# ROANE MEDICAL CENTER

## MEDICAL STAFF

## RULES AND REGULATIONS


November 2019

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**The Medical Staff is responsible for following these approved Rules and Regulations. Instances where these Rules and Regulations have not been followed will be forwarded to the appropriate department for recommendations and actions.**

# Patient Care

## Admissions

A. Patients may be admitted only by Tennessee medical licensed doctors of medicine, osteopathy, or qualified oral and maxillofacial surgeons with Medical Staff privileges.

B. Except in an emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

C. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever.

D. In concert with the needs of the community (through strategic planning), the hospital will admit those patients with diseases and surgical needs (based on patient's age and complexity of the case) within the financial constraints and scope of the hospital's ability to provide the services with available competent staff, and appropriate equipment and space. The hospital will transfer those patients requiring services not provided at this facility.

## Continuity of Care

Medical Staff members are responsible for providing continuous care for their patients. If and when patient care calls for expertise, opinions or skills outside the delineation of clinical privileges of the attending physician or when additional opinions are needed, the attending should document the rationale and request a consultation from another physician. Pertinent progress notes shall be recorded at the time of observation and be sufficient to permit continuity of care and transferability. Such notes should be written not less than: daily for acute care patients, weekly for swing bed patients, and as the patient's condition warrants for those patients under hospice care.

## Emergency Care and Coverage

A. The screening of individuals seeking emergency medical care in the Emergency Department, for the purpose of determining whether the individual has an emergency medical condition that requires stabilizing treatment, shall be done by the Emergency Department physician, or by an appropriately credentialed Physician Assistant and/or Nurse Practitioner privileged to perform medical screening examinations working within the practitioner's approved scope of practice under the supervision of the Emergency Department physician. In the cases of pregnant patients in possible labor, the medical screening examination shall be done by the Emergency Department physician.

B. All primary care physicians on the Active Medical Staff shall be assigned to the emergency room back-up duty on a rotating basis. Assignments shall be from 8 a.m. to 8 a.m., and the dates shall be posted at least one month in advance by the chairperson of the ED Committee.

C. Back-up duty includes:
   1. Being available for back-up for the Emergency Department in the event of an officially declared emergency in which the emergency management plan of the hospital has been initiated,
   2. Providing follow-up for those patients seen in the ED without a designated physician,
   3. Providing follow-up for patients who are hospitalized under the hospitalist without a designated physician, and
   4. Responding to urgent or emergency situations within the hospital if additional assistance is needed after notifying the ED physician and the Hospitalist on shift.

D. No physician shall be excused from Emergency Department duty except those who have reached the age of 65 and request to be excused, or those who are excused by the majority of the vote of the physicians who are themselves required to accept ED duty. All non-primary care physicians on the Active Medical Staff shall be available, or have someone available for them, for ED duty on a rotating basis within their own specialty. All non-primary care physicians on the Courtesy Medical Staff shall be available or have someone from their specialty available for consultation.

E. If the ED back-up physician should choose to admit any patient from the ED to the hospital, the patient shall become a part of his own service. Those patients who have expressed preference for another physician shall have such preferences honored at the earliest practical time, commensurate with good medical care.

F. Any physician who plans to be unavailable will arrange for another physician who is appropriately credentialed to provide care for his patients. The name of the physician who accepts this responsibility shall be made known to the ED and the nursing units prior to the absence.

**OR Scheduling**

Surgeons should be in the operating room and ready to commence operation at the time scheduled. The operating room will be held for no longer than 15 minutes after the time scheduled except for extenuating circumstances.

**Discharge**

Patients shall be discharged only on order of the attending physician. The supervising physician must evaluate the patient and document the plan of care within twenty-four hours prior to patient's discharge.

## Medical Directors

**Director of Anesthesia Services**

Anesthesia services will be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of osteopathy (DO). The director will be a member of the Active Staff with unrestricted

privileges in a surgical specialty or Anesthesiology; of good reputation and character, including physical and mental health and emotional stability; and the ability to work harmoniously with others sufficiently so that the medical staff will be able to operate in an orderly and civil manner.

**Director of Emergency Services**

Emergency services will be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of osteopathy (DO). The director will be a member of the Active Staff with unrestricted privileges in Emergency Medicine; of good reputation and character, including physical and mental health and emotional stability; and the ability to work harmoniously with others sufficiently so that the medical staff will be able to operate in an orderly and civil manner.

**Director of Respiratory Care/Critical Care Services**

Respiratory/Critical Care services will be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of osteopathy (DO). The director will be a member of the Active Staff with unrestricted privileges in Internal Medicine with critical care training, or Pulmonary Medicine; of good reputation and character, including physical and mental health and emotional stability; and the ability to work harmoniously with others sufficiently so that the medical staff will be able to operate in an orderly and civil manner.

**Director of Nuclear Medicine Services**

Nuclear Medicine services will be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of osteopathy (DO). The director will be a member of the Active Staff with unrestricted privileges in Radiology with Nuclear Medicine privileges; of good reputation and character, including physical and mental health and emotional stability; and the ability to work harmoniously with others sufficiently so that the medical staff will be able to operate in an orderly and civil manner.

# Medical Records

*This policy applies to all members of the Medical Staff holding clinical privileges. The policy also applies to advanced practice professionals (APPs).*

**General Keeping of the Medical Record**

A. **Completion and Signature Requirements**
   1. The attending physician shall be responsible for the preparation of a complete, legible medical record for each patient.

   2. All entries shall be dated, timed and authenticated by the author of the entry.

   3. A medical record is defined as complete at the expiration of thirty (30) days post discharge and all required documentation and authentication are present. The medical record is then determined to be a Closed Medical Record.

   4. All clinical entries shall be accurately timed, dated and authenticated by signature, identifiable initials, or computer key. A rubber stamp of a printed name may be used to clarify a signature that might otherwise be illegible.

*No rubber stamp bearing an actual signature may be utilized. This regulation applies to both Inpatient and Outpatient charts and orders.*

5. A list of unapproved/unacceptable abbreviations is identified below. Other abbreviations may be used. If the abbreviation is unclear, the author is to be contacted and the abbreviation clarified then documented within the record. Please refer to the Covenant Health policy on abbreviations for complete information.

"Do Not Use" Abbreviations include:

| **Abbreviation** | **Preferred Term** |
|---|---|
| U (for unit) | "unit" |
| IU (for international unit) | "international unit" |
| Q.D. (once daily)<br>Q.O.D. (every other day) | "daily" and<br>"every other day" |
| Trailing zero (3.0 mg)<br>Lack of leading zero (.3 mg) | Do not use a zero by itself after a decimal point (3 mg) and always use a zero before a decimal point (0.3 mg) |
| MS<br>MSO4<br>MgSO4 | "morphine sulfate" or<br>"magnesium sulfate" |

B. **APP Entries / Patient Care Requirements**

1. APPs may perform daily rounds under the supervision of the physician. Evidence of daily communication between the supervising physician and APP is required in the medical record.

   A supervising physician may choose for their APP (NP or PA) to perform daily rounds. The APP will function under the direct supervision of the collaborating physician/group. The phrase "under the direct supervision of a physician" shall be construed as a periodic evaluation and clinically appropriate follow-up of the medical plan of care. Factors influencing the frequency of this evaluation include the patient's condition during the course of the medical treatment and the patient's ability to understand his/her care. The supervising physician must be readily available for in person consultation upon the request of any patient under the care of a physician-directed health care team.

2. Supervising physicians are required to co-sign the following APP entries no later than 30 days post discharge, except where noted otherwise

   a. discharge summary
   b. history and physical
   c. consults
   d. admission order

3. A physician co-signature is not required for APP orders or daily progress notes.

4. APPs are responsible for completion of their documentation and signature requirements, including their own verbal/telephone orders.

C. **Documentation by Medical Students, Interns and Residents**

Charting guidelines for these participants are as follows:

| | **History & Physical Examinations** | **Progress Notes** | **Orders** | **Discharge Summary** |
|---|---|---|---|---|
| **Medical Students** | Documentation only in electronic student documentation form. This documentation is not part of the permanent record. | Documentation only in electronic student documentation form. This documentation is not part of the permanent record. | Medical students may not place orders. | Documentation only in electronic student documentation form or paper form. |
| **Residents** | May perform with follow-up note from attending physician within the next 24-hours | May create with the attending to co-sign on the next visit. | *May place orders.* | May create or dictate with co-signature required. |

D. **Administrative Closure of Medical Records**

1. No medical staff member shall be permitted to complete a medical record on a patient unfamiliar to him/her in order to retire a record that was the responsibility of another staff member who is deceased or unavailable or other reasons.

2. HIM will make all reasonable attempts to complete every record, however, in the event a provider is no longer available, the record will be administratively closed. The appropriate Committee will be notified of all closed records.

## Content of the Medical Record

A. The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately, and facilitate continuity of care among health care providers. Each medical record contains at least the following:

1. The patient's name, sex, address, date of birth, and the name of any legally authorized representative, allergies to foods and medicines, the patient’s language and communication needs;

2. Records of communication with the patient regarding care, treatment, and services, (for example telephone calls or email) if available;

3. Patient-generated information (for example, information entered into the record over the Web or in previsit computer systems) if available;
4. The patient's legal status, for patients receiving mental health services;
5. Emergency care provided to the patient prior to arrival, if any;
6. The record and findings of the patient's assessment;
7. A statement of the conclusions or impressions drawn from the medical history and physical examination;
8. The reason(s) for admission or treatment;
9. The goals of treatment and the treatment plan; Evidence of known advance directives;
10. Evidence of informed consent for procedures and treatments for which informed consent is required by organizational policy, including explanation of risks and benefits of the procedure/treatment and of the alternatives to the procedure/treatment;
11. Diagnostic and therapeutic orders, if any;
12. All diagnostic and therapeutic procedures and tests performed and the results;
13. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
14. Progress notes made by the medical staff and other authorized individuals;
15. All reassessments, when necessary;
16. Clinical observations, including the results of therapy;
17. The response to the care provided;
18. Reports of all consultations provided;
19. Every medication ordered or prescribed for an inpatient;
20. Every dose of medication administered and any adverse drug reaction;
21. Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge;
22. All relevant diagnoses established during the course of care;
23. Conclusions at termination of hospitalization; and
24. Any referrals/communications made to external or internal care providers and to community agencies.

B. **History and Physical**

1. The member of medical staff admitting a patient must assure that a complete and current medical history and a complete and current physical examination of the patient are carried out by an appropriately credentialed practitioner with privileges at this hospital.

2. The history and physical must be created no more than 30 days before the admission, or within 24 hours after admission, or registration, and in any event, prior to any surgery or procedure requiring anesthesia services.

3. H&Ps created within 30 days prior to admission must be updated by an appropriately credentialed practitioner with privileges at the hospital to include an examination for changes in the patient's condition. This update must occur within 24 hours after the admission or registration and prior to any surgery or procedure requiring anesthesia services.

4. Please note that a History and Physical must be signed (or cosigned, as appropriate) by the physician. The physician's signature on the H&P update does not satisfy the requirement for an H&P Update as outlined above. Both must be signed or cosigned.

5. Documentation of the history and physical, completed and updated as required herein, must be documented in the patient's record prior to any procedure involving risk and all procedures requiring anesthesia services.

6. With the exception of emergencies, patients shall not be taken to the operating room unless a compliant history and physical examination report appears in the record. In cases of emergency surgery, a brief admission note and evidence that a history and physical examination report has been recorded.

7. The H&P must contain, at minimum, the following:

    a. chief complaint;

    b. details of the present illness;

    c. allergies and current medications, including supplements;

    d. when appropriate, assessment of the patient's emotional, behavioral, and social status;

    e. relevant past, social, and family histories;

    f. pertinent review of body systems;

    g. appropriate physical exam as dictated by patient's clinical presentation or anticipated procedure to include, at a minimum, a documented examination of the heart and lungs; and

    h. conclusions or impressions, assessment and plans for treatment.

8. Documentation of informed consent, when applicable and appropriate

9. OB Records

    a. Obstetrical medical records shall include prenatal information. A durable, legible original or reproduction of the prenatal record is acceptable for use as the H&P, provided the patient has been seen within 30 days of admission.

    b. If a patient has a scheduled C-section, the H&P update process applies as outlined

previously in this policy.

10. Minimally invasive procedures

    a. Procedures listed in Appendix A do not require an H&P unless anesthesia or moderate sedation is used. Moderate sedation as defined by CMS is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulations.

    b. A post procedure progress note / brief op note must be documented immediately after the procedure and must include:

        1) procedure performed
        2) pertinent findings
        3) estimated blood loss, if any
        4) specimens removed, if any
        5) complications, if any

    c. Note that if the full operative/procedure report is created, immediately available and signed immediately after the procedure, the immediate post-op note (aka Brief Op Note) is not required.

11. Recurring 'outpatient in a bed' visits for infusions, transfusions and chemotherapy on stable patients require an updated progress note at a minimum of once per year.

C. **Consultation Reports**

1. Contain a recorded opinion by the consultant that reflects the examination of the patient and review of the patient's medical record.

D. **Operative Reports**

1. Must be recorded immediately following the surgical or invasive procedure, before the patient is moved to the next treatment area.

2. Must be recorded by the person who performed the procedure.

3. Shall contain

    a. the date of the procedure

    b. preoperative and postoperative diagnoses

    c. the procedure(s) performed

    d. a description of the procedure

    e. findings

f. the technical procedures used

g. specimens removed, if any

h. estimated blood loss, if any

i. complications, if any

j. prosthetic devices, grafts, tissues, transplants, or devices implanted, if any

k. the name of the primary surgeon and any assistants

4. Postoperative Progress Notes / Brief Op Note

   a. In the event the full operative report has not been recorded, a postoperative progress note / brief op note shall be recorded by the surgeon immediately following the procedure and prior to transfer to next level of care. Note that if the full operative report is created immediately after surgery using front end dictation, the postop progress note / brief op note is not needed.

   b. Required elements

      1) The procedure performed
      2) Description of the procedure
      3) Complications, if any
      4) Estimated blood loss, if any
      5) Findings
      6) Specimen(s) removed, if any
      7) Name of surgeon and any assistant(s)
      8) Postoperative diagnosis

E. **<u>Anesthesia Documentation Requirements</u>**

1. Pre-Anesthesia Evaluation

   a. Must be completed and documented by an individual qualified to administer anesthesia, performed within 48 hours prior to surgery or a procedure.

   b. Required elements

      1) Pre-procedural education
      2) Patient's condition immediately prior to induction of anesthesia.

2. Post Anesthesia Evaluation

   a. Shall be documented by a physician or CRNA qualified to administer anesthesia

   b. Must be performed after the patient's recovery from anesthesia and no later than 48 hours following the procedure

c. Required elements

1) Respiratory function, including respiratory rate, airway patency, and oxygen saturation
2) Cardiovascular function, including pulse rate and blood pressure
3) Mental status
4) Temperature
5) Pain
6) Nausea and vomiting
7) Postoperative hydration

F. **Diagnostic and Therapeutic Orders**

1. Must be

a. Typewritten, computer-generated, or handwritten in ink

b. Dated, timed and signed by the ordering provider

c. Clear and legible

2. Verbal and telephone orders

a. Should be used only when absolutely necessary

b. Must be cosigned within 14 days (current law and regulation) following the 'read back and verify' process.

1) Must be cosigned by either the ordering provider or another provider responsible for the care of the patient.
2) If the 'read back and verify' process is not followed, the orders must be cosigned within 48 hours.

c. Please refer to Covenant Health's policy on Telephone and Verbal Orders for complete and detailed information.

3. Other persons listed below may take orders limited to their specific license, training and function.

a. Physical Therapist

b. Physical Therapy Assistant (PTA)

c. Occupational Therapist

d. Occupational Therapy Assistant (OTA)

e. Psychologist

f. Respiratory Technologist

g. Respiratory Therapist

h. Speech Therapist

i. Pharmacist

j. Radiology Technologist

k. Ultrasonographers

l. Nuclear Technologist

m. Dietitian

n. Sleep Techs

o. Neuro Techs

G. **Progress Notes**

1. Must be recorded by an appropriately credentialed provider on a daily basis or may be documented more frequently based upon patient condition.
2. Shall denote the patient's status, detail of any changes, and the condition of the patient.

H. **Discharge Summary**

1. Required for all inpatient and observation stays. In the event of a death, a Death Summary/Record of Death serves as the discharge summary.
2. Required anytime the patient stays after midnight due to clinical condition (e.g., after day surgery when clinical condition unexpectedly changes)
3. The provider who writes the discharge order is responsible for the discharge summary.
    a. When the discharge summary is dictated by the APP, the APP must include the name of the physician who should be flagged to cosign the report.
4. Must be in the record no later than 30 days post discharge
5. Required elements
    a. Reason for admission
    b. Principal diagnosis
    c. Secondary and chronic diagnoses that are treated/monitored, and whether the condition was new or present on admission
    d. Any complications and co morbidities
    e. Operative procedures performed
    f. Pertinent lab, radiology, test results and physical findings

g. Course of treatment

h. Condition at discharge

i. Disposition

j. Instructions given at discharge

k. Final diagnosis without abbreviations or symbols

6. A short stay discharge summary will be accepted for stays of less than 48 hours, provided the stay was uncomplicated. The following elements are required:

   a. Outcome of the hospitalization

   b. Plans for follow up care

   c. Discharge Disposition

I. **Coding Queries**

1. Coding queries are necessary for complete and accurate coding and core measure abstraction. Unanswered queries are treated like other chart deficiencies. Providers may be suspended if these are left unanswered as addressed under Section III of this policy.

J. **Access to the Medical Record**

1. All patient records are the property of the hospital wherein the patient is treated and shall not be removed from that hospital except by court order, subpoena, or statute and in accordance with Covenant Health's policies.

2. Free access to all medical records of all patients shall be afforded to medical staff members in good standing, their extenders and students for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. *Access must be in accordance with Covenant Health's privacy and security policies, and includes only those patients for which the provider has a legitimate treatment relationship.*

## Timeliness

In all cases the medical record shall be completed within 30 days following patient discharge or the physician/provider will be subject to the suspension process. APPs who are delinquent in completing medical records will not be allowed to assist their sponsoring physician(s) in the hospital until all delinquent records have been completed.

A. **Notification of Providers**

1. Providers shall be notified of all incomplete medical records on a regular basis, no less than monthly. Incomplete records must be completed prior to the date of suspension in order to avoid suspension of elective admission privileges.

B. **Failure to Complete Records – Automatic Suspension**

A suspension for incomplete medical records is considered to be administrative in nature and is not reportable to the National Practitioner Data Bank. This type of suspension is not related to professional competence or conduct that could adversely affect the health or welfare of the patient.

1. Failure to complete records by the suspension deadline results in an automatic administrative suspension of privileges.
2. HIM sends written notification of suspension to the physician's practice by fax or email. The notification includes the requirement for the physician to arrange for appropriate coverage for patients by another medical staff member with like privileges.
3. The automatic administrative suspension includes all admitting privileges and scheduling of any new procedures. The physician on suspension may continue to care for patients currently admitted to the physician's service for up to 15 days from the date of suspension. Admissions and procedures that have been scheduled prior to the date of suspension will be honored for up to 15 days after the date of suspension.
4. A suspended physician may continue to take emergency call and admit and care for patients in emergency situations.
5. A physician may not admit patients under the services of another physician or perform surgical or other invasive procedures when he/she is on the suspension list.
6. Reinstatement of these privileges is allowed immediately upon completion of all delinquent record(s). Suspension of these privileges cannot be based upon a minimum or maximum numbers of records to be completed. Any and all delinquent records are expected to be completed.
7. The suspension list will be distributed to the following areas/departments by Health Information Management:

    - Administration
    - Quality Care Management
    - Central Scheduling
    - Chief of Staff
    - Day Surgery
    - Emergency Department
    - Endoscopy Lab
    - Medical Staff Office
    - Outpatient Registration
    - Pre-admission Testing
    - Registration
    - Surgery

8. If a physician has been suspended for a third time in the calendar year, all clinical privileges are automatically relinquished until all delinquent medical records are completed. The automatic relinquishment is not grounds for a fair hearing and is not reportable to the NPDB. *(Refer to Credentials Policy, 6.F AUTOMATIC RELINQUISHMENT)*
9. Reinstatement from the automatic relinquishment may be requested upon completion of all delinquent medical records. The request is to be submitted through Medical Staff Services.

Payment of a fine may be required as determined by the MEC.

10. If the physician does not complete all delinquent records within 60 days after the automatic relinquishment is in effect, the matter will be referred to the MEC and may be considered an automatic resignation from the Medical Staff.

# APPENDIX A

## Minimally invasive procedures that DO NOT require an H&P

A. Minimally invasive procedures as listed below do not require a history and physical. An immediate post-procedure progress note should be written to include, at minimum:

1. the name of physician performing procedure,
2. procedure performed, and
3. any other pertinent medical findings or events.

B. Minimally invasive procedures are defined as all:

1. Epidural steroid injections or diagnostic injections
2. Nerve root blocks, sympathetic blocks, IV regional blocks
3. Image guided biopsy, image guided drainage, image guided aspiration
4. Myelograms, lumbar punctures
5. Arthrocentesis, joint injections, arthrograms
6. Central venous line, Q Port flush
7. Newborn circumcisions
8. EEG
9. Esophageal motility studies, rectal motility studies
10. Labor checks
11. Manometry
12. Tilt table test
13. Breast biopsy if no sedation
14. Apheresis
15. Aspiration
16. Biliary tube change
17. Blood patch
18. Coronary CTA
19. PFT
20. Fistulogram
21. Gastrotomy tube replacement
22. Nephrostogram
23. Paracentesis, thoracentesis
24. PEG tube replacement
25. Perma cath removal
26. Percutaneous transhepatic choangiogram

27. Pill cam
28. PICC line placement
29. Spirometry
30. Stress test
31. Ureteral stent placement
32. Venogram
33. pH study
34. Bone marrow biopsy

## Procedures that DO require H&Ps

Include but are not limited to:

A. Any procedure involving sedation requires an H&P (including radiology).

B. Angiogram

C. Device implants (e.g., pH probe)

D. Heart catheterization

E. Chemotherapy, blood transfusions and drug infusions

1. Stable patients receiving any of the above require an H&P or updated progress note once a year.

***REVISED AND APPROVED:***

December 1, 2008
October 5, 2009
June 21, 2010
June 11, 2012
October 1, 2012
December 2, 2013
February 3, 2014
March 26, 2015
July 23, 2015
November 19, 2015
November 21, 2019