MEDICAL STAFF
RULES AND REGULATIONS

of

Virtua Mount Holly Hospital, Virtua Marlton Hospital, Virtua Voorhees Hospital, Virtua Our Lady of Lourdes Hospital, and Virtua Willingboro Hospital

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ARTICLE I

GENERAL

1.1. Definitions:

The definitions that apply to terms used in the Medical Staff Bylaws and all the Medical Staff Supporting Documents including these Rules and Regulations, are set forth in the Medical Staff and Advanced Practice Provider Credentials Policy.

1.2. Delegation of Functions:

(1) When a function under these Rules and Regulations is to be carried out by a member of Hospital administration, 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 a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. In addition, if the designee is performing ongoing functions, the delegation is subject to the review of the applicable MEC.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function under these Rules and Regulations, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

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, sexual orientation, gender, gender identity, 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 inpatient or accepted into observation status at the hospital only by a member of the Medical Staff or certified nurse midwife (CNM) 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.

2.1.4 Admitted patients must be seen by the attending physician or their designee or CNM, and a progress note written on the chart within 12 hours from the time of admission. There are three 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 and 3) patients admitted to the Behavioral Health Unit (Mt Holly ONLY). 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.

2.1.5 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 Hospital Chief Medical Officer (or designee) 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 preadmission testing completed in accordance with the Virtua Medical Staffs 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 and in accordance with the Policy for Admissions, Direct or Emergency Dept. Unassigned Patients. 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.

2.3.5 Observation Admissions. *Reserved.*

2.4. Documentation at the Time of Admission:

2.4.1 History and Physical (H & P):

All patients admitted to the hospital or registered for outpatient invasive procedures or who will have moderate or deep sedation or regional or general anesthesia will have a history and physical documented in the medical record in accordance with Appendix B in the Medical Staff Bylaws.

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, if available (patients may be with scant or no prenatal care, or care outside our area, etc). 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 Outpatient 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), an Advanced Practice Provider, 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 or C N M 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, CNMs, APNs and PAs 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 Advanced Practice Provider. 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 or CNM shall be responsible for the appropriate oversight of the clinical services provided to the attending physician's or CNM'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/CNM 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/CNM 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/CNM 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/CNM'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 Providers may perform consultative services under their collaborative practice agreement protocols and in accordance with departmental approval and/or any written policies.

3.2.6. Medical Staff members/CNMs 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 document 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. 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 Staffs are restricted from acting as physician to their immediate family members (relatives such as spouses, parents, siblings, children, grandparent, grandchildren, in-laws) 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. Any exception to this requires approval from the Department Chair and the Hospital CMO or VPMA. The complexities of acting as physician for family members are clearly expressed in AMA Code of Medical Ethics: 1.2.1 "Treating Self or Family" referenced here: Treating Self or Family | AMA-Code.

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:

3.4.3.2 the necessity of the plan/procedure;

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

3.4.3.4 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.

3.4.3.5 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 documented 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 documented into the electronic medical record, handwritten or dictated.

3.7. Informed Consent:

3.7.1. Please refer to the **Virtua Policy on Informed Consent and related policies**

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 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 Staffs.

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 House Physicians or Trainees 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 or Advanced Practice Provider. 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, designee or Advanced Practice Provider 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 or Advanced Practice Provider who dictated the verbal order must authenticate the verbal order by signing his or her name to it in the timeframe delineated in section 5.3.1 of these rules and regulations.

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 telephone / verbal orders are:

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

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

Registered respiratory therapists or **certified respiratory therapy technicians** may accept verbal

Orders from Physicians or Advanced Practice Providers 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 write orders relating to dietary.

Licensed Speech Pathologists may modify food and/or liquid consistencies as deemed appropriate based on Clinical Swallow Assessment, Video swallow study and/or subsequent follow up treatment session. No diet consistency entries or modifications will take place without prior communication with the physician.

For patients on NPO diet, the Speech Language Pathologist will communicate with physician for approval prior to entering or changing a diet consistency.
Licensed speech pathologists may accept verbal orders relating to speech pathology.

Dieticians may accept verbal orders for serum protein levels.

3.10.Outpatient Orders:

3.10.1 Any outpatient services may be ordered by licensed physicians or Advanced Practice Providers who are not members of Virtua's
Medical Staffs with the exception of outpatient chemotherapy.

3.10.2 Outpatient chemotherapy orders require a consultation with a Virtua Medical Staff physician prior to treatment.

ARTICLE IV

DISCHARGE

4.1. General:

4.1.1 Medical Staff members and Advanced Practice Providers 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 or APP. 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, CNM APN, or PA. 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 recognition of the fact that occasional unusual cases may require more than 60 working days for completion, particularly when external consultation is required. If the case is going to exceed 60 working days, there should be documentation of the reason for delay and of ongoing review of 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 or APP 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 or responsible provider 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 or designee 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/CNM 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 (Trainees, House Physicians and APPs) who are credentialed by Virtua are subject to the medical records policies of the Medical Staffs.

5.1.4.1 Trainee Physicians, House Physicians:
The responsible attending physician/CNM shall co-sign with or without attestation 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 within 24 hours

5.1.4.2 Advanced Practice Providers:

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 Emergency Department Encounter Notes - when completed and signed by the Advanced Practice Provider

5.1.4.2.1.2 History and physical – when completed and signed by Advanced Practice Provider;

5.1.4.2.1.3 Consultation – when completed and signed by APP;

5.1.4.2.1.4 Discharge summary – when completed and signed by APP;

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 APP;

5.1.4.2.2.2 Progress notes – when completed and signed by APP;

5.1.4.2.2.3 Orders – when completed and signed by APP; and

5.1.4.2.2.4 Narcotic order – when completed and signed by APP.

5.1.4.2.2.5 Determine cause of death and execute the death certification of a patient when the APP is the primary caregiver and the collaborating physician is not available.

5.2. Access and Retention of Record:

5.2.1 Information about patients will be handled according to applicable Virtua Privacy 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 Staffs 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/CNM 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. Additionally, all post-operative notes are required to be completed within 24 hours of procedure as per Article IX of this document. 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 For medical record deficiencies, excluding post-operative notes, 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 Provider will receive on the 3 week an email notice of “suspension” which

takes effect the following day. The Provider’s name will be placed on the suspended list and their privileges will be automatically relinquished. Such relinquishment shall 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 Post-operative notes that have not been completed within 24 hours of the procedure shall be considered delinquent post-operative notes. Any physician with a delinquent post operative note and the physician’s Department Chair shall be notified of such delinquency. The Department Chair will follow collegial progressive steps with the clinician to resolve. If the clinician continues to not comply with this requirement despite collegial efforts, the

Department Chair, at their discretion, can implement the automatic relinquishment immediately including suspension of operating privileges. The matter will then be referred to the MEC for review as outlined in Article 8 of this document.

5.3.4 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 6.E.2(a)(4) of the Medical Staff and Advanced Practice Provider Credentials Policy. 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.

5.3.5 The President of the Medical Staff, the System Chief Medical Officer, VPMA, Hospital CMOs or their designees may override a relinquishment in the case of emergencies or other justified reasons, as defined in Section 6.E.2(a)(4) of the Medical Staff and Advanced Practice Provider Credentials Policy.

5.3.6 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.

5.3.7 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 Staffs Bylaws and applicable Medical Staff policies.

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 2.A.1(3) of the Medical Staff and Advanced Practice Provider Credentials Policy.

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. Licensed providers delivering care for Obstetrical triage may complete the Medical Screening Exam (MSE) in the Obstetrical unit, and will obtain appropriate consult and/or transfer patients with non-obstetric complaints to the Emergency Department proper as applicable. "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;
(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 qualified anesthesiologist.

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

7.1.1.3 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. "Anesthesia" does not include topical or local anesthesia. Policies regarding moderate (conscious) sedation, are described in Article VIII.

7.1.4 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 Unless infeasible, patients who have received anesthesia in an outpatient setting will be discharged to the company of a designated adult. All patients who have had anesthesia will have a safe discharge plan.

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.

ARTICLE VIII

MODERATE (CONSCIOUS) and DEEP SEDATION by Non-Anesthesia Licensed Providers

8.1. General:

8.1.1 The purpose of this Article is to establish guidelines whereby the administration of minimal and moderate (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 Non-anesthesia providers performing moderate (conscious) and/or deep sedation for procedures and/or diagnostic testing must be credentialed and privileged in accordance with the medical staff credentialing policy.

8.1.3 Please refer to the following policies and procedures which outline the requirements for non-anesthesia providers to provide moderate and/or deep sedation for procedures and/or diagnostic testing.

- Sedation - Care of Adult Patients Requiring Moderate Sedation
- Sedation - Care of Pediatric Patients Requiring Moderate or Deep Sedation for Diagnostic and Therapeutic Procedures by Non-Anesthesia Personnel
- Sedation - Care of Pediatric Patients Requiring Moderate or Deep Sedation for Diagnostic and Therapeutic Procedures by Non-Anesthesia Personnel

8.1.4 This Article is not intended to apply to Anesthesia providers, minimal sedation (e.g. Anxiolysis and/or routine pain management).

8.2. Policies and Protocols:

8.2.1 Moderate (conscious) and/or deep sedation practices throughout the organization will be monitored and evaluated by the Department of Anesthesia as required by CMS.

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

8.2.3 The physician must give the initial dose of sedation and analgesia as required by NJDOH.

ARTICLE IX

SURGICAL SERVICES

9.1 General:

9.1.1 The use of the Operating & Endoscopy Rooms shall be limited to members of the Medical Staff whose privileges include procedures which normally require the use of these rooms. Procedures may be performed in the Operating & Endoscopy Rooms only in accordance with the privileges delineated by the Medical Staff Bylaws.

9.1.1.a The scope and extent of surgical privileges for dentists and podiatrists shall be as specified in the Policy on Appointment, Reappointment and Clinical Privileges.

9.1.2 Non-surgical medical staff members such as radiologists and cardiologists who have been granted the appropriate privileges may also schedule procedures in the Operating & Endoscopy Rooms.

9.1.3 A list of all physicians' surgical privileges will be available on the Colleague Corner (located at https://iprivileges.virtua.org/PrivilegeViewer/ as of the date hereof) for reference by the nursing staff.

9.2 Preoperative Testing

9.2.1 Minimum Testing requirements for surgery shall be as developed by a system wide collaboration of the anesthesia service providers and approved by the Medical Executive committees. It is strongly recommended that all preoperative testing be performed at Virtua. It is the responsibility of the operating physician to provide all appropriate preoperative x-ray and laboratory test reports which have been done outside of the Virtua system.

9.3 Delivery of Service

9.3.1 All history & physicals, consults, reports, and test results should be provided 2 days prior to the procedure, but they **must** be on the chart 1 day in advance of scheduled surgery. . The procedure is subject to cancellation at the discretion of the Medical Director of the Operating Room or designee should these not be available.

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

9.3.3 In the event that the History and Physical has been performed and dictated, but the document

is lost or otherwise fails to reach the chart, the surgeon shall redo the History and Physical. The patient will not be transported 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 and the Medical Director of the Operating Room or designee.

9.3.5 A H&P will be considered current if it was performed within 30 days prior to surgery. A H&P over one day old but within the 30 day window must be updated prior to the case. The update must contain either the changes in medical history or physical exam, or a statement indicating that no changes have occurred

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

9.3.7 **Laterality** must be written as Left or Right on the History and Physical and surgical consent in cases requiring laterality.

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

9.3.9 Consent: Details concerning Informed Consent may be found in Virtua's Consent Policy.

9.3.10 The anesthesiologist will obtain informed consent from the patient or legal representative 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 When an anesthesiologist decides that a case should be canceled or postponed, it is his/her responsibility to discuss the case with the attending surgeon prior to the patient being informed of the cancellation or postponement.

9.3.12 It is the responsibility of the surgeon to initiate a call to the anesthesiologist in charge when booking an add-on procedure during the work week after regular OR hours or over the weekend to discuss the case and procedure classification. The anesthesiologist will then call the nursing supervisor, who will notify the OR call team.

9.3.13 Surgeons should be in the Operating Room suite and ready to commence surgery twenty (20) minutes before the time scheduled. It is the responsibility of the surgeon to check in with the appropriate Preoperative personnel to let them know he/she has arrived. Repeated surgeon lateness will be addressed according to the Virtua Policy on Surgeon Lateness. Markings for verification of surgical site are to be performed in accordance with the Virtua Surgical Site Verification policy.

9.3.13a If a surgeon is unable to be present twenty (20) minutes before a case, the surgeon

should so notify the Operating Room no later than thirty (30) minutes prior to that scheduled time. Attempts will be made to reschedule the case at a time mutually acceptable to the surgeon and the Operating Room. In the absence of such notification, the Operating Room shall be held no longer than fifteen (15) minutes past the scheduled time. Such a delayed case shall be rescheduled at the prerogative of the Director of Surgical Services and the Medical Director of the operating room. The surgeon will be notified of the rescheduling by the Medical Director of the operating room. Should a case be delayed by the Operating Room, the surgeon will be notified at least thirty (30) minutes prior to his/her anticipated arrival time if possible.

9.3.13b Surgeon lateness is defined as the surgeon arriving in the preoperative area less than twenty (20) minutes before a scheduled case. Repeated instances of surgeon lateness will be addressed in accordance with the Policy on Surgeon Lateness.

9.3.14 When cases are scheduled, it is the responsibility of the surgeon to inform the operating room of special services or preparation needed for the patient. The surgeon must also notify the Surgical Services scheduling staff whether an x-ray technician and/or qualified surgical assistant is required for the surgery. It is the surgeon's responsibility to procure or notify the need for a qualified assistant.

9.3.15 Patients may not be transported to the OR unless the attending surgeon is physically in the hospital.

9.3.16 Patients may not be transported to the OR unless the operative site has been marked according to the OR policy on site verification and marking.

9.3.17 Surgery may not commence until a Time Out is performed and documented according to the policy on Time Out.

9.3.18 Patients may not leave the OR until a Surgical Debriefing has been performed and documented according to the policy on Postoperative Debriefing.

9.4 Post-Procedure Protocols

9.4.1 Immediately following each surgical procedure, the surgeon will create a brief post-operative note in the EHR to include:

a. Pre-op diagnosis
b. Post-op diagnosis
c. Procedure(s) performed
d. Name of surgeon/assistants
e. Type of anesthesia
f. Estimated Blood loss if applicable
g. Findings
h. Specimen(s) if applicable
i. Any unusual events in the OR

9.4.2 A complete operative note, detailing the events of surgery, should be electronically created as

soon after a procedure as possible, but in no case later than 24 hours after a procedure. If such a note is created immediately after a procedure, a brief operative note is not necessary.

9.4.3 Surgeons may leave the OR after the 1st sponge and instrument count and the RF scan are correct and all that remains to be done is wound closure, including fascia and skin closure, which they may delegate to another surgeon, resident, or fellow. A surgeon who leaves the OR must remain in the building until the patient enters PACU, to be available to return to the OR quickly if need be.

9.5 Operating area Protocol and permitted personnel

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

9.5.2 a Physician-employed staff if they have been credentialed in accordance with the credentialing Policy of the Medical Affairs Office

9.5.2b Physicians, dentists, podiatrists, nurse anesthetists, physician assistants, nurse practitioners and RNFAs in training. If the training program has a formal affiliation with Virtua, then duties will be in accordance with the Virtua Policies on Graduate Medical Education or Student Activity in the Clinical Setting. If the training program does not have a formal affiliation with Virtua, prior approval must be obtained from the Office of Graduate Medical Education or Office of Academic Affiliations, as applicable, in accordance with its policies. Medical and other (such as biomedical engineering) students are allowed into the Operating Room in accordance with Virtua's Policy on Undergraduate Medical Education.

9.5.2c The surgeon of record will be responsible for the acts of and adherence to all hospital and medical staff policies and procedures by his/her approved assistants or requested observers.

9.6 Physician first assistant requirements

9.6.1 The Medical Staff shall maintain a list of those operative procedures requiring a physician as a first assistant. The physician first assistant must hold appropriate medical staff privileges.

9.6.2 The Medical Staff shall maintain a list of those operative procedures requiring a physician as a first assistant. The physician first assistant must hold appropriate medical staff privileges.

9.6.2a OR cases requiring a physician (attending, resident, fellow) as first assistant:

General/Vascular/Thoracic/Colorectal Surgery:

Whipple procedure
Total pancreatectomy
Major hepatic resection (lobectomy)
Open aortic surgery
Pulmonary embolectomy

Neurosurgery:
Craniotomy for posterior fossa tumors
Trans-sphenoidal surgery

Otolaryngology and Head and Neck Surgery:
Extensive composite cancer resection of the head and neck
Extensive reconstructive maxillofacial surgery

Oral and Maxillofacial surgery:
Surgical correction of major maxillofacial deformities

Plastic and Reconstructive Surgery:
Composite resection of mandible and maxilla combined with neck dissection
Surgical correction of major maxillofacial deformities

Urologic Surgery:
Laparoscopic or open radical nephrectomy
Laparoscopic or open radical cystectomy with urinary diversion
Radical prostatectomy

Transplant surgery:
Liver transplant

9.7 Operating room order entry

9.7.1 During surgical procedures when the performing physician is physically involved in performing the procedure and unable to complete the Order Entry Process the following protocol will be implemented: Nursing staff involved in the care of the patient will obtain order information from the physician verbally for x-rays, medications, or pathology or laboratory examination of specimens obtained from the patient. The nursing staff member will enter the orders into the EHR for x-rays, medications, or for Tissue Pathology, Non-Gyn Pathology, Tissue Pathology Frozen Section, Microbiology and other miscellaneous laboratory testing on specimens or material removed from the patient during surgical and other procedures.

9.8 Tissue processing requirements

9.8.1 All tissues removed at operation shall be sent to the hospital pathology department which shall make such examinations as considered necessary to arrive at a tissue diagnosis. An authenticated report shall be made part of the patient's medical record. The following are exempted from this necessity, but the surgeon may request that these be sent for examination and/or identification:

Cartilage from rhinoplasty and septoplasty
Cataracts
Fat from liposuction
Foreign bodies
Foreskin from circumcision of newborns
Normal placenta

Orthopedic appliances, screws, or plates
Previous surgical scars
Redundant skin from facelifts, abdominoplasties or other plastic surgery procedures.
Teeth: provided the number, including fragments, is recorded in the medical record
Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements
Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary.
Salivary stones
Healthy bone
Removed devices

9.9 Operating Room Scheduling:

9.9.1 The Nurse Director of the Operating Room, in collaboration with the Anesthesiologist Charge Physician or designee shall be in complete charge of the daily Operating Room schedule.

9.9.2 Block time: will be awarded, monitored, and adjusted according to the Virtua Policy on Block Time Management.

9.9.3 Urgent/Emergent cases may be scheduled at any time, but will be done at a time suggested by the Nurse Director of the Operating Room in conjunction with the Medical Director of the OR and the surgeon. If more than one emergency should arise, the order of surgery will be determined by the Medical Director of the OR in consultation with the surgeons involved.

9.9.3.1 Exception, Virtua Willingboro hospital- Urgent/Emergent cases during off hours (nights after 1530, weekends, and holidays) must be transferred to an accepting provider at another hospital capable of performing the procedure.

9.9.4 If an emergency requires "bumping" a scheduled procedure, it is the responsibility of the operating surgeon to notify the surgeon whose case is being "bumped" and obtain his/her consent to this. In the event of disagreement, priority shall be determined by the Medical Director of the OR.

ARTICLE X

GRADUATE, UNDERGRADUATE MEDICAL EDUCATION AND TRAINEE SUPERVISION

10.1. General:

10.1.1 This Article sets out the requirements for participants in Medical Education programs at Virtua.

For purposes of this section, Trainees are defined as:

10.1.1.1 Fellows: Completed training in and are Board eligible/certified in a primary specialty (i.e.-Internal Medicine for Cardiology), but require supervision for the advanced elements of the fellowship program in which they are training. Fellows may have an unrestricted license. In which case they may write prescriptions in electronic medical record or on appropriate health system prescription pads and in accordance with Virtua policy as well as State and Federal regulations. Fellows functioning on a New Jersey training permit must have discharge prescriptions filled in hospital pharmacy or be co-signed by the supervising physician.

10.1.1.2 Residents: are graduates of medical school. They are authorized by the State to participate in patient care (registration or permit). Residents can evaluate patients and write all orders including testing and medications. Residents participate in and perform invasive procedures for which varying levels of supervision are required based on documented level of competency for each Resident. Residents' discharge prescriptions must be filled in hospital pharmacy or be co-signed by the supervising physician.

For purposes of this section, Students are defined as:

10.1.1.3 Students currently enrolled in a school (Medical, CNM and Advanced Practice Provider): are supervised. Students can evaluate patients and do limited physicals (excludes breast/pelvic/rectal unless directly supervised). Students cannot write orders except as defined by the UME policy.

10.1.2 The Medical Director of Medical Education / Designated Institutional Official (DIO) is responsible for oversight of all medical education programs, reviewing issues within programs and assuring program and Medical Staff compliance with institutional regulatory guidelines.

10.1.2.1 The Medical Director of Medical Education / DIO will chair the Graduate Medical Education Committee, ("GME") which has representation from the QSC, the Virtua Medical Staffs, the teaching faculty and the training program.

10.1.2.2 The Graduate Medical Education Committee will be ultimately responsible for oversight of all GME program activities, provision of patient care, including safety, and quality of care, as well as the related educational and supervisory

needs of the participants in the graduate educational programs.

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

10.1.4 The Medical Director of Medical Education / DIO will be responsible for communicating the proceedings of the GME 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 Medical Education / DIO will present in writing to the QSC and to the MEC the names of the Trainees who have been promoted as well as the level of responsibility and authority granted to, and any restrictions or limitations placed on, the role of any Trainee.

10.1.6 All of these tasks will be coordinated by the Office of Medical Education. All Resident and Fellows (Residents and Fellows are referred to throughout this document as "Trainees") in GME programs who are working with any providers within Virtua's inpatient facilities or Virtua-owned practices shall be supervised by their individual program with coordination from this office.

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

10.2.1 All Trainees will be supervised by a licensed member of the Virtua Medical Staffs who possesses privileges in the area being supervised, in accordance with both Joint Commission standards as well as policies of the national oversight body of that program.

10.2.2 All supervising physicians must follow the regulatory procedures and protocols of Virtua as well as the policies of the training program.

10.2.3 In advance of the Trainee's clinical experience, all direct supervisors and the relevant hospital staff, will receive either in writing or by posting to the Virtua intranet, the descriptions of the Trainee's roles, responsibilities, learning objectives, and approved patient care activities.

10.2.3.1 Such descriptions for Trainees at Virtua will be provided by the appropriate Residency/Fellowship Program Director in consultation with the Medical Director of Medical Education / DIO.

10.2.3.2 External sponsors who are sending Trainees to Virtua must provide the Office of Medical Education with a written description of the goals and objectives of the rotation, as well as a detailed list of expected and approved Trainee activities, including anticipated level of authority/responsibility and documentation of procedural competency. Such descriptions will then be reviewed by the Office of Medical Education and forwarded to the appropriate Medical Staff members.

10.2.4 Trainee schedules will be supplied by the Office of Medical Education either in writing or by posting to the intranet site, to the appropriate, supervising Medical Staff offices and relevant areas of all hospital or ambulatory settings.

10.3. Responsibilities of GME Trainees and Students within Virtua:

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

10.3.2 Trainees and Students are expected to comply with all Medical Staff Rules and Regulations, as well as all policies of the program they are participating in.

10.3.3 Trainees' orders:

10.3.3.1 All orders written by Trainees in GME programs must comply with all Medical Staff's Rules and Regulations and the Medical Records Policies.

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

10.3.3.3 Students cannot write orders except as defined by the UME policy.

10.3.4 Trainee documentation:

10.3.4.1 Trainees who are involved in care for a patient are expected to follow medical record policies regarding appropriate completion and content of history and physicals, as well as subsequent documentation.

10.3.4.2 All Trainees, who are involved in a patients' care, are required to write an original documentation daily in the electronic medical record for their assigned patients. This progress note must include, at minimum, the patient's current condition, presenting and on-going symptoms/complaints, the reason for continued hospitalization, the treatment plan, and short-term and long- term goals. 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 following appropriate Virtua electronic medical record policies.

10.3.4.3 Operative and delivery reports may be documented in the electronic medical record (strike written or dictated) by the Trainee who was involved in the care of the patient and must be countersigned by the attending physician within 24 hours.

10.3.4.3.1 The report by the Trainee 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 Trainees may perform consultations.

10.3.4.4.1 Non-operative orders can be processed after the Trainee has communicated with the attending consultant.

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

10.3.4.4.3 The patient must be seen personally and the consult countersigned by the attending consultant who is supervising the Trainee before any operations or procedures are performed. Exceptions to this requirement are for procedures for which the Trainee has documented competency as noted in the GME programs policy.

10.3.4.5 Trainees who are providing care for hospitalized patients on the primary service of record may perform discharge summaries for the attending physician. The attending is responsible for the content and countersignature of those discharge summaries.

10.4.Supervising Physician's Responsibilities:

10.4.1 The Medical Staffs must comply with all accreditation guidelines of individual GME programs as they pertain to the supervising physician's role in overseeing a Trainee' activities. This includes provisions for when supervision must be direct as well as situations when it may be indirect.

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 Trainees 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 Trainees on an obstetrical rotation.

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

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

10.4.3 No patients should be taken to the Operating Room without first being evaluated by the attending physician unless the patient requires an emergent procedure, in which case patients

may be evaluated by Trainees in accordance with GME program training policy and oversight.

10.4.4 Trainees 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 more than two overlapping procedures.

10.4.4.3 For any "scopic" procedures, the teaching physician must be present for the entire procedure. **Exceptions to this requirement are for patients requiring an emergent procedure for which a delay may pose an undue threat to life or limb and for procedures which the Trainee has documented competency as per the individual GME training programs policy. Please refer to program GME policy for procedure specifics.**

10.4.5 Supervising Physician's Documentation:

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

10.4.5.1.1 The supervising physician's progress note must indicate that the Trainee's note was reviewed, contains all required/necessary elements and was amended/corrected as appropriate.

10.4.5.1.2 Simple countersignature of Trainee notes is not acceptable.

10.4.5.2 All entries by a Trainee into the medical record must be reviewed, countersigned, dated, and timed within 24 hours.

10.4.5.3 DNR/DNI orders entered by a Trainee must be countersigned and a relevant progress note written by an attending physician within 24 hours.

10.4.6 The Medical Staffs must comply with all Medicare rules regarding billing when care involves Trainees, including any required medical records compliance.

10.4.7 Supervising Physician Evaluations:

10.4.7.1 Supervising physicians are obligated to provide timely direct feedback to Trainees and complete written evaluations requested by the trainees' program. Evaluations should be completed as soon as possible, but no later than 2 weeks after completion of the training experience. Failure to do so may jeopardize the ability of the supervising physician to continue to participate as a teaching attending.

10.4.7.2 Supervising physicians working with Trainees have a responsibility to inform the Trainee's program of any critical incidents that occur within 24 hours of the event.

10.4.7.2.1 Critical incidents may initially be reported verbally, but must be subsequently documented in writing to the training program and the office of Medical Education and, must also be documented, in the Virtua electronic event reporting system.

10.4.7.3 Supervising physicians have a responsibility to assure a Trainee's 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 training program immediately.

10.4.7.3.1 Quality and competency issues must be communicated in writing to the training program as well as the Office of Medical Education.

10.5 <u>Medical Students and Advanced Practice Provider students (doing rotations at Virtua)</u>

10.5.1 All Students must be directly supervised in all patient care activities. Direct Supervision may be performed by a medical staff credentialed physician, Advanced Practice Provider, or by an approved GME Trainee with the attending physician/CNM supervising indirectly.

10.5.2 A supervising physician / CNM may delegate some medical student teaching and supervising responsibilities to non-physician care providers after ensuring the non-physician providers are appropriately credentialed and working within the scope of their practice.

10.5.3 Students may enter notes in the electronic medical record utilizing the approved Student note templates. All student notes must be reviewed, amended for accuracy, and countersigned by the attending physician with feedback given to the Student.

10.5.4 Information documented in Student notes may not be utilized for medical decision making or for billing and may not be copied into other notes except as noted in the UME documentation policy.

Refer to UME policy for specific information and restrictions on student documentation.

ARTICLE XI

VIRTUA INSTITUTIONAL REVIEW BOARDS

11. General

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 Institutional review board requirements

11.2.1 The Board has established three 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 – Our Lady of Lourdes, Virtua – Willingboro, 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 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. Additionally, the Virtua IRBs have the authority to permit the use of central IRBs. 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 Physician principal investigator responsibilities

11.3.1 Physicians acting as principal investigators must comply with and ensure that all study personnel 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 at856- 761-3844. 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

DUES AND SPECIAL ASSESSMENTS

12.1 Dues:

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

12.1.1.1 Members practicing in more than one Division will pay dues to the primary and secondary Division.

12.1.2 In accordance with the Medical Staffs Bylaws, dues shall be paid as follows: Active Staff Full Dues, Associate Staff Full Dues, Affiliate Staff Full Dues, and Adjunct Practitioners Full Dues

12.1.2.2 Honorary Staff members are not required to pay dues.

12.1.2.3 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).

12.1.3 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.

12.1.4 Dues will be prorated for new appointments to the Medical Staffs 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.

12.1.5 No refunds for Medical Staff dues will be made.

12.1.6 Non-payment of Medical Staff dues and/or special assessment will result in automatic suspension of staff membership until such time as dues are paid. Notice of such delinquency

and suspension will be sent by email the first week of February. Suspension notices will be sent by email on February 15th or the next business day. Certified mail, return receipt will be sent March 15th of each year. 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 Staffs. ***Any physician who has not made payment on April 15th or the next business day, will be automatically removed 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 Staffs.

12.1.7 Advanced Practice Providers will be charged an annual assessment to be determined by the Executive Committee(s)

12.2 Special Assessments:

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

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

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

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

12.3 Bank Transaction/Account Procedures:

12.3.1 All monies collected pursuant to these Rules and Regulations will be deposited in the Medical Staff Fund.

12.3.2 Transactions related to the Fund may only be carried out by the President, Vice-President, and Secretary-Treasurer of the Medical Staffs. 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 Staffs.

ARTICLE XIII

AMENDMENTS

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