “incomplete”.

If the medical record deficiencies are not completed within 15 days, the deficiency is considered delinquent and the physician will receive on the 3rd week an email notice of "suspension" which takes effect the following day. The physician's name will be placed on the suspended list and the physician's privileges will be automatically relinquished. Such relinquishment shall be entail:

5.3.2.1 Admitting clinical privileges

5.3.2.2 Consulting privileges

5.3.2.3 Voting eligibility

5.3.2.4 Committee membership

5.3.2.5 Access to CIS (Clinical Information System) temporarily suspended until delinquent deficiency completion

5.3.3 Such relinquishment shall be effective until medical records are completed in accordance with the Rules and Regulations and this Policy, unless the period of relinquishment exceeds 45 days. Relinquishments in excess of 45 days will be considered an automatic relinquishment of staff appointment, except as described in Section 2.4.1(b) of the Virtua Medical Staff Bylaws. No procedural fair hearing rights shall apply. The practitioner may be eligible to reapply for staff appointment. Such reapplication shall be processed in the same manner as if it were an initial application for staff appointment.

5.3.4 The President of the Medical Staff, the Chief Medical Officer, or their designees may override a relinquishment in the case of emergencies or other justified reasons, as defined in Section 7.4.1(b) of the Bylaws.

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

5.3.6 Department and/or section chiefs will verbally counsel the Medical Staff members who are delinquent. Repeated medical record delinquency may be construed as disruptive behavior and will be handled in accordance with the Medical Staff Bylaws.

ARTICLE VI

EMERGENCY SERVICES

6.1. General:

6.1.1 A Physician Specialist on-call list will be provided to the Emergency Department by the head of each Department or Section for each major clinical service in a timely manner. On-call physicians must arrive in the Emergency Department in accordance with the requirements set forth in Section 4.3.3 of the Bylaws.

6.1.2 The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a departmental Policy and Procedure Manual. The contents of such a manual or any changes to it will be developed by a committee including representatives from the Emergency Medicine Department, nursing service, and hospital administration, and approved by the Executive Committee.

6.2. Medical Screening Examinations:

For purposes of providing an appropriate medical screening examination to any person who presents to the Emergency Department, the initial triage shall be performed by a registered professional nurse or "qualified medical personnel" as defined below. The medical screening examination itself shall be performed by any of the following persons ("qualified medical personnel"): a physician who meets the requirements at N.J.A.C. 8:43G-12.3, or an advanced practice nurse certified by the New Jersey State Board of Nursing, or a physician assistant licensed by the New Jersey State Board of Medical Examiners. The advanced practice nurse or licensed physician assistant shall have training and experience in emergency care. "Medical Screening Examination" means an examination within the capability of the hospital's emergency department, including ancillary services routinely available in the emergency department performed to determine whether or not an emergency medical condition exists.

6.3. Medical Orders and Records:

6.3.1 All orders for hospital care written by an Emergency Department Physician must be reviewed by the attending physician within 24 hours.

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

- Mode, date and time of arrival;
- Allergies;
- Medications used before admission to the emergency department;

- Immunizations when relevant;
- Timed vital signs;
- Chief complaint;
- Physician assessment;
- Nursing assessment;
- Treatment rendered, time-stamped and signed by the person who rendered treatment;
- Medications prescribed and administered while in the Emergency Department, time-stamped and signed by the person who prescribed and the person who administered the medications;
- Discharge instructions; and
- Last menstrual period, if relevant.

6.3.3 As described in the Hospital Care Policy section 2.4, the care of that patient becomes the responsibility of the attending physician once the attending physician acknowledges acceptance of the patient's admission to the hospital, regardless of the patient location in the hospital (i.e., including patients boarded in the Emergency Department).

6.3.4 Each patient's Emergency Services medical record shall be signed by the practitioner in attendance, who is responsible for its clinical accuracy.

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

6.4. Additional Policies:

6.4.1 The Emergency Department will have written policies to address:

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

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

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

6.4.3 The Emergency Department shall perform functions described in the Virtua Health Disaster Plan in the event of mass casualties at the time of any major disaster.

6.4.4 Primary physicians may choose to refer to predetermined specialty consultants without a call from the Emergency Department. If so, they will be asked to furnish consultant names to the Emergency Department, so that appropriate predetermined specialty referrals may be made. If not, the Emergency Department will place a call to discuss the care of the patient with the primary physician and ascertain referral names. If the primary physician does not return the call within the 30 minutes (or sooner if circumstances necessitate), the Emergency Department physician will refer to the appropriate specialist or the "on-call" specialist. In the interest of providing timely patient care and smooth Emergency Department function, the relevant Section Chief or Department Chair will be notified if members have neither provided a list nor returned calls within 30 minutes.

ARTICLE VII

ANESTHESIA SERVICES

7.1. General:

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

7.1.1.1 a qualified anesthesiologist;

7.1.1.2 an M.D. or D.O. (other than an anesthesiologist);

7.1.1.3 a CRNA who is supervised by an anesthesiologist who is immediately available.

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

7.1.3 "Anesthesia" means general or regional anesthesia, monitored anesthesia care or deep sedation "Anesthesia" does not include topical or local anesthesia. Policies regarding minimal, moderate or conscious sedation, are described in Article VIII.

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

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

7.2. Pre-Anesthesia Procedures:

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

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

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

7.2.2.2 an interview and examination of the patient;

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

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

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

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

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

7.3. Monitoring During Procedure:

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

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

7.3.2.1 the name and hospital identification number of the patient;

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

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

7.3.2.4 the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

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

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

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

7.4. Post-Anesthesia Evaluations:

7.4.1 A post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area. Where post-operative sedation is necessary for the optimum care of the patient, the evaluation can occur in the PACU/ICU or other designated recovery area. For outpatients, the post-anesthesia evaluation must be completed prior to the patient's discharge.

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

7.4.2.1 respiratory function;

7.4.2.2 cardiovascular function;

7.4.2.3 mental status;

7.4.2.4 temperature;

7.4.2.5 nausea and vomiting; and

7.4.2.6 postoperative hydrations.

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

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

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

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

7.5. Minimal, Moderate or Conscious Sedation:

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

ARTICLE VIII

MINIMAL, MODERATE, AND CONSCIOUS SEDATION

8.1. General:

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

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

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

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

8.2. Policies and Protocols:

8.2.1 Minimal, moderate and conscious sedation practices throughout the organization will be monitored and evaluated by the Department of Anesthesia and the Performance Improvement Committee.

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

8.2.3 The physician must give the initial dose of sedation and analgesia.

8.2.4 An individual different from the physician performing the procedure or individual assisting the physician must monitor the patient. The person may be an anesthesiologist, CRNA, credentialed physician or qualified registered professional nurse. In accordance with Virtua Nursing Administration Policies, the qualified RN must be ACLS/PALS-certified and/or able to demonstrate current experience with monitoring devices used, and have documented

competency in the ability to anticipate and recognize potential complications of sedation and analgesia in relation to the type of medication administered.

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

8.2.6 Documentation of a preanesthesia assessment will be recorded on each patient's chart. The planned procedure, a plan for anesthesia administration, and the options, alternatives and risks will be discussed with the patient and/or responsible person prior to administration of sedation and documented in the clinical record.

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

8.2.7.1 verification of correct patient;

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

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

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

8.2.7.5 assessment of neurological status and level of consciousness;

8.2.7.6 assessment of NPO status;

8.2.7.7 assessment of potential pregnancy;

8.2.7.8 ASA determination; and

8.2.7.9 verification of signed consent for the procedure.

8.3. Equipment:

Available equipment will include, but is not limited to:

8.3.1 IV access supplies;

8.3.2 pulse oximeter;

8.3.3 blood pressure monitoring equipment;

8.3.4 cardiac monitor;

8.3.5 supplemental oxygen;

8.3.6 suction source;

8.3.7 resuscitation bag;

8.3.8 defibrillator;

8.3.9 airways;

8.3.10 intubation equipment; and

8.3.11 emergency medications (Narcan and Romazicon).

8.4. Pre-Procedure:

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

8.4.2 All patients will be monitored throughout the procedure in accordance with Section 8.4.4 below. At **NO** time may the patient be left unattended and/or without monitoring by a qualified clinician during the procedure.

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

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

- assessment of the level of consciousness (baseline and every 15 minutes during the procedure);
- vital signs: heart rate, blood pressure, and respiratory rate. Signs are reassessed at a minimum of every five minutes throughout the procedure;
- continuous monitoring of the EKG;
- assessment of the baseline pulse oximetry and continuous monitoring of the oxygen saturation;
- all medications (name, dose and route) administered during the procedure; and
- any hypersensitivity or unusual patient reaction.

8.5. Intra-Procedure:

8.5.1 Medication shall be administered in compliance with the drug manufacturer's recommendation and Virtua policies and procedures.

8.5.2 The first dose of minimal, moderate or conscious sedation or analgesia must be given by a credentialed physician, anesthesiologist, or CRNA. Subsequent doses may be given by a qualified RN by order and under the direct supervision of a credentialed physician.

8.5.3 The clinician monitoring the patient will immediately alert the physician of any untoward effects/responses which occur during the procedure. These may include, but are not limited to:

- cardiac arrhythmias and/or change in heart rate or rhythm;
- change in blood pressure from pre-procedural level (> 20 mm HG);
- oxygen saturation less than 90% or inability to maintain oxygen saturation; or
- change in airway status, such as increased secretions, bloody secretions, choking, increased restlessness.

8.5.4 Patients who exhibit hemodynamic instability, oxygen desaturation, or respiratory depression or failure are NOT appropriate candidates for continuation of the procedure under moderate sedation.

8.5.5 Emergency care of the patient will proceed per physician orders.

8.6. Post-Procedure:

8.6.1 Post-procedural monitoring will include:

- vital signs: heart rate, blood pressure and respiratory rate;
- oxygen saturation on room air;
- EKG monitoring, if indicated;
- level of consciousness; and
- pulse checks, if indicated.

8.6.2 These must be monitored and documented post-procedural at a minimum of every 15 minutes times three or until the patient returns to the baseline assessment.

8.6.3 Documentation must indicate all medications and oxygen administered during the post-procedural phase. Assessment and documentation must indicate that the patient has met the discharge criteria prior to discharge from the post-procedural recovery area.

8.7. Patient Discharge Instructions and Procedures:

8.7.1 Assessment and documentation must indicate that the patient has met the discharge criteria below in Section 8.8 prior to discharge from the post-procedural recovery area.

8.7.2 A discharge or transfer order from the anesthesiologist or physician performing the procedure must be obtained for all patients.

8.7.3 Admitted patients may be discharged from the procedural area to the general clinical area after meeting the discharge criteria and upon clearance for transport by the physician performing the procedure.

8.7.4 Critical Care patients who receive minimal, moderate or conscious sedation for a procedure done within Critical Care may receive appropriate post-procedural monitoring within the Critical Care area.

8.7.5 Critical Care patients who have received minimal, moderate or conscious sedation in any other department (for the purpose of performing a procedure) may return to Critical Care when discharged by the physician performing the procedure following the discharge criteria. The transfer back to Critical Care MUST include appropriate monitoring and supplemental oxygen during transport.

8.7.6 For patients being discharged home, discharge instructions must be given to a responsible adult.

8.8. Discharge Criteria:

8.8.1 Respiratory:

- retains the ability to maintain and protect the airway (such as the ability to cough or tolerate liquids);
- absence of signs of respiratory distress;
- adequate oxygen saturation.

8.8.2 Consciousness:

- full orientation to time, person, and place OR returns to baseline assessment;

- adequate gag and cough; if vomiting has occurred, the patient must demonstrate the ability to swallow;

- particularly for patients being discharged home, sufficient mobility and absence of dizziness or lightheadedness to assure patient safety.

8.8.3 Circulation:

- stable vital signs for a minimum of 30 minutes;

- consistent oxygen saturation greater than 95% on room air (or return to baseline/pre-procedural oxygen saturation level).

8.8.4 Pain:

Pain minimal or controlled with medication prior to discharge.

8.8.5 Activity:

- demonstration of controlled, coordinated movements;

- ambulation with a steady gait or sits without assistance, as appropriate;

- achievement of pre-sedation level of responsiveness (or a level as close as possible to baseline for the patient).

8.9. Discharge Form Guidelines:

Front of Form:

- Stamp form with patient's addressograph plate.
- Enter date.
- Complete checklist for chart readiness.
- Document procedure.
- Document procedural physician.
- Document allergies for latex, food or drug.
- Complete pre-procedure assessment checklist.

- Document oxygen administration.
- Document IV access and fluids.
- Document procedure start time.
- Check first dose of sedation given by physician.
- Sedation scale: to be documented every 15 minutes throughout procedure. Included in this documentation is:
    - emotional effect
    - LOC
    - vital signs
    - physical reaction to procedure

  The total sedation score is documented. A score of 3-5 is desired.

  Medications: document time, type of medication, dose, route, patient response and nurse initials.
- Vital signs: document time, blood pressure, heart rate, respiration, oxygen, and EKG rhythm every five minutes.
- Check box if monitoring rhythm strips are available through cardiac and blood pressure.
- Document post-procedure vital signs every 15 minutes times three, or until patient returns to baseline.
- Document nurse initials and signatures.
- Check box for Division/location.
- Document time of completion of procedure.

Back of Form:

- Nursing diagnosis/intervention section: initial when expected outcome met.
- Narrative documentation: use for any additional documentation needed during procedure.
- Check box if supplemental nursing notes are documented in patient care.
- Discharge criteria: check as criteria met.
- Discharge: document time, destination and accompanied by.

    - If inpatient: document person report given to.
- Discharge instruction: check boxes and initial.
- Patient teaching: check boxes when teaching completed.
- Initial on signature of nurse completing documentation.

ARTICLE IX

OPERATING ROOM PROCEDURES

9.1. General:

9.1.1 Procedures may be performed in the Operating Room only in accordance with the privileges delineated in compliance with the Medical Staff Bylaws.

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

9.1.3 The scope and extent of surgical privileges for dentists and podiatrists shall follow granted clinical privileges and be in accordance with the Policy on Appointment, Reappointment and Clinical Privileges.

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

9.1.5 A roster of physicians with delineation of current surgical privileges, including those with temporary privileges, shall be maintained in each Operating Room.

9.2. Operating Room Committee:

9.2.1 The oversight of the Operating Room will be the responsibility of the Operating Room Committee, whose title may vary according to each hospital's policies. This committee will comprise Medical Staff members, as well as members of the Nursing Staff, Virtua and/or hospital Administration, and such other individuals as designated in each hospital's Policy. It will report on matters relating to the Medical Staff to the Medical Executive Committee.

9.2.2 This committee will have authority to make decisions regarding:

9.2.2.1 allocation of Operating Room time (blocks);

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

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

9.2.3 This committee will advise and recommend regarding other matters:

9.2.3.1 determination of allocation of resources for equipment, etc. The committee will work in close dialogue with the Virtua administration to establish strategic vision, define priorities, and formulate budgets;

9.2.3.2 efforts to monitor and improve the efficiency and cost of the Operating Room; and

9.2.3.3 Virtua-wide Operating Room policies.

9.3. Delivery of Services:

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

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

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

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

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

9.3.6 Laterality must be written as left or right on the history and physical and OR consent.

9.3.7 For inpatients and surgery outpatients (including patients expected to stay 24 hours or more post-surgery), the history and physical examination must be performed within 30 days prior to the hospital or outpatient surgery admission or 24 hours after a hospital admission, but in all cases prior to surgery, as long as the medical record contains the following:

9.3.7.1 a current history and physical;

9.3.7.2 an appropriate assessment, which should include a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior history and physical or to address any areas where more current data is needed, completed within seven days prior to a hospital or outpatient surgery admission or registration, or within 24 hours after a hospital admission or registration confirming that the necessity for the procedure/care is still present and the history and physical is still current; and

9.3.7.3 an updated note written by the physician addressing the patient's current status and/or changes to the patient's status, regardless of whether there were any changes in the patient's status, within seven days prior to a hospital or outpatient surgery admission or registration, or within 24 hours after a hospital admission or registration. The updated note must be on or attached to the history and physical.

9.3.8 The history and physical, including all updates and assessments, must be included in the patient's medical record, except in emergency situations, within 24 hours after a hospital admission or registration or prior to surgery for an outpatient, whichever comes first.

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

9.3.10 Informed consent is required for all surgical procedures consistent with these Rules and Regulations. The anesthesiologist will obtain informed consent from the patient for the anesthesia portion of a procedure. It is the anesthesiologist's responsibility to obtain the appropriate signatures on the appropriate consent form.

9.3.11 The following will also occur before all surgical procedures:

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

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

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

9.3.11.4 The attending physician is in the hospital.

9.3.11.5 The procedure site is marked and a "time out" is conducted immediately before starting the procedure, as described in the Operative Procedure Site Verification and Time Out Protocol.

9.4. Post-Procedure Protocol:

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

9.4.1.1 the patient's name and hospital identification number;

9.4.1.2 pre- and post-operative diagnoses;

9.4.1.3 date and time of the procedure;

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

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

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

9.4.1.7 findings;

9.4.1.8 estimated blood loss;

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

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

9.4.1.11 specimen(s) removed, if any; and

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

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

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

9.4.2.2 procedure(s) performed;

9.4.2.3 findings;

9.4.2.4 estimated blood loss, when applicable or significant;

9.4.2.5 specimens removed; and

9.4.2.6 post-operative diagnosis.

ARTICLE X

GRADUATE MEDICAL EDUCATION AND RESIDENT SUPERVISION

10.1. General:

10.1.1 This Article sets out the requirements for training resident physicians at Virtua. For the purposes of these Rules and Regulations, "residents" refers to fellows, residents, and medical students, except as otherwise specified.

10.1.2 Institutional oversight of the residency program and assurance of compliance with residency standards will be the responsibility of the Quality and Safety Committee ("QSC") of the Virtua Board.

10.1.3 The Medical Director of Graduate Medical Education ("GME") is responsible for coordinating all resident education, reviewing residency issues, and assuring Medical Staff compliance with institutional guidelines.

10.1.3.1 The Medical Director of GME will chair the Graduate Medical Education Committee, which has representation from the QSC, the Virtua Medical Staff, the teaching faculty and the residency program.

10.1.3.2 The Graduate Medical Education Committee will oversee patient treatment, safety, and quality of care, and the related educational and supervisory needs of the participants in the graduate educational programs.

10.1.4 The Medical Director of GME will be responsible for communicating the findings of the Graduate Medical Education Committee to the Medical Executive Committee and the QSC of the Virtua Board.

10.1.5 At the end of each academic year, the Medical Director of GME will present in writing to the QSC and to the MEC the names of the residents who have been promoted and any restrictions or limitations in the role of any advanced resident.

10.1.6 All of these tasks will be coordinated by the Office of GME. All residents working with any providers within Virtua's inpatient facilities or Virtua-owned practices shall be supervised by this office.

10.2. Guidelines for Participation in a Virtua-Sponsored or Hosted GME Program:

10.2.1 All residents will be directly supervised by a licensed member of the Virtua Medical Staff with privileges in the area being supervised, in accordance with Joint Commission standards.

10.2.2 All supervising physicians must follow the regulatory procedures and protocols of Virtua.

10.2.3 In advance of the resident's clinical experience, all direct supervisors, the relevant organized Medical Staff, and the hospital staff will receive written descriptions of the resident's roles, responsibilities, learning objectives, and patient care activities.

10.2.3.1 Such descriptions for Virtua residents will be provided by the Medical Director of GME.

10.2.3.2 All residents from outside sponsors must provide the Office of GME with a written description of the goals and objectives and a detailed list of expected resident activities. Such descriptions will then be reviewed and forwarded to the appropriate Medical Staff members.

10.2.4 Resident schedules will be supplied to all Medical Staff offices and relevant areas of all hospital or ambulatory settings by the Office of GME.

10.3. Responsibilities of Residents/Fellows/Students within Virtua:

10.3.1 Residents are expected to comply with all Virtua policies, procedures, and protocols.

10.3.2 Residents are expected to comply with all Medical Staff Rules and Regulations.

10.3.3 Resident orders:

10.3.3.1 All resident orders must comply with the Medical Staff's Rules and Regulations and the Medical Records Policy.

10.3.3.2 Nurses will accept resident orders. All orders must be countersigned by the attending physician or designee within 24 hours.

10.3.3.3 Medical student orders may not be processed without countersignature by the resident or attending.

10.3.4 Resident documentation:

10.3.4.1 Residents providing primary care for a patient are expected to follow medical record policies regarding appropriate completion and content of history and physicals. In addition, all resident history and physicals must be dictated.

10.3.4.2 All residents are required to write a daily progress note for patients whom they are following. This progress note must include, at minimum, the patient's condition, the treatment plan, and short-term and long-term goals. In addition, each progress note must be dated, timed, and signed. If multiple medical record entries are made on the same day, each must include date, time, and signature.

10.3.4.3 Operative and delivery reports may be written or dictated by the resident and must be countersigned by the attending physician within 24 hours.

10.3.4.3.1 The resident's report must indicate the teaching physician's presence for all key portions of the procedure. The attending must document personally in each chart the key portion of the surgery observed and the immediate availability of the primary surgeon or assistant.

10.3.4.4 Residents may perform consults.

10.3.4.4.1 Non-operative orders can be processed after the resident has been in phone consultation with the attending consultant.

10.3.4.4.2 All non-operative consults performed by a resident must be reviewed and countersigned by the attending consultant within 24 hours.

10.3.4.4.3 The patient must be seen and the consult countersigned by the attending consultant supervising the resident before any operations or procedures.

10.3.4.5 Residents providing significant care for hospitalized patients are required to perform discharge summaries for the attending physician. The attending is responsible for the content and countersignature of those discharge summaries.

10.3.4.6 Residents may write prescriptions on hospital prescription pads as per hospital policy.

10.4. Supervising Physician's Responsibilities:

10.4.1 The Medical Staff must comply with all accreditation guidelines of individual residencies as they pertain to the supervising physician's presence or lack thereof for individual resident activities.

10.4.1.1 All patients admitted to the ICU or PCU must be seen by the attending within the time frame dictated in the Medical Staff rules.

10.4.1.2 Patients admitted to Labor and Delivery by residents must be seen within one hour by an attending.

10.4.1.3 In accordance with the Residency Review Committees of the Accreditation Council for Graduate Medical Education, the supervising physician is required to be on site within the hospital proper when a patient is in labor and in the delivery room for deliveries to supervise residents on an obstetrical rotation.

10.4.1.4 All admissions that do not fall under the above categories must be seen within 24 hours by the attending of record.

10.4.2 All admissions, admission orders, diagnostic tests, and consults performed by a resident must be discussed with and authorized by the attending physician.

10.4.3 No patients will be taken to the Operating Room without first being evaluated by the attending physician.

10.4.4 Residents may assist in surgery with the following provisions:

10.4.4.1 The attending physician must be in the OR for the key portion of all surgeries.

10.4.4.2 The attending physician may not be supervising or performing/supervising more than two overlapping procedures.

10.4.4.3 For any "scopic" procedures, the teaching physician must be present for the **entire** procedure.

10.4.5 Supervising Physician's Documentation:

10.4.5.1 The supervising physician must see patients and write a daily progress note on all patients.

10.4.5.1.1 The supervising physician's progress note must indicate that the resident's note was reviewed, any difference of findings, documentation of the plan of action, including discharge planning, and issues of outstanding significance.

10.4.5.1.2 Simple countersignature of resident notes is not acceptable.

10.4.5.2 All orders, discharge summaries, histories and physicals, and operative and delivery notes that are documented by a resident must be countersigned within 24 hours and must be dated and timed.

10.4.5.3 DNR orders must be countersigned and a relevant progress note written within 24 hours.

10.4.6 The Medical Staff must comply with all Medicare rules on attending billing of care provided by residents, including any medical records compliance that is necessary.

10.4.7 Supervising Physician Evaluations:

10.4.7.1 Supervising physicians are obligated to complete evaluations requested by the resident sponsor within 60 days of completion of an experience with the resident. Failure to do so may jeopardize the ability of the supervising physician to continue as a teaching attending.

10.4.7.2 Supervising physicians working with residents have a responsibility to inform the residents' sponsor of any critical incidents that occur within 24 hours.

10.4.7.2.1 Critical incidents may be reported verbally, but must be subsequently documented in writing to the residency sponsor and the Medical Director of GME.

10.4.7.3 Supervising physicians have a responsibility to assure resident competency to complete the patient care tasks assigned. If a competency issue arises, the supervisor physician must take over the care of the patient and inform the residency sponsor immediately.

10.4.7.3.1 Quality and competency issues must be communicated in writing to the residency sponsor and the Medical Director of GME.

ARTICLE XI

VIRTUA INSTITUTIONAL REVIEW BOARDS

11.1. Under Food and Drug Administration ("FDA") regulations, an Institutional Review Board ("IRB") is an appropriately constituted group that has been formally designated to review and monitor biomedical research involving human subjects. In accordance with FDA regulations, an IRB has the authority to approve, require modifications in (to secure approval), or disapprove research. This group review serves an important role in the protection of the rights and welfare of human research subjects.

11.2. The Board has established two IRBs to ensure protection of the rights and welfare of all human subjects [46,102 (f)] involved in research [46.102 (d)] performed at or through any Virtua facility or other entity that has an affiliation with Virtua (each a "Facility" and, collectively, the "Facilities"). The Facilities include, but are not limited to, Virtua – Memorial Hospital Burlington County, Inc., Virtua – West Jersey Health System, Inc., Virtua Health and Rehabilitation Center at Mount Holly, Inc., Virtua Health and Rehabilitation Center at Berlin, Inc., Summit Surgical Center – Virtua Health, Virtua Home Care – Community Nursing Services and certain private entities with Virtua affiliations. The Virtua Oncology IRB reviews and monitors all protocols conducted in the Facilities that relate to the treatment and prevention of cancer. The Virtua General IRB reviews and monitors all protocols that do not relate to oncology. These two IRBs are under the control of Virtua and follow substantially the same policies and procedures and will cooperate in identifying those studies that should be reviewed by the General IRB and those studies that should be reviewed by the Oncology IRB. The IRBs are responsible to ensure compliance with FDA, Department of Health and Human Services ("HHS") and the Office for Human Research Protections ("OHRP") regulations pertaining to research involving human subjects.

11.3. Additionally, the IRBs review, consider and approve, if appropriate, any research involving patients at any of the Facilities, even if such research does not require IRB approval as a matter of law.

11.4. Physicians acting as principal investigators must comply with the IRB policies and procedures specific to the General or Oncology IRB. Additional information on other IRB policy requirements can be obtained by contacting the IRB Coordinator at 609-267-0700, Extension 44190. Copies of the full text of IRB policies and procedures containing the requirements for submission of studies and other requests may be obtained by contacting the Medical Affairs Offices at Virtua Memorial (609-267-0700, Extension 43220) or Virtua One Carnie (856-325-4736).

ARTICLE XII

BOARD CERTIFICATION

12.1. Board Certification Exception:

12.1.1 The Medical Staff Bylaws (Section 4.7) require Medical Staff members to achieve board certification within the time periods set forth in that Section. Also described in Section 4.7 is a process for "exceptional" Medical Staff members. Some Medical Staff members and some applicants to the Medical Staff who have not met the board certification requirement have asserted that their failure to achieve board certification is the result of a medical or psychological or other test-taking impairment. The Medical Staff Bylaws do not specify a process to evaluate these claims. The purpose of this Article of the Rules and Regulations is to establish a process whereby such claims can be evaluated uniformly, fairly and with sensitivity to both the medical/psychological circumstances of the member/applicant and the goals of the Medical Staff in establishing the board certification requirement in the Bylaws.

12.1.2 A Medical Staff member or applicant who asserts that he or she has been or will be unable to achieve board certification within the required time because of a medical/psychological impairment shall so advise the chairman of the section/department and the President of the Medical Staff in writing and request a medical waiver of the board certification requirement. The member/applicant may request a waiver of up to five years extension of time to satisfy the requirement, only after showing that he or she otherwise meets the qualifications for appointment outlined in Section 2.2 and, in the case of reappointment, Section 3.2 of the Virtua Medical Staff Policy on Appointment, Reappointment and Clinical Privileges. Upon receipt of such a communication, the President of the Medical Staff shall appoint a Board Certification Medical Staff Task Force, as described below.

12.1.3 On an ad hoc basis, the President of the Medical Staff shall establish a Board Certification Medical Staff Task Force ("Task Force"). At a minimum, the membership of the Task Force shall include the following members of the Medical Staff: a psychiatrist, a psychologist, and at least one other member of the Medical Staff. The DMO shall also be a member of the Task Force. No person shall be appointed to the Task Force if he or she is or will be a practice associate of or in actual or potential economic competition with the member or applicant in question. The President of the Medical Staff shall designate one of the Task Force members to be chairman.

12.1.4 The Task Force shall contact the member/applicant in question and request documentation supporting the assertion of medical/psychological impairment. The documentation shall include all previous evaluations by specialists in the mental health field and as much additional information as is available that would indicate

the source of the impairment, e.g., public speaking anxiety or written test anxiety. The Task Force will evaluate the documentation provided. The Task Force may choose to interview the member/applicant to obtain additional information.

12.1.5 By requesting a medical waiver from the board certification requirement, the member/applicant in question agrees to provide any and all waivers of confidentiality which may be required in order for the Task Force to have access to whatever information it believes in good faith to be relevant to its investigation. The failure of the member/applicant to cooperate with the Task Force shall be considered a withdrawal of the member/applicant's request for a medical waiver of the board certification requirement.

12.1.6 Following its review of the documentation supplied by the member/applicant, including the results of the interview, if any, of the member/applicant, the Task Force in its discretion may require the member/applicant to be evaluated by a mental health professional approved by the Task Force but who has no formal connection to Virtua. In approving the mental health professional who will perform the evaluation, the Task Force shall take into consideration the expertise of that individual as it relates to the type of impairment claimed by the member/applicant. The Task Force shall advise the chosen mental health professional of the nature of the matter and may indicate whether it wishes any particular type of testing to be conducted. The Task Force shall receive a written report. The Task Force may establish a time frame within which this must be received.

12.1.6.1 By requesting a medical waiver from the board certification requirement, the member/applicant in question agrees to cooperate fully with the mental health professional selected by the Task Force and to provide such person with any waivers of confidentiality which are needed in order for that person to communicate with the Task Force. The failure of the member/applicant to cooperate in that manner shall be considered a withdrawal of the member/applicant's request for a medical waiver of the board certification requirement.

12.1.7 Following its review of all the material before it, the Task Force shall submit a written recommendation to the Medical Executive Committee. The Task Force may recommend:

12.1.7.1 that the member/applicant not be given any waiver of the board certification requirement;

12.1.7.2 that the member/applicant be given an extension of time to satisfy the board certification requirement with any such extension being for a specified period of time not in excess of two years; or

12.1.7.3 that the member/applicant be given a waiver of the board certification requirement for a period not to exceed five years. This waiver may be renewed.

Any recommendation to grant a waiver must include the specific basis for such.

12.1.8 Following receipt of the Task Force's recommendation, the Medical Executive Committee shall vote to accept, reject or modify the recommendation; however, the Medical Executive Committee's decision must conform to one of the three options described in Section 12.1.7.

12.1.9 The Medical Executive Committee shall submit its decision in the form of a recommendation to the Board for final approval. Any recommendation to grant a waiver must include the specific basis for such. If the Board gives final approval to a decision which is consistent with Section 12.1.7.2 above, the affected member/applicant shall be required to acknowledge and agree in writing that if he or she fails to achieve Board certification within the allotted time, his or her staff membership shall automatically terminate, without appeal.

12.1.10 The grant of a waiver is discretionary. No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

12.1.11 The granting of a waiver or extension in a particular case is not intended to set a precedent for any other individual or group of individuals.

12.1.12 The Task Force and the Medical Executive Committee shall take all prudent steps to preserve the confidentiality of the information presented to them throughout this process. Communication of information regarding the member/applicant's request and evaluation(s) shall be on a "need to know" basis.

12.1.13 The cost of all evaluations, testing or other activities required to carry out this process shall be borne by the member/applicant.

12.1.14 If the request for a medical waiver of the board certification requirement is made by an applicant for membership on the Medical Staff, his or her application shall be deemed incomplete until the process described herein is completed. If the request is made by a member of the Medical Staff whose membership is subject to automatic termination under the Medical Staff Bylaws, the member's membership shall not be so terminated until the process described herein is completed.

12.2. Board Recertification – Extension of Privileges Pending Recertification:

12.2.1 A practitioner who does not become recertified may request an annual extension of privileges for up to two successive years from expiration of certification while he or she is seeking recertification. The practitioner must submit documentation of 100 Category I CME credits in his/her specialty for each year of the extension.

12.2.2 The practitioner must submit a written request for extension of clinical privileges to the department chief. This request must document:

- date of Board certification expiration;
- reason Board certification not completed; and
- number of years of extension request (maximum of two years from expiration date).

12.2.3 Upon approval of the request by the department chief, a request will be made to the Medical Executive Committee for extension of clinical privileges for the practitioner.

12.2.4 Upon approval of the Medical Executive Committee, the practitioner will be notified of approval of the extension of clinical privileges, identifying the date of expiration.

12.2.5 It will be the responsibility of the practitioner to provide documentation of 100 Category I CME credits in his/her specialty to the Office of Medical Affairs, which will provide this information to the department chief.

12.3. Voluntary Relinquishment of Privileges:

Practitioners who do not fulfill the CME requirement each year until recertified or who do not achieve board certification within the two-year extension period will be deemed to have voluntarily relinquished staff appointment and privileges.

ARTICLE XIII

DUES AND SPECIAL ASSESSMENTS

13.1. Dues:

13.1.1 The amount of dues shall be determined annually by the Executive Committee(s).

13.1.1.1 Members practicing in more than one Division will pay dues to the primary Division.

13.1.2 In accordance with the Medical Staff Bylaws, dues shall be paid as follows:

- Active Staff — Full Dues
- Associate Staff — Full Dues
- Affiliate Staff — Full Dues
- Adjunct Practitioners — Full Dues

13.1.2.1 The Consulting Staff will pay dues as decided by the joint Medical Executive Committees.

13.1.2.2 Honorary Staff members are not required to pay dues. Medical Staff members who are retired but maintain staff membership are exempt from dues.

13.1.2.3 Divisional Medical Executive Committees shall retain the power to exempt or reduce dues for special circumstances (e.g., dentists working in the Camden Dental Clinic).

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

13.1.4 Dues will be prorated for new appointments to the Medical Staff in accordance with the date upon which the Board approves the application. Those physicians who request, and are granted, temporary privileges must pay dues as of the date they receive such temporary privileges.

- Those practitioners who are appointed by the Board from January 1 through May 31 of any given year shall pay a full year's dues.

- Those practitioners who join the staff from June 1 through September 30 of any given year shall pay one-half of a full year's dues.

- Those practitioners who join the staff from October 1 through December 31 of any given year shall pay one-quarter of a full year's dues.

13.1.5 No refunds for Medical Staff dues will be made.

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

13.1.7 Dependant Allied Health Practitioners will be charged an annual assessment to be determined by the Executive Committee(s)

<u>13.2. Special Assessments</u>:

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

13.2.1.1 The amount and payment terms of any such assessments shall be determined by the Medical Executive Committee.

13.2.1.2 Deadlines for payment shall be in accordance with the special assessment deadline established by the Executive Committee.

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

<u>13.3. Bank Transaction/Account Procedures</u>:

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

13.3.2 Transactions related to the Fund may only be carried out by the President, Vice-President, and Secretary-Treasurer of the Medical Staff. The Medical Staff Office will assist in carrying out transactions pursuant to these Rules and Regulations, but only the officers have signatory authority for the funds. Proper

authorization signatures are obtained when the officers assume their positions as President, Vice-President, and Secretary-Treasurer of the Medical Staff.

13.3.3 All checks received for deposit must be payable to the appropriate medical staff. Procedures for incoming checks shall include:

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

13.3.3.2 Photocopy the check to retain for records.

13.3.3.3 Document the check in the ledger.

13.3.3.4 Credit the appropriate account.

13.3.3.5 List the check for deposit in the bank records.

13.3.3.6 All deposits are made through the hospital cashier.

13.3.4 A minimum balance, as determined by the Medical Executive Committee, is to be maintained in the checking account at all times.

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

13.3.6 An annual audit of the Fund will be conducted each year.

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

ARTICLE XIV

AMENDMENTS

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