# RULES AND REGULATIONS OF THE

# MEDICAL STAFF

# ATLANTICARE REGIONAL MEDICAL CENTER

**Approved by the Board 12/8/22**

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Defined terms used in these regulations are defined in the AtlantiCare Regional Medical Center Medical Staff Bylaws.

# DEFINITIONS

1. Advanced Practice Provider or APP means an advanced practice nurse ("APN"), physician assistant ("PA"), certified nurse midwife ("CNM"), or other licensed or certified individual who collaborates or consults with, or practices under the supervision and direction of a Physician.

2. APN means an advanced practice nurse.

3. Associated Physician means a collaborating physician as to an APN, a supervising physician as to a PA, and a consulting physician as to a CNM.

4. Board of Governors or Board means the governing body of the Hospital.

5. Chief Executive Officer means the individual appointed by the Board of Governors to act on its behalf in the overall administrative management of the Hospital, or his designee.

6. Clinical Privileges or Privileges means those services and procedures which the Medical Staff has determined, with the approval of the Board, that a Practitioner or APP may provide to patients of the Hospital. Clinical Privileges are separate and distinct from Membership.

7. Days means calendar days.

8. Direct Communication/Communicate Directly means Physician to Physician interaction either verbally or in person.

9. Ex officio means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

10. Executive Committee means the Executive Committee of the Medical Staff.

11. Hospital means the AtlantiCare Regional Medical Center.

12. Medical Staff or Staff means the formal organization of all Practitioners who are privileged to attend and/or visit patients in the Hospital.

13. Membership or Member, unless otherwise indicated, means that status with the Medical Staff as determined by the Medical Staff with the approval of the Board, which defines a Practitioner's rights, prerogatives and responsibilities to participate in the Medical Staff organization.

14. Oral Surgeon means an individual who is licensed to practice dentistry in the State of New Jersey and is board-certified in Oral and Maxillofacial Surgery.

15. Physician means an individual who is licensed to practice medicine, osteopathic medicine, dentistry or podiatry in the State of New Jersey.

16. Physician Designee means a Physician in the same specialty with comparable privileges as the Attending Physician.

17. Practitioner means, unless otherwise expressly limited, any Physician or Psychologist applying for or exercising Clinical Privileges in the Hospital.

18. Provider means, unless otherwise expressly limited, all Physicians, Psychologists and APPs.

19. Specified Professional Personnel means individuals who qualify as APPs.

20. Chief Medical Officer means the medical officer appointed by the Board who has primary responsibility for liaison between the Medical Staff and the Hospital administration.

21. Written Notice means written notification sent by hand delivery with a signed receipt, certified mail, return receipt requested, or a commercial delivery service which obtains a signed receipt upon delivery.

22. These Rules and Regulations apply with equal force to both sexes. For convenience only, the masculine gender has been used throughout. Use of the masculine gender shall not be interpreted as excluding the feminine. The singular shall be read to include the plural and vice versa, as the context permits. The captions or headings are for convenience only and none shall be interpreted as limiting, defining the scope of, broadening or affecting any substantive provision.

## Article I

## Admission of Patients

1.1. Types of Patients

The Hospital admits patients for care and treatment without regard to race, creed, color, sex, sexual preference, national origin, or source of payment. Admission of any patient is contingent on adequate facilities and personnel being available to care for the patient, as determined by the Chief Executive Officer after consultation with the applicable Department Chairman.

1.2. Admitting Prerogatives

1.2-1. Generally

Only a Member in good standing of the Active or Senior Medical Staff may admit a patient to the Hospital, subject to the conditions provided below and to all other official admitting policies of the Hospital as may be in effect from time to time. Notwithstanding the foregoing, only AtlantiCare Hospitalists may admit adult medical patients not admitted to Cardiology, Critical Care, Pediatrics, Obstetrics, Perioperative Hospitalists, Psychiatrists or a Surgical Service. Only intensivists may admit patients into the ICU.

1.2-2. Attending Physician

The Physician to whose service a patient is admitted is the attending Physician responsible for managing and coordinating the patient's care at the Hospital. The attending Physician shall issue or review and approve all orders for diagnostic or therapeutic procedures, drugs or other services, referrals for consultations, transfers of responsibility, and discharge orders; and review all entries present in the patient's medical record, at the time of record completion.

1.2-3. Dentists, Oral Surgeons and Podiatrists

Dentists, Oral Surgeons and Podiatrists may admit patients to the Hospital and may be the attending Physician but, except as provided below or as set forth in the Medical Staff Bylaws to the contrary, a Physician Member of the Staff shall perform a basic medical appraisal (including history and physical examination) for each dental, oral surgery and podiatric patient and shall perform an evaluation of the risk of the procedure to the patient's health. An Oral Surgeon with the requisite qualifications may be granted the privilege of performing an admission history and physical examination and assessing the medical risks of the proposed procedure to the patient. A Podiatrist with the requisite qualifications may be granted the privilege of performing pre-surgical history and physical examinations and assessing the medical risks of the proposed procedure to the patient.

1.3. Restricted Bed Use Areas

Areas of restricted bed utilization and assignment of patients are as follows: all critical care units, step down units, the pediatric special care unit, the neonatal intensive care unit, inpatient psychiatric unit, psychiatric intervention program and the maternity unit.

1.3-1. Questionable Cases

Questions regarding admission to or discharge from any of the units listed in §1.4 shall be referred to the Unit director or Physician in charge, or to the applicable Department Chairman.

1.3-2. Deviation from Rules

When deviations are made from the rules governing assignment to restricted bed use areas, the attending Physician shall be notified and shall arrange for the transfer of the patient to the appropriate unit or Service as soon as possible, in keeping with the transfer priorities set forth in the critical care policies.

1.4. Admission Information

Except in an emergency, a patient will not be admitted to the Hospital until a provisional diagnosis or valid reason for admission is provided by the Physician requesting admission. The admitting Physician is also responsible for providing any available information about the patient concerning any source of communicable or significant infection, behavioral characteristics that could disturb or endanger others, or any need for protecting the patient from self-harm.

1.5. Timely Visitation After Admission

The attending Physician or Physician Designee shall see the patient within the time frames provided below or within a shorter time if the patient's condition requires it:

(a) Patients admitted directly to or transferred into an intensive or coronary care area -- by a Physician, APN, or CNM, or by a PA with the supervision of the Attending Physician – within four (4) hours;

(b) Patients admitted via the emergency department to a general care area -- within eighteen (18) hours which may be extended to twenty-four (24) hours if seen by an intern, resident or APP within eighteen (18) hours;

(c) Elective admissions -- within twenty-four (24) hours;

(d) Newborns -- within twenty-four (24) hours; and

(e) Patients under eighteen (18) years of age admitted to a Medical Critical Care Unit - - pediatrics consultation is mandatory within twenty-four (24) hours.

1.6. Timely Visitation after Assignment to Observation Unit

The Attending Physician, Physician Designee or Advanced Practice Nurse shall see the patient assigned to observation status within eight (8) hours and shall seek consultation as set forth in §3.5-4(e).

## Article II

## Assignment and Attendance of Patients

2.1. Attendance of Patients

2.1-1. Patients with Current Staff Physicians

Adult medical patient admissions, other than patients admitted to Cardiology, Critical Care, Pediatrics, Obstetrics, Perioperative Hospitalists, Psychiatry or a Surgical Service (hereinafter "Medical Patient Admissions"), shall be admitted by and attended by an AtlantiCare Hospitalist. With respect all other admissions, and consistent with the conditions of §2.2 below, each patient under the current care of a Physician will be attended by that Physician or Physician designee, if desired by the patient, provided the Physician is a Member of the Medical Staff and has admitting privileges. A patient applying for admission that previously was a Hospital patient and signed out against medical advice (AMA) is not considered to be under "current care." Consultants may not decline to be consulted on patients they have treated within the previous six (6) months unless such patient was discharged from the Physician's practice under the rules of the New Jersey Board of Medical Examiners.

2.1-2. Patients without Personal Physicians on Staff

Other than for adult Medical Patient Admissions who shall be assigned as set forth in§2.1-1, patients having no personal Physician shall be admitted by and attended to by an AtlantiCare Hospitalist. In such event, the patient may request any Physician who is a Member of the Medical Staff who has the appropriate Clinical Privileges. When no such request is made, or when the requested Physician chooses not to undertake the care of the patient, a Member of the Active Medical Staff with the requisite Clinical Privileges will be assigned to the patient according to the on-call schedule of the applicable Department or Division. An on-call Physician may not refuse assignment of a patient on the basis of inability to pay or source of payment. Patients who are members of a managed care organization which requires care only by attending Physicians who are contracted with the organization shall be assigned to that organization's designated on-call Physician, if any.

2.2. Responsibilities of Participation in the On-Call Roster

Unless specifically exempted by the Executive Committee for good cause shown, each Member of the Active Medical Staff agrees that, when he is the designated Physician on-call, he will accept responsibility, in accordance with the rules of his Department or Division, during the time specified by the published schedule for providing care to any patient in any unit of the Hospital referred to the service for which

he is providing on-call coverage. If the Physician who is assigned has a conflict with the published schedule, it is the Staff Member's responsibility to arrange appropriate substitute coverage and notify the Emergency Department prior to the beginning of the assigned call coverage period.

## Article III

## General Responsibility for and Conduct of Care

3.1. Generally

A Member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completion and accuracy of those portions of the medical record for which he is responsible and for transmitting reports of the condition of the patient to the referring Physician, if any, and to the family of the patient. Such Member shall be responsible for the management and coordination of the patient's general medical condition and the overall care, treatment and services provided to the patient in the Hospital. Primary responsibility for these matters belongs to the admitting Physician except when transfer of responsibility is effected pursuant to §3.2. Privacy and confidentiality of patient records is maintained per HIPAA regulations.

All patients are to be seen by the Physician or his authorized Physician Designee within twenty-four (24) hours of admission or as delineated in Section 1.5. Thereafter, the patient must be seen by the Physician or his authorized Physician Designee at a minimum every other day, or more often as set forth in the Change of Patient Status policy, provided that the patient is seen by an APP on those days when not seen by the Physician or his authorized Physician Designee.

3.2. Transfer of Responsibility

When the attending Physician seeks to transfer a patient to the care of another Staff Member, the transferring Practitioner shall communicate directly with the accepting Physician and shall document the transfer and acceptance of responsibility in the medical record.

3.3. Alternate Coverage

Each Physician shall assure timely, adequate professional care for his patients in the Hospital by being available or designating a qualified alternate Physician with whom prior arrangements have been made and who has the requisite Clinical Privileges to care for the patient.

3.3-1. Coverage by Advanced Practice Nurses (APN)

If a Physician utilizes an APN for call coverage, the Physician must be able "to attend a patient in person within thirty (30) minutes under normal traveling conditions when on call" (§4.2, Bylaws). Otherwise he shall designate a Physician Designee with whom prior arrangements have been made. The attending Physician shall communicate directly with the Physician Designee and shall document the same in the medical record.

3.3-2. Assignment of Alternate Coverage

In the absence of such designation, the President of the Medical Staff of the applicable Department Chairman has the authority to call any Member of the Staff with the requisite Clinical Privileges.

3.3-3. Enforcement

Failure of an attending Physician to meet the requirements of §3.3 may result in loss of Staff Membership or such other disciplinary action as the Executive Committee deems appropriate.

3.4. Dentists, Oral Surgeons and Podiatrists

Dentists, Oral Surgeons and Podiatrists may admit patients under the conditions provided in §6.3-3 and 6.3-4 of the Medical Staff Bylaws and in §1.2-3 of these Rules and Regulations. Each Dentist, Oral Surgeon and Podiatrist is responsible for documenting in the medical record, in timely fashion, a complete and accurate description of the services he provides to the patient, including the following:

(a) A detailed history and description of the problem documenting the need for hospitalization and any surgery;

(b) A detailed description of the examination of the patient's problem and a pre-operative diagnosis;

(c) A complete operative report, describing the findings, technique, specimens removed and postoperative diagnosis;

(d) Progress notes as are pertinent to the patient's condition;

(e) Pertinent instructions relative to the condition for the patient and/or "significant other" at the time of discharge; and

(f) Discharge summary.

3.5. Consultations

3.5-1. Responsibility

The attending Physician is primarily responsible for calling a consultation from a qualified Practitioner when indicated or required pursuant to the guidelines in §3.5-3 below. Consultations may also be called by interns, residents and APPs after discussion with the attending Physician. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending Physician.

3.5-2. Imposed Consultations

When a consultation is required under these Rules or when the best interests of the patient will be served, any of the following may direct that a consultation be performed and, if necessary, arrange for it: the applicable Department Chairman; the Physician director of a special unit; the President of the Medical Staff. If the attending Physician disagrees with the necessity for consultation, the matter shall be brought immediately to the attention of the President of the Medical Staff or the applicable Department Chairman for final decision and direction.

3.5-3. Guidelines for Required Consultations

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

(a) When any patient is known or suspected to be suicidal, or has taken an intentional chemical overdose, a psychiatric consultation shall be required;

(b) When any patient exhibits behavioral symptoms requiring treatment or demonstrates a significant change in behavioral status, a psychiatric consultation shall be required;

(c) When these Rules or the rules of any clinical unit, including any intensive or special care units, or of the Staff require it;

(d) When required by state law;

(e) When requested by patient or family and clinically pertinent;

(f) When required as a condition of delineated Clinical Privileges; and

(g) In a case in which a suspected normal pregnancy may be interrupted an obstetric consultation shall be required.

3.5-4. Qualifications of a Consultant

A qualified Provider on the Active, Senior, or APP Staff, may be called as a consultant pursuant to the terms of this provision. A consultant shall be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty Board or by a comparable degree of competence based on equivalent training and extensive experience. A consultant may be qualified on the basis of knowledge of a specific patient. The Executive Committee shall determine which specialties may utilize Telemedicine consultants. The procedures applicable to Physicians answering call from the Emergency Department shall not be governed by this provision, but instead shall be governed by the Medical Staff On Call Policy.

(a) Consultation Request: When requesting consultation the attending Physician, APP, intern or resident shall indicate in writing on the order sheet or on the consultation record the reason for the request, the time

frame in which consultation is required, and the extent of involvement in the care of the patient expected from the consultant.

(b) Inpatient Routine Consultations: Consultant Providers shall respond to routine inpatient consultations within twenty-four (24) hours. The request for consultation may be initially answered by a resident on the consultant's service or by an APP. If the request for consultation was answered by a resident or APP, a consultant Physician shall see the patient requiring consultation within twenty-four (24) hours, either in-person or via Telemedicine if the Executive Committee has determined that the specialty may use Telemedicine consultants or using Telehealth if the consultant Physician has been permitted to use a Telehealth modality.

(c) Inpatient Urgent Consultations: Consultant Providers shall respond to urgent inpatient consultations within fourteen (14) hours. The request for consultation may be initially answered by a resident on the consultant service or by an APP. If the request for consultation was answered by a resident or APP, a consultant Physician shall see the patient requiring consultation, within fourteen (14) hours either in-person or via Telemedicine if the Executive Committee has determined that the specialty may use Telemedicine consultants or using Telehealth if the consultant Physician has been permitted to use a Telehealth modality. Urgent consults should be made Provider to Provider.

(d) Inpatient Emergent Consultations: If an inpatient consultation is required emergently, there should be direct communication with the on-call consultant. The consultant shall respond by telephone within twenty (20) minutes of receiving a call from Hospital clinical staff. If the treating Physician wishes to present a patient to the on-call consultant Physician, the need and the time frame for an in-person emergent consultation shall be determined by the treating Physician and shall be directly communicated to the consultant by the treating Physician. If the treating Physician and the consultant Physician are unable to reach an agreement as to an appropriate in-person response time for the consultant Physician, then the opinion of the treating Physician shall govern. The consultant Physician shall have the ability to appear in person within the timeframe that is applicable to him or her in the context of Emergency Department call. The treating Physician may determine that a consultant's in-person response time may be greater than, but not shorter than, the timeframe applicable to him or her in the context of Emergency Department call. The request for an inpatient emergent consultation may be initially answered by a resident on the consultant's service, but may not be answered by an APP.

(e) Outpatient Observation Status Consult: The consultant Provider shall respond to consultations within sixteen (16) hours either in-person or via Telemedicine if the Executive Committee has determined that the

specialty may use Telemedicine consultants or using Telehealth if the consultant Provider has been permitted to use a Telehealth modality The request for consultants to observe patients, shall include a notification to the consulting Provider that the patient is subject to observation status.

(f) Consultant's Report: The consultant shall examine the patient and the medical record and shall make and sign a report of his findings, opinions and recommendations on the form designated for consultation reports. The report shall become part of the patient's medical record. Re-consultation during the same admission may be documented in the progress notes or on the consultation report.

(g) Attending Physician's Response to Consultant's Opinion: In cases of required consultation as under §3.5-3, when the attending Physician does not agree with the consultant, he shall either seek the opinion of a second consultant or refer the matter to the consultant's Department Chair for advice. In cases of elective consultation, when the attending Physician elects not to follow the advice of the consultant, he shall either seek the opinion of a second consultant or record in the progress notes his reasons for electing not to follow the consultant's advice.

(h) Operative Procedures: When operative procedures are involved, except in emergency, the consultant's notes shall be recorded prior to the operation.

(i) In-Person Consultations following Telemedicine Consults. In-person consultations following Telemedicine consultations shall be conducted in accordance with the Hospital's Telemedicine consultation policy.

3.6. Returning Patient Related Calls/Pages

It is the responsibility of each Practitioner and APP to timely respond to calls and pages about patients regardless of whether such calls originate from other Staff members, nursing, social work, etc. and regardless of whether such calls are with respect to the Practitioner or APPs own patients or the patients they are covering. Each Practitioner and APP shall be responsible to ensure that they check their messages and instruct their answering services to promptly route calls. It is the expectation that Practitioners and APPs shall return all patient calls and pages within thirty (30) minutes. All Practitioners and APPs shall utilize secure messaging technology.

3.7. Completion of Diagnostic Testing Teaching Staff Obligation

There shall be voluntary Teaching Staff and non-Teaching Staff within Departments involved in the training of residents. Members of the Teaching Staff will be appointed by the Office of Graduate Medical Education in accordance with RRC guidelines and will carry out teaching assignments designated by the Program Director. Teaching Staff may be required to attend and supervise the Resident Staff in the Ambulatory Care Clinic and other ambulatory settings at the discretion of the Program Director. Periodic review of teaching performance shall be carried out by the Program Director.

3.7-1. Medical Staff participation in a teaching program is voluntary

Medical Staff appointment and privileges shall not be affected if a Medical Staff Member chooses not to participate in a teaching program.

3.8. Psychiatric and Substance Abuse Services

The Medical Staff shall have a policy addressing multidisciplinary treatment plans for psychiatric patients and the need for Physician approval of such plans.

3.9. Observation Status

Patients requiring additional observation but not meeting the criteria for acute care admission may be placed in observation status. Observation status will be assigned only where diagnosis, treatment, stabilization and release from observation can reasonably be expected within twenty-four (24) hours. Patients in observation status will be managed by APNs or Attending Physicians.

## Article IV

## Transfer of Patients

4.1. Documentation of Internal Transfer

When the attending Physician seeks to transfer a patient from one service in the Hospital to another, he shall write an order for transfer and Directly Communicate with the accepting Physician. All orders are cancelled at time of transfer, and new orders shall be written by the attending Physician. However, transfers within equivalent units, regardless of whether inter- or intra-division, do not require new orders.

4.2. Transfer to Another Facility

A patient shall be transferred to another medical care facility only upon the order of the attending Physician, after arrangements have been made for admission with the other facility, including its consent to receiving the patient by Direct Communication with the receiving Physician or designee, and after the patient is considered sufficiently stabilized for transport. Pertinent medical information necessary to insure continuity of care shall accompany the patient.

4.3. Compliance with EMTALA

All Members of the Medical Staff and APPs shall comply with the requirements of EMTALA and with Hospital policies regarding EMTALA, as they may be amended from time to time. Neither the Hospital, the Medical or Affiliate Staff or Practitioners may impose sanctions, coerce, intimidate, and/or retaliate against any person for reporting an EMTALA violation and/or assisting with an investigation pertaining to EMTALA. The Hospital, the Medical and Affiliate Staff and all Practitioners shall comply with the Hospital's whistle-blower policy.

## Article V

## Discharge of Patients

5.1. Required Order

Patients shall be discharged only upon the order of the attending Physician, resident or intern, duly authorized within this Hospital to do so, at the direction of the attending Physician.

5.2. Leaving Against Medical Advice

If a patient desires to leave the Hospital against the advice of the attending Physician or without proper discharge, the attending Physician shall be notified and the patient will be requested to sign the appropriate release form, attested by the patient or his legal representative and witnessed by a competent third party. If a patient leaves the Hospital against the advice of the attending Physician or without proper discharge, a notation of the occurrence shall be made in the patient's medical record which includes documentation of any discussion concerning the risks of the inappropriate discharge.

5.3. Discharge of Patients Who Cannot Consent

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, authorized surrogate decision-maker, person standing in loco parentis, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction except for newborn infants (see below). If the parent or guardian directs that discharge be made otherwise, he shall so state in writing, and the statement shall be made a part of the patient's medical record.

For newborn infants the discharge procedural guidelines in the NICU-Step-down-Newborn Unit will be followed.

## Article VI

## Orders

6.1. General Requirements

All orders for treatment or diagnostic tests shall be written clearly, legibly and completely and timed, dated and signed by the Practitioner, intern, resident or APP responsible for them. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "Repeat," "Resume," "Renew" or "Continue" orders by themselves is not acceptable. Orders for diagnostic studies which necessitate the administration of substances or medications will be considered to include the order for administration.

6.2. Standard Orders

Standard orders for any department or other clinical unit may be recommended by the Department Chair or Physician Director of a unit (after consultation with nursing) to

the Pharmacy and Therapeutics Committee. Standard orders shall utilize the most current format approved by the HIM Department. Standard orders shall be signed, dated and timed by the attending Physician or APN. Standard orders shall be considered a specific order by the attending Physician or APN for that patient and shall be followed in the absence of other specific orders, insofar as the proper treatment of the patient will allow. Standard orders shall be reviewed by the Pharmacy and Therapeutics Committee at least annually and revised as necessary.

6.3. Pre-Printed Orders

Pre-printed Physician or APP orders on AtlantiCare Regional Medical Center designated hospital forms which are individually prepared by a Member of the Medical or Affiliate Staff for a specific patient are considered acceptable as written orders and are not considered Standard Orders.

6.4. Verbal Orders

6.4-1. Acceptance

Emergency verbal orders may be accepted and recorded only by a registered nurse or, in an outpatient setting, by properly trained licensed practical nurses, except that physical therapy orders may be accepted and recorded by a licensed physical therapist, drug orders may be accepted and recorded by a pharmacist, respiratory therapy orders may be accepted and recorded by a respiratory therapist, dietary orders may be accepted and recorded by a registered dietitian or registered dietitian nutritionist, diagnostic radiology orders may be accepted and recorded by radiologic, nuclear medicine, ultrasound and MRI technologists, and orders for laboratory tests may be accepted by laboratory technologists. Social work consults may be accepted by licensed social workers. Licensed Practical Nurses may not accept verbal orders. Telephone orders will be accepted only from the responsible Practitioner or APP, and only when it is not practical for the order to be given in writing. To assure accuracy of transcription of verbal and telephone orders, all such orders will be "read back" by the receiver for verification.

6.4-2. Documentation

All verbal orders shall be transcribed and placed in the medical record, shall include the date, time, name and signature of the person transcribing the order and the name of the individual giving the order, and shall be authenticated by the prescribing individual or covering Practitioner, intern, resident, or APP within forty-eight (48) hours. All verbal order documentation and authentication shall comply with the provisions of Article VII of these Rules and Regulations.

6.4-3. Hazardous Verbal Orders

All verbal orders for restraints, seclusion, and DNR ("Do Not Resuscitate") must be authenticated (countersigned), timed, and dated within twenty-four (24) hours by the attending Physician or Physician Designee.

6.5. Orders by Advanced Practice Providers

6.5-1. Advanced Practice Nurses

Except for admission orders, which require countersignature, orders written by Advanced Practice Nurses within the scope of their licensure, practice and Clinical Privileges do not require a countersignature.

6.5-2. Certified Nurse Midwives

Orders written by CNMs within their scope of license, practice, and Clinical Privileges do not require countersignature.

6.6. Physician Assistants

6.6-1. Orders by Physician Assistants

Orders may be written by Physician Assistants within the scope of their licensure, Clinical Privileges, and delegation agreement. Orders written by Physician Assistants do not require countersignature by the Associated Physician unless the Physician Assistant's delegation agreement provides otherwise. Notwithstanding, admission orders written by PAs require countersignature.

6.6-2. Orders by Interns and Residents

Orders by interns and residents shall be authenticated (countersigned) by the trainee's supervising Physician. Hazardous verbal orders must be authenticated (countersigned) and timed and dated by the attending Physician or by his Physician designee within twenty-four (24) hours.

6.7. Orders by Registered Dietitians and Registered Dietician Nutritionists

6.7-1. Registered dietitians ("RD") and registered dietitian nutritionists ("RDN") are individuals whom are permitted to order diets under New Jersey law and have been privileged by the Hospital to provide delegated nutrition orders, but are not members of the Medical or Affiliate Staff. For purposes of this Section 6.7, "provider" means the attending Physician or an Advanced Practice Nurse.

6.7-2. Providers must place all initial nutrition orders.

6.7-3. Providers may delegate nutrition therapy orders to RDs or RDNs following discussion with the RD or RDN. To exercise such option to delegate, providers must place an order for consult with the RD or RDN. Nutrition orders and modifications thereto placed by the RD or RDN shall not require provider countersignature.

6.7-4. Providers may delegate enteral nutrition orders to RDs or RDNs following discussion with the RD or RDN. To exercise such option to delegate, providers must place an order for consult with the RD or RDN and

countersign enteral nutrition orders placed by RDs or RDNs. Providers are not required to countersign modifications to enteral nutrition support so long as the RD or RDN has discussed the same with the provider.

6.7-5. Providers may delegate modifications to parenteral nutrition support macronutrients to RDs or RDNs following discussion with the RD or RDN. To exercise such option to delegate, providers must countersign RD or RDN modifications to parenteral nutrition support macronutrients.

6.7-6. This Section 6.7 does not apply to pediatric patients or neonatal patients.

6.7-7. Providers shall comply with Hospital policies pertaining to nutrition orders. If Hospital policy conflicts with this Section 6.7, the Hospital policy shall control.

6.8. Cancellation of Orders Upon Transfer to Other Services

When orders are discontinued post-operatively or when a patient is transferred to another service or level of care as under §4.1, at the time of the transfer order, new orders shall be written by the attending Physician, his or her Physician Designee, or appropriate APP.

6.9. Automatic Stop Orders

Orders containing automatic stop dates are identified in the Medication Management: Automatic Stop Order Policy (#1044) for medication orders, in the Provision of Care: Admission and Discharge Criteria for Centralized Telemetry Monitoring (#542) and within the Computerized Provider Order Entry tool for non-medication orders such as laboratory and diet orders.

6.10. Orders for Restraints

Orders for restraints must be time-limited and not to exceed twenty-four (24) hours. The clinical justification for restraints must be written on the chart.

6.11. Formulary and Investigational Drugs

6.11-1. Formulary

The Hospital formulary lists drugs available for ordering from stock. Each member of the Medical and Affiliate Staff assents to the use of the formulary as approved by the Pharmacy and Therapeutics Committee. All drugs and medications administered to patients, with the exception of drugs for approved clinical investigations, shall be those FDA approved or Investigational New Drugs (IND). Whenever possible, Physicians and APPs with prescriptive authority shall use medications in the Hospital formulary. When non-formulary medications are necessary, they may be obtained subject to established protocols for non-formulary drugs.

6.11-2. Investigational Drugs

Use of investigational drugs shall be in accordance with regulations of the Food and Drug Administration and shall be approved by the Institutional Review Committee (IRC). The attending Physician shall be responsible for supplying information required by the IRC including documentation of the patient's informed consent to the patient's record and to the Pharmacy for administration of investigational drugs for patients participating in protocols approved by this Hospital or another organization's IRC.

6.12. Drugs Not Dispensed by Hospital Pharmacy

Drugs brought into the Hospital by a patient may not be administered unless the drugs have been identified by a Hospital pharmacist and the attending Physician or APP specifically so orders.

6.13. Blood and Blood Products Usage

(a) When the surgeon schedules elective surgery and there is a reasonable expectation (which shall exist when blood typing and cross-matching are ordered) of the need for blood product usage, the surgeon shall inform the patient of the risks, benefits and alternatives to blood product usage and of the options of receiving autologous, designated or homologous blood transfusions, except in an emergency or where medically contraindicated. The physician who will perform the surgery must document this process in the medical record. If the patient decides pre-donation, time must be allowed before surgery for pre-donation.

(b) When blood or blood product transfusion is ordered, the ordering Physician shall note the indication for transfusion in the medical record and inform the patient of the risks, benefits and alternatives to blood product usage.

(c) When blood or blood product transfusion is ordered during surgery, the indication for the transfusion and the estimated blood loss during surgery shall be stated in the medical record.

(d) When blood or blood product transfusion is ordered in an outpatient area, the Physician's note with the indication for the transfusion shall include pre-transfusion laboratory values to support the need for transfusion.

(e) An Advanced Practice Nurse or Physician Assistant may order blood and blood products subject to the requirements of this Section 6.12.

6.14. Order Not to Resuscitate

DNR orders and Practitioner Orders for Life-Sustaining Treatment ("POLST") forms shall be documented in accordance with Hospital policies. Upon patient transfer to the Operating Suite, the attending Physician, anesthesiologist, and/or APPs with the concurrence of the attending Physician shall review DNR orders and POLST forms.

6.15. Orders for Diagnostic Tests by Non-Medical Staff Members

(a) For purposes of this section "Physician" shall mean a physician possessing a plenary license to practice medicine and surgery and practitioners legally licensed to practice chiropractic or podiatry.

(b) The Pathology Department and the Medical Staff Members of the Department of Pathology will provide laboratory services to all "Physicians" without discrimination on the basis of classification of license.

(c) The Radiology Department and the Medical Staff Members of the Department of Radiology will provide diagnostic radiologic services to all "Physicians" without discrimination on the basis of classification of license.

(d) The Respiratory Department and the Medical Staff Members of the Division of Pulmonary Diseases will provide services to all "Physicians" without discrimination on the basis of classification of license.

(e) The Physical Therapy Department and the Medical Staff Members of the Division of Physical Medicine and Rehabilitation will provide services to all "Physicians" without discrimination on the basis of classification of license.

## Article VII

## Inpatient Medical Records

7.1. Required Content

The attending Physician, other Medical Staff Members, interns, residents and APPs involved in the care of the patient shall be responsible for the preparation of a complete and legible medical record for each patient. Only authorized individuals may make entries into the medical record. The record's content shall be pertinent, accurate, legible, timely and current. The record shall include:

(a) Identification data;

(b) Reason for Admission;

(c) Description and historical of present complaint or illness;

(d) Personal and family medical histories;

(e) Social history;

(f) Physical examination report;

(g) Written informed consents;

(h) Documentation of the existence or nonexistence of an advance directive and the Hospital's inquiry of the patient concerning advance directives;

(i) Voluntary/Involuntary status of patients in the Inpatient Psychiatric Unit;

(j) Orders for treatment and medication;

(k) Medication record reflecting the drug given, date, time, dosage, route of administration, and signature and status of the person administering the drug, and including known allergies;

(l) A record of self-administered medications, if applicable;

(m) Treatment provided;

(n) Progress notes and other clinical observations, including results of therapy;

(o) For surgical patients, (i) evidence of compliance with the Blood Safety Act; (ii) an operative report, including technique used, findings, tissue removed or altered and postoperative diagnosis; (iii) a pre-anesthesia note made by the anesthesiologist before administration of anesthesia; (iv) an anesthesia record by the anesthesiologist or Advanced Practice Nurse specializing in anesthesia; (v) a post-anesthesia note made early in the postoperative period and after release from the recovery room by the anesthesiologist; and (vi) a post-anesthesia care unit record, if applicable. In cases of strictly regional anesthetic where no anesthesiologist is assigned to the case, no pre-anesthesia, anesthesia or post-anesthesia notes by an anesthesiologist are required;

(p) Consultation reports, where applicable, including assessment mechanisms used, findings, and opinion;

(q) Reports of laboratory, radiological, and other diagnostic services;

(r) Histopathological reports, if any;

(s) Other relevant reports;

(t) Discharge summary signed by Physicians or APPs, including admission and discharge dates, reason for admission, history and pertinent physical findings, pertinent laboratory and x-ray findings, procedures performed and treatment, Hospital course, complications, condition on discharge, abnormal lab and radiologic reports, abnormal physical findings, diet, permitted activities, follow up, medication on discharge, final diagnosis, prognosis, treatment plan, and, in the case of death, the events leading to

death and the cause of death. The discharge instruction form shall indicate any specific instructions given to the patient relating to physical activity, medication, diet and follow-up care. If no instructions were required, a record entry shall be made to that effect. When the patient is discharged within forty-eight (48) hours of admission and is not transferred to another facility, for normal newborns, and for uncomplicated deliveries, a discharge note and a discharge instruction form dated and signed by the attending Physician or APP may be substituted for the discharge summary. The short stay discharge note includes at least the patient's condition on discharge, medications on discharge, discharge instructions and instructions for follow up care, and is dated and signed by the attending Physician, APP, or Physician designee; and

(u) Report of autopsy, if performed, with provisional anatomic diagnoses recorded in the medical record within three (3) Days, and complete protocol in the medical record within thirty (30) Days.

7.2. Pre-operative Documentation

7.2-1. History and Physical Examination

All patients undergoing surgery or any procedure requiring anesthesia (including but not limited to endoscopy or interventional radiologic procedures) must receive a history and physical examination (H&P). The H&P must be completed and documented by a qualified Practitioner or APP in accordance with State law no more than thirty (30) days before or within twenty-four (24) hours after patient registration or admission to the Hospital, but before surgery or any procedure requiring anesthesia. An H&P shall be either a comprehensive H&P or a focused H&P, the definitions of which shall be set forth in a policy adopted by the Medical Staff. The Medical Staff, through a policy, shall establish the circumstances under which each type of H&P is utilized. A comprehensive or focused history and physical examination report, as applicable, along with an update on the day of registration or admission that includes relevant additions to the history and pertinent changes in the physical findings subsequent to the original report, must be on the chart at the time of surgery or the procedure along with the required laboratory tests. In an emergency (so certified in writing by the operating Physician), the responsible Physician or Advanced Practice Nurse/Anesthesia shall enter a written note in the chart regarding the patient's condition prior to induction of anesthesia and start of the procedure, and the appropriate H&P shall be recorded immediately after the emergency surgery has been completed. On subsequent admissions for the same condition, within thirty (30) days of discharge, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings may be used.

7.2-2. Pre-operative and Pre-anesthesia Diagnostic Testing

Clinically appropriate diagnostic tests shall be performed not more than twenty-one (21) Days prior to admission for elective surgery. The timing for completion of diagnostic testing should be guided by the patient's clinical condition. Certain laboratory evaluations, e.g., pregnancy test and fasting blood sugar, should be performed as close to

the proposed procedure as clinically feasible. If the results are abnormal, or if the patient's clinical condition changes, further studies may be required.

7.2-3. Pre-operative Anesthesia Evaluation

All patients shall be evaluated pre-operatively in accordance with the American Society of Anesthesiologists (ASA) Basic Standards for Pre-Anesthesia Care. The evaluation shall include review of the medical history, medication usage, prior anesthetic experience, review of relevant diagnostic studies and physical assessment. The ASA Physical Status Classification shall be used to define the patient's overall status. An anesthesia plan shall be developed based on the pre-operative evaluation, anticipated surgery and the patient's or guardian's understanding of the proposed anesthesia plan. The patient or guardian shall be informed of the risks, benefits and reasonable alternatives to the anesthesia plan. Immediately prior to the surgery/anesthesia, the anesthesiologist shall reassess the patient's overall medical status, review pertinent diagnostic studies and determine if the patient is a suitable candidate for the proposed anesthetic. Only under extreme emergencies may these standards be modified.

7.2-4. Verification

Patient procedure and site verification shall be performed in accordance with the designated time-out procedure.

7.3. Progress Notes

Pertinent progress notes may be recorded by Practitioners, APPs, interns and residents and shall be sufficient to permit continuity of care and transferability of the patient. Unless required by a Physician Assistant's delegation agreement, progress notes recorded by a Physician Assistant need not be personally reviewed by the Associated Physician. Whenever possible, each of the patient's clinical problems shall be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

Progress notes shall be written whenever clinical services are provided to a patient and shall be timed, dated and signed at the time of observation/provision of clinical services and shall be written by the attending Physician or Physician Designee or APP at least daily on all patients. The attending Physician shall record the progress note at least every other day consistent with the Physician's duty to see the patient pursuant to §3.1. Ancillary clinical personnel involved in the care of an individual patient may make entries in the progress notes.

Progress notes that are not written or dictated contemporaneously with the observation/provision of clinical services shall also set forth the time and date of the later writing or dictation of the progress note along with the date and time of the observation/provision of clinical services.

7.4. Operative and Invasive Procedure and Tissue Reports

7.4-1. Operative and Invasive Procedure Reports

Operative and invasive procedure reports shall contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, the name of the primary performing Physician and any assistants, anesthesia, blood loss, drains and complications.

(a) The Physician shall enter an operative progress note in the medical record immediately after the procedure providing the required information for use by any Physician who attends the patient; and

(b) If the immediate note does not contain the required information as described above, a comprehensive report shall be completed and filed in the medical record as soon after the procedure as possible and promptly signed by the primary performing Physician.

7.4-2. Tissue Examination and Reports

Tissues, foreign bodies and prostheses that are removed from a patient and are to be sent to the Department of Pathology for examination shall be properly labeled, packaged and identified as to patient and source at the time of removal. All tissues sent to the Department of Pathology shall receive a gross and microscopic examination by a pathologist. An authenticated report of the pathologist's examination shall be made a part of the medical record.

7.5. Entries at Conclusion of Hospitalization

7.5-1. Discharge Summary

A discharge summary or, if appropriate, a completed discharge template which serves as a discharge summary, which reflects the patient's course of treatment in the Hospital and condition at discharge, shall be recorded for each patient and shall be signed and dated by the attending Physician or APP, as described in §7.1(t).

7.5-2. Unreported Laboratory Results

The attending Physician shall review all lab reports, which were unreported at the time of discharge, to determine whether follow-up is necessary.

7.6. Failure to Complete Medical Records

7.6-1. Definitions

(a) Incomplete chart - a chart not completed within 72 hours/Three (3) Days after discharge;

(b) Delinquent chart - a chart not completed by the Tenth (10th) Day after discharge or any medical record received at discharge without a history and physical prepared in accordance with the Bylaws; and

(c) Suspension - For purposes of only this section of the Rules and Regulations (§7.6) and the Health Information Management Department (HIM) policy on Medical Record completion; a voluntary relinquishment of Clinical Privileges. A Physician or APP suspended for failure to complete medical records may not admit new patients, do consults, or schedule surgical or endoscopic procedures until delinquent charts have been completed. This suspension does not apply to service call, nor does it apply to prior scheduled admissions, prior scheduled surgical or endoscopic procedures or current inpatients, unless the Physician or APP fails to complete the medical records within a period of thirty (30) days, in which case the suspension shall apply to all aspects of the Physician's or APP's Clinical Privileges.

7.6-2. Completion of Medical Records and Sanctions

Records are to be completed within thirty (30) Days of discharge according to the Joint Commission. The HIM staff will conduct a weekly tracking and notification process and communicate the outcome according to the HIM policy on Completion of Medical Records. Physicians and APPs not in compliance with the HIM policy on delinquent records shall be subject to discipline as contained in the HIM policy.

7.6-3. Reinstatement Process

A Physician or APP's suspended Clinical Privileges will be reinstated after completion of all incomplete records. Failure to pay relevant fines within twenty-four (24) hours of reinstatement will result in re-suspension.

7.6-4. Vacation

Prior to a Physician or APP's vacation ALL records should be completed. Only with prior notification to the HIM Department regarding a vacation will tracking of incomplete records be deferred until the Physician or APP's return. Upon the day of return, tracking of incomplete and delinquent records will resume.

7.6-5. Illness and Leave of Absence

If a Staff Member or APP is unable to complete medical records because of illness which is verified in writing by the Staff Member's Physician, then voluntary relinquishment will not occur and fines will not be charged until seven (7) Days after the Staff Member or APP's return from illness. Before a leave of absence is granted for reasons other than illness ALL records must be completed.

7.6-6. Repeated Violations

A Physician or APP who repeatedly fails to complete records in a timely fashion will be subject to corrective action.

7.7. Authentication

7.7-1. Generally

All clinical entries in the patient's record shall be accurately dated, timed and individually authenticated by written signature or by electronic signature. If an electronic signature is utilized, a signed statement shall be on file that only the author will utilize the electronic signature.

7.7-2. Specifically

(a) The following areas of the medical record require authentication by the author:

(1) History and physical exams;

(2) Operative or invasive procedure reports;

(3) Consultations;

(4) Discharge summaries; and

(5) Verbal and telephone orders.

7.8. Nomenclature, Symbols and Abbreviations

Nomenclature used in describing diseases and procedures shall be consistent with current ICD and CPT codes. The "Do Not Use" list of abbreviations is maintained by the Pharmacy. Use of abbreviations is discouraged.

7.9. Errors

If an error is made on an entry in the medical record, a single line shall be drawn through the incorrect entry, with the correct entry written with date, time and signature by the Practitioner, intern, resident or APP. The error shall be identified as an error and shall not be obliterated or erased.

7.10. Filing

No medical record shall be filed until it is complete and properly signed. In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible Physician to complete the record, the HIM staff shall consider the circumstances and may enter such reasons in the record and order it archived.

7.11. Ownership

All original medical records are the property of the Hospital and may not be removed from the Hospital except by subpoena, court order or statute.

## Article VIII

## Consents

8.1. General

Each patient's medical record shall contain evidence of the patient's or legal representative's general consent for treatment during Hospitalization.

8.2. Informed Consent

The performing Physician or Advanced Practice Nurse, Physician Assistant, Nurse Midwife or APN/Anesthesia who is operating within the scope of his/her practice is responsible for obtaining the patient's or legal representative's informed consent for procedures, treatments and blood transfusions in accordance with Hospital policies. The informed consent process shall be documented by the performing Physician, Advanced Practice Nurse, Physician Assistant, Nurse Midwife or APN/Anesthesia in the patient's medical record and shall include an explanation, in terms the patient can understand, of the proposed procedures or treatment and its risks, potential complications and benefits, the alternatives available, if any, and the risks, potential complications of foregoing the proposed or alternative procedures or treatments. Appropriate consent forms shall be signed by the patient or on the patient's behalf by the patient's authorized representative in accordance with Hospital policy, and may be witnessed by the Hospital staff.

8.3. Emergency

If in the judgment of the treating Physician or designee immediate treatment is necessary to preserve life or limb to prevent serious impairment to health, and an attempt to secure consent would result in delay of treatment which would increase the risk to the patient's life or health, the Physician may provide such treatment without obtaining express consent. The attending Physician shall document in the progress notes all of the relevant factors which entered into the decision. Where possible, the attending Physician shall obtain consultation and the results of the consultation shall be entered in the progress notes.

## Article IX

## Hospital Deaths and Autopsies Hospital Deaths

9.1. Hospital Death

9.1-1. Pronouncement

(a) Pronounce the patient's death. Notification of a patient death must be made as soon as possible, but not later than sixty (60) minutes after the patient's death.

(b) Notify the Next of Kin (NOK) immediately of death. Notification of death shall be documented electronically in Power Chart in the Post Mortem

Record Provider Death Pronouncement power form in the Ad hoc folder. In the event that the Physician is unable to contact the family, the Physician shall handoff to the Primary Nurse/ Clinical Manager/ Administrative Supervisor for continued follow-up and documentation.

(c) In the event of a patient death in hospital, the deceased shall be pronounced dead by the attending physician, intern or resident promptly.

9.1-2. Reportable Deaths

Reporting of deaths to the Medical Examiner's Office shall be carried out when required by and in conformance with local law.

9.1-3. Death Certificate

Complete the Electronic Death Registration System (EDRS) appropriate fields within twenty-four (24) hour of pronouncement. If pronouncement occurs in the Emergency Departments, the responsible ED Physician will initiate the EDRS with in twelve (12) hours or by end of shift.

9.1-4. Release of Body

The body may not be released until the Electronic Death Registration System (EDRS) has been completed or a verbal release authorization given by the attending Physician. In a Medical Examiner's case, the body may not be released to other than Medical Examiner personnel, except upon the receipt of an "Order to Release Body" form issued by the Medical Examiner. All other policies with respect to the release of remains shall conform to local law.

9.2. Autopsies

9.2-1. Responsibility

It is the responsibility of every Member of the Medical and Affiliate Staff to secure autopsies whenever possible. Consent for autopsy shall be obtained in accordance with state law. All autopsies shall be performed by a Hospital pathologist or by his qualified designee. The provisional anatomic diagnoses shall be recorded on the medical record within twenty-four (24) hours, and the complete protocol shall be made a part of the medical record within sixty (60) Days. These rules do not apply to cases which according to law shall be referred to the Medical Examiner's Office.

(a) Physician requested autopsies for natural deaths are performed by AtlantiCare. Refer to Physician Requested Autopsy/Consent and Authorization and the Post Mortem Authorization policies.

(b) Family requested autopsies are performed by a third party outside of AtlantiCare. AtlantiCare offers information for third party autopsy assistance. Information may be obtained on the AHS Starfish page, forms section, Post Mortem folder. Refer to Family Requested Autopsy/Consent and Authorization.

(c) Complete documentation in the electronic folder of Power Chart in the Post Mortem Record Provider power form in the Ad hoc folder as applicable.

(d) Complete the paper documentation (if applicable), forms may be printed form the hyperlink found in the power form.

- Postmortem Examination Consent/Authorization faxed to Laboratory/Pathology

- Communicable Disease Form (if applicable) should be completed and placed in the patient's medical record chart and a copy should accompany the deceased patient to the morgue. Form should be placed on the outside of the shroud.

9.2-2. Criteria for Forensic Postmortem Examination

(a) Accidental

To include, but not limited to:

- MVA, Boating, Jet Ski, Aircraft
- Fall
- Fire/Burn/Scalding/Smoke Inhalation
- Suspected Assault or Abuse
- Restraint While in (Police) Custody
- Suspected Carbon Monoxide Poisoning
- Suspected Drug Overdose
- Drowning
- Hyperthermia/Hypothermia
- Animal Attack

(b) Homicide

(c) Suicide

(d) Death within 24 hours of admission to the Hospital/Emergency Room

(e) Diagnostic/Therapeutic Procedure

- Patients who die during a surgical procedure or within 24 hours after a surgical procedure

- Malfunction of equipment during a procedure that may have contributed to the death of a patient

(f) Threat to Public Health or Safety

(g) Prison Inmates

(h) Suspicious Death

(i) Institutional State Facility Residents

(j) Fetal demise weighing more than 500 grams

(k) Children under the age of 3 years; case must be reported immediately after pronouncement.

(l) Occupational/Industrial/Job Related

To include, but not limited to:

- Firefighter
- Police Officer
- EMTs
- Airplane Pilot
- Electrician
- Commercial Painter

9.2-3. Trauma Patient Death

All trauma patients' deaths MUST be reported to the Medical Examiner's office, regardless of the length of time or location of patient at time of death by the unit secretary or nurse in charge of patient's care

9.2-4. Criteria for Non-Forensic Postmortem Examination

Deaths in which an autopsy should be considered for request by the attending Physician are as follows:

(a) Deaths in which an autopsy may help to explain unknown, unanticipated medical complications to the attending Physician;

(b) Deaths in which the exact cause of death is not known with certainty on clinical grounds;

(c) Unexpected or unexplained deaths occurring during or following any medical or surgical diagnostic procedures and/or therapies;

(d) Unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction;.

(e) All obstetric deaths;

(f) All neonatal and pediatric deaths; and

(g) Deaths in which it is believed that all autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs.

## Article X

## Infection Control

10.1. Cultures

All suspected clinically significant infections of the skin or surgical incisions shall be cultured for organism(s) and the antibiotic sensitivity of the organism(s). Suspected infection of other organs by communicable organisms shall be cultured when practical. The infection control practitioner shall call suspected cases of infection to the attention of the attending Physician.

10.2. Patients with Infectious or Communicable Diseases

Any patient with a suspected infectious or communicable disease will be treated using appropriate isolation techniques, as ordered by the attending Physician, intern, resident or APP and consistent with the principles outlined in the Infection Control Function, Section 8 of the Administrative Policy & Procedure Manual. The infection control coordinator may call cases which may need isolation to the attention of the attending Physician. If the attending Physician refuses to order isolation, this information shall be given to the chair of the Infection Control Committee who will consult with the Chair of the Department involved. The Chair shall consult with the attending Physician and make the final decision concerning isolation of the case for the protection of patients, visitors and staff.

10.3. Reporting of Infections or Communicable Diseases

All cases of infection and communicable disease shall be reported to the Infection Control Committee by the infection control practitioner. Those found in special care units shall also be reported to the Medical Director of the Unit. All communicable disease in the Hospital will be reported to the Department of Health by the infection control practitioner. Every Medical or APP Staff Member should also report promptly to the Infection Control practitioner infections which develop after discharge and which may be Hospital-acquired.

10.4. General Authority

The Infection Control Committee is authorized to institute any appropriate control measures or studies when there is the potential of harm from an infectious source to patients or personnel.

## Article XI

## Medical Critical Care Units (CU)

11.1. Definition

Critical Care Units include the Medical Intensive Care Unit (ICU), Coronary Care Unit (CCU) and the Intermediate Intensive Care Unit (IICU).

11.2. Director

The Director of the Critical Care Units shall be appointed by Administration and approved by the Board of Governors. The Director shall have overall responsibility for administrative, professional, educational, research and quality issues, and reports to Administration.

11.3. Admission to Critical Care Units

Patients needing intensive care may be admitted directly to the CUs or transferred from any other area of the Hospital, or from other Hospitals. The Director or Designee must approve all admissions to the CU's. Priority for admissions will be determined by the Director or Designee based on the clinical urgency and available space. If a patient under eighteen (18) years of age is admitted to a CU, a pediatrics consultation is mandatory.

11.4. Discharge from Critical Care Units

Patients will be discharged when criteria for admission to CU's are no longer met and medical condition allows for transfer. Decisions regarding discharge are made by the attending Physician. The Director has the ultimate responsibility and authority for the timely and appropriate triage of patients.

## Article XII

## Amendment

12.1. Amendment

These Rules and Regulations may be amended as provided in §14.1-1 of the Bylaws of the Medical Staff.

October, 1996
Revised November, 1998
Revised October, 1999
Revised December, 2000
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