

**RULES AND REGULATIONS
OF
THE MEDICAL STAFF
MORRISTOWN-HAMBLEH HOSPITAL**

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**RULES AND REGULATIONS
OF
THE MEDICAL STAFF**

MORRISTOWN-HAMBLEEN HOSPITAL ASSOCIATION

ARTICLE I. ABORTION - (OB/GYN DEPARTMENT)

Section 1. Operative or Therapeutic Abortion: This procedure is considered permissible under circumstances in which there are documented lethal defects of the fetus or circumstances in which the continuance of pregnancy will constitute a threat to the life of the expectant mother.

Every patient scheduled for pregnancy termination shall have documented in their medical record, before initiation of the procedure, the menstrual history, physical findings, and sonographic confirmation. A written, documented consultation by a physician qualified and competent to render an opinion in this area shall be required and shall be a part of the medical record before the procedure is initiated.

This policy in no way compromises or relates to emergency medically indicated termination of pregnancy.

Section 2. The operative permit clearly explaining the nature of the proposed abortion, signed by the patient and properly witnessed by one or more persons, must be on the medical record of the patient prior to any operative abortion.

Section 3. All products of conception delivered spontaneously or operatively shall be sent to the pathologist. The pathologist's report shall be included in the patient's medical record.

Section 4. All therapeutic terminations of pregnancy shall be reported to the Tennessee Department of Health and Environment as required by the Tennessee Code Annotated 68-3-505 (a).

ARTICLE II. ADMISSION OF PATIENTS

Section 1. Admission to Morristown-Hamblen Hospital (MHH) shall be by authorization of an Active Staff or Courtesy Staff member, as prescribed by the bylaws.

- Section 2.** A provisional diagnosis and admission order must be on the patient's chart at the time of admission to the hospital.
- Section 3.** Patients will not be admitted for psychiatric services for which the hospital is not staffed or equipped, except in dire emergency and then only as a temporary expedient.
- Section 4.** A new admission shall be examined by the attending physician or on call physician for the attending physician within 24 hours of admission to the hospital or sooner if warranted by the clinical conditions. (Refer to Article X, Section 2--ICU Admissions). An appropriately credentialed APP may perform the initial evaluation of patients to be admitted, but this does not substitute for the evaluation by the admitting/supervising physician. The attending physician/on call physician, or other appropriately credentialed practitioner shall be responsible for the completion of the admission History and Physical within 24 hours of admission.
- Section 5.** Medical services for which the hospital is adequately equipped, and which are normally provided by the hospital, shall be provided on a non-discriminatory basis. This means that those services will be provided regardless of race, sex, religion, age, national origin, creed, color, or handicap.

ARTICLE III. AUTOPSY

- Section 1.** Any patient expiring after admission to the hospital is considered a hospital death. It is desirable at times for such patients to have autopsies whenever possible. The hospital shall make autopsy permits available for the purpose of obtaining permission for postmortem examination. The staff is encouraged to solicit permission for autopsy from the surviving next of kin when appropriate.
- Section 2.** No autopsy may be performed without the signed consent of the legally responsible heir, the next of kin, or through the order of authorized officers of the court having jurisdiction in the county in which the death occurred.
- Section 3.** The report of such an autopsy shall become a part of the permanent medical record of the patient.
- Section 4.** Provisional Anatomic diagnosis should be completed within 72 hours. Final Anatomic diagnosis should be completed within 60 days.

Section 5. An autopsy is indicated if one of the following criteria is met:

Unknown and/or unanticipated medical complications may have occurred

Cause of death or a major diagnosis is not known with reasonable certainty on clinical basis

Autopsy may help family and/or public understand death and provide assurance

Unexpected death or unexplained death following any dental, medical, or surgical diagnostic procedure or therapies

Obstetric death

Prenatal and Pediatric deaths

Patient participated in clinical trials approved by IRB

Natural deaths waived by ME/Coroner such as:

- a) DOA
- b) Deaths within 24 hours admission to hospital
- c) Deaths in which the patient sustained or apparently sustained an injury while hospitalized

Death resulted from high risk infections and contagious diseases

ARTICLE IV. CONSULTATIONS

Section 1. Consultant: A consultant shall be a qualified physician or limited license professional credentialed in accordance with Medical Staff Bylaws. [eligible for medical privileges] with medical staff membership in this hospital and competent to render an opinion in the medical area in which his opinion has been solicited.

Section 2. Required Consultations: Except in cases of emergencies, consultations with qualified physicians are required in the following situations:

- A. Therapeutic Abortion
- B. Medically Indicated Sterilizations

Section 3. Recommended Consultations

- A. High Risk Operative Patients
- B. When continued hospitalization is required due to an unclear diagnosis.
- C. Therapeutic Problems

In case of questions, Department Chief, Chief of Staff, or Medical Executive Committee shall have final authority to determine the advisability of such consultation.

- Section 4.** Consults should be labeled Routine/non-emergent, ASAP/urgent, or STAT/emergent.
- A. If a consult is Routine/non-emergent, the consultant should see the patient within 24 hours of notification.
 - B. If the consult is ASAP/urgent, the consultant should see the patient or contact provider that day.
 - C. If the consult is STAT/emergent, the consultant should see the patient, or be in contact with provider within 1 hour of notification.
- The consultant's written report should be on the chart within 24 hours and should reflect adequate examination of the patient and recommendations for care or management of the patient's problem for which consultation is requested.
- Section 5.** Consultation notes required for procedures shall be recorded in the medical record prior to the operation unless immediate surgery is required to prevent loss of life or limb.
- Section 6.** The attending physician/on call physician should assess the patient before consultation is requested. When consultation is desired or required, it is the responsibility of the attending physician to provide the consulting doctor beforehand with specific information regarding the reason for consultation (i.e. specify points of examination, suspected diagnosis or problem, and desired level of participation of consultant in directing care of the patient). In a STAT/emergency situation, the attending physician/on call physician shall communicate with the consultant directly.
- Section 7.** Psychiatric consultation is recommended for the patient who has attempted suicide or has taken a chemical overdose. Notes must be entered in the chart documenting that this recommendation has been made to the patient or responsible family member.

ARTICLE V. DEATH

- Section 1.** The County Medical Examiner and the County Coroner are to be notified by the physician of any death in which: The cause of death is uncertain; the death is sudden or unexpected; and/or the death is the result of an accident, regardless of when such accident occurred; or, in which the cause of death appears to be violent or otherwise associated with circumstances of a suspicious nature.
- A. Any death occurring within 24 hours of admission to the hospital is also notifiable with regard to the Medical Examiner and the Coroner, when the patient has not been under the care of the physician certifying death for the condition causing the death.
 - B. In any case involving the County Medical Examiner and the County Coroner, the patient's remains, i.e. his corpse and personal property, are to be kept in the hospital until released by written or verbal order of the above mentioned authorities.

Tennessee Code Annotated Number 38-7-108 (1983) reads as follows:
Any physician, undertaker, law enforcement officer, or other person having knowledge of the death of any person from sudden violence, or by casualty, or by suicide, or suddenly when in apparent good health, or when found dead, or in prison, or in any suspicious unusual or unnatural manner, or where the body is to be cremated, shall immediately notify the County Medical Examiner or the District Attorney General, the local police, or the County Sheriff, who in turn shall notify the County Medical Examiner.

ARTICLE VI. DISASTER

Section 1. The hospital shall have and maintain an emergency preparedness plan or disaster plan. This plan may be implemented by any emergency room physician or the hospital administrator or their designee. This plan shall be reviewed and revised as necessary and made available to Medical and hospital staff.

ARTICLE VII. DISCHARGE OF PATIENTS

Section 1. Patients shall be discharged only on the order of the attending physician or designee, except in cases when the hospital is operating under the authority of the Emergency Preparedness Plan.

ARTICLE VIII. EMERGENCY ROOM

Section 1. The hospital shall maintain a center for the care and treatment of medical emergencies. The operation of the Emergency Room shall be under the supervision of the Emergency Room Committee which will develop policies and procedures for the operation of the Emergency Room.

Section 2. The Emergency Room shall offer services on a 24-hour basis.

Section 3. 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 an Emergency Department physician, OB physician, or registered nurses with special competence in obstetrics, in consultation with an obstetrician.

ARTICLE IX. EMERGENCY ROOM BACK-UP

- Section 1.** Each active staff physician will serve on a schedule as a back-up consultant to the Emergency Room physician according to department assignment or specialty as approved by the medical Staff. This schedule shall be posted at the hospital switchboard, in the hospital Emergency Room, Medical Staff Office, and a copy shall be provided to each participating physician.
- Section 2.** Any physician acting as a substitute for the assigned back-up consultant has the same responsibility as the assigned physician and is required to provide advance notice to the switchboard, house supervisor, and Emergency Room.
- Section 3.** When the Emergency Room back-up consulting physician signs out to another member of the Medical Staff, the physician accepting ER backup cannot sign out to another Medical Staff member during this assignment. The person accepting ER backup must accept responsibility and/or Patient Care Management for any type of problem within that specialty.
- Section 4.** A consulting physician on the back-up schedule is to be available for consultation to the emergency room physician within a reasonable amount of time after notification.
- Section 5.** An active staff physician serving on the schedule as a back-up consultant to the Emergency Room will respond within a reasonable amount of time after notification. After contact is made, the back up consulting physician must present to the Emergency Room in an appropriate amount of time upon request by the Emergency Room physician.
- Section 6.** Any medical staff member having obtained the age of sixty (60) or with 25 years on the medical staff at this Hospital may be, upon written request, relieved of Emergency Room back-up call without affecting attending staff privileges.

ARTICLE X. INTENSIVE CARE UNIT

- Section 1.** The operation of the Intensive Care Units will be under the supervision of the Special Care Committee. The chairman of the Special Care Committee shall provide medical direction to the Intensive Care Units.
- Section 2.** For all Intensive Care Unit admissions, the attending physician/on call for the attending physician shall see and assess the patient within 8 hours of admission. All Admissions to the Intensive Care Unit shall be subject to review by the Special Care Committee and/or Chairman.
- Section 3.** The attending physician shall revise and review orders on all patients transferred from other care areas into the Intensive Care Unit. All prior

orders shall be automatically discontinued upon admission to or discharge from the Intensive Care Unit.

Section 4. A patient will be admitted to the Intensive Care Unit in accordance with the severity of illness and the need for admission to The Intensive Care Unit. If a conflict arises concerning admission and discharge, the Special Care Committee Chairman will serve as the final authority.

ARTICLE XI. MEETINGS

Section 1. Regular meetings of the General Medical Staff will be held on the third Tuesday of every other month at 7:00 P.M. in the Morristown-Hamblen Hospital cafeteria or designated location.

Section 2. Medical Staff Departments and Committees of the Medical staff shall meet as directed by the bylaws of the Medical Staff. Each Department and committee shall designate a time and place for their meeting.

ARTICLE XII. OB/GYN DEPARTMENT

Section 1. A standard hospital consent form for labor and delivery shall be obtained and maintained on all obstetrical patients. The standard hospital form for the conduct of labor and delivery shall be maintained on labor patients. A prenatal record, when available, with a completed history and physical is required as part of an obstetrical admission.

Section 2. Physicians engaged in obstetrical practice must keep the labor and delivery room and obstetrical floor apprised of their whereabouts and be reasonably accessible. When the physician is not available, they must designate a qualified staff member to be responsible for their obstetrical practice and notify the Labor and Delivery Room and obstetrical floor as to their substitute.

Section 3. The induction and stimulation of labor shall be initiated only on the direct order of the attending physician after the patient has been properly assessed.

Section 4. Oxytocic drugs shall be used with caution on the pregnant patient. When such drugs are used, a qualified observer shall monitor the patients' progress. Ergot derivatives shall not be administered to undelivered obstetrical patients.

Section 5. No patient shall be left unattended while in delivery position in the birthing bed.

Section 6. Once the patient is admitted to Labor and Delivery, the attending physician or his qualified designee must see and assess the patient within two (2) hours.

ARTICLE XIII. ORDERS

Section 1. No treatment or medication or diagnostic procedure may be ordered on any patient in this hospital without the expressed order of a physician, or limited licensed professional acting within scope of their clinical function either written or verbal, except in cases where immediate action is required for preservation of life or limb of a patient.

Section 2. Verbal orders may be written on the chart of the patient by a Registered Nurse, L.P.N., and countersigned by the attending physician.

The following may write department specific orders in the Medical Record after discussion with the physician:

- A. Registered Dietitians (Diet Orders)
- B. Pharmacist (Medication/TPN Orders)
- C. RRT or CRRT (Ventilator, Bronchial hygiene, O₂ Therapy)
- D. Physical Therapist (Orders related to functional ability)
- E. Radiologic Technologists
- F. Medical/Laboratory Personnel
- G. Admissions Personnel for Outpatient Lab and X-Ray

Section 3. Except when the duration of dosage has been specified, all injectable narcotics shall be automatically discontinued after three (3) days. Drug usage, dosage, and duration shall be in conformity with the United States Pharmacopeia and National Formulary, except as indicated by previously approved protocol.

Section 4. Standing orders may be formulated by the attending physician. These shall be submitted to the Pharmacy and Therapeutics Committee for approval, but a request may be made by the attending physician for the immediate institution of the orders. In this event, the orders will be considered valid pending a review and approval of Pharmacy and Therapeutics Committee. Standing orders, whether approved immediately or by the committee, shall be maintained in the Medical Staff office and that office shall notify all personnel involved. Standing orders shall remain in force until changed by the attending physician and should be reviewed periodically by the attending physician.

ARTICLE XIV. MEDICAL RECORDS

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

I. 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) Q.O.D. (every other day)	“daily” and “every other day”
Trailing zero (3.0 mg) 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 MSO4 MgSO4	“morphine sulfate” or “magnesium sulfate”

B. APP Entries / Patient Care Requirements

1. APP’s 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. APP’s are responsible for completion of their documentation and signature requirements, including their own verbal/telephone orders.

C. Documentation by Medical Students, Interns and Residents

1. 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.	<i>May place orders.</i>	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.

II. 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; and
23. Conclusions at termination of hospitalization
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. Anesthesia Documentation Requirements

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, with the exception of hospice patients (see bullet 3 below).
- 2. Shall denote the patient's status, detail of any changes, and the condition of the patient.
- 3. For inpatient hospice patients, a physician progress note must be recorded, at a

minimum, once a week. If a change in plan of care is necessary, such as diagnostic testing or medication orders, this will be communicated to the primary physician for evaluation and ordering.

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

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
5. 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.

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.*

III. 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. APP's 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

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

- 28. PICC line placement
- 29. Pill cam
- 30. Spirometry
- 31. Stress test
- 32. Tilt table test
- 33. Ureteral stent placement
- 34. Venogram

II. 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 on a regular basis require an H&P or updated progress note once a year.

ARTICLE XV. PEDIATRIC (NURSERY)

- Section 1.** Standard infant formula will be used routinely.
- Section 2.** Nursery tests will be performed on all newborns as required by Tennessee State Law. Standard neonatal screening as determined by the Department of Pediatrics will be performed.
- Section 3.** Hospital protocol will be available for nurses for use on infants and will be reviewed by the physician in a timely manner.
- Section 4.** Physicians with newborn nursery privileges will be assigned to the on call rotation.

ARTICLE XVI. PHARMACY

- Section 1.** Drugs used shall meet the standards of the United States Pharmacopeia and National Formulary. Drugs for bonafide clinical investigation shall be used only upon approval of the Pharmacy and Therapeutics Committee.
- Section 2.** Substitution of drugs is administered in accordance with the approved Hospital Formulary.

ARTICLE XVII. REHABILITATION SERVICES

Section 1. The Medical Staff will provide clinical guidelines to the Department of Rehabilitation Therapy, through an annually appointed representative chosen from its membership. This Medical Director will act as a consultant to the staff and the Rehabilitation Therapy Department.

ARTICLE XVIII. RESPIRATORY THERAPY

Section 1. The Medical Staff will provide clinical guidance to the Department of Respiratory Therapy through an annually appointed Special Care Committee chosen from its membership. The Special Care Committee will act as a consultant to the staff and the Respiratory Therapy Department.

Section 2. Physician orders for inhalation treatment shall specify the type, frequency, and dose of medication, and, as appropriate, the type of diluent, and the oxygen concentration.

Section 3. The physician should document in the patient record a timely, pertinent clinical evaluation of the overall results of respiratory therapy. The need for long-term oxygen therapy should be documented for patients discharged on such therapy as well as pertinent discharge instructions.

ARTICLE XIV. RESTRAINTS

The intent of these Rules and Regulations is to be interpreted in accordance with Morristown-Hamblen Hospital Policy regarding restraints. These Rules and Regulations shall be understood as consistent with this Restraint Policy.

Section 1. Restraint use shall be in accordance with Hospital and Medical Staff policy. A physician order is obtained as soon as possible following initiation of restraint or seclusion for emergency situation.

Section 2. Restraint or seclusion implementation for behavior management requires face to face evaluation by the physician within one hour. Continuation of restraints requires face to face evaluation every 24 hours.

ARTICLE XX. SURGERY

Section 1. No surgical operation shall be performed without the written consent of the patient or their legal representative, except in case of extreme

emergency. In such case, consent shall be obtained as soon after the operation as is possible for inclusion in the chart.

Section 2. Each operative report must include a description of the findings, the technical procedures used, the specimens removed, the pre-and postoperative diagnoses, the name of the primary surgeon, and the names of any assistants. All surgery procedures must be dictated immediately after surgery, and the typed report shall become a part of the patient's medical record.

Section 3. Any and all tissue, except specimens that do not permit productive examination as delineated by the Surgery Department Rules and Regulations, removed from a patient at operation must be sent to the hospital pathologist who will make such examinations as they deem necessary to arrive at a pathological diagnosis. The report of the hospital's pathologist regarding these tissues shall become a permanent part of the patient's medical record.

Section 4. The operating surgeon must be in the operating room and ready to commence the operation procedure at the scheduled time, when at all possible; in no case shall the operating room be held longer than fifteen (15) minutes after the time a case is scheduled to begin. When a fifteen (15) minute wait has passed without the surgeon appearing, the following case will be moved up and may begin as soon as possible. The scheduled case which has been delayed may be rescheduled to follow at the end of the regular operating day, or with the permission of all parties concerned, may be inserted into the operative schedule for that day whenever possible.

Section 5. No patient shall undergo operative procedure without the following items being included in the permanent hospital records:

- A. Pre-operative diagnosis and a statement of any factor which might complicate anesthesia.
- B. A history and physical examination has been completely done with risks, benefits, potential complications, and alternative methods explained and patient is cleared for surgery. If the patient is having a procedure and the History and Physical is completed over 30 days prior to the procedure, there must be a new History and Physical examination completed.

When these requirements are not recorded before the time stated for operation, the operation shall be cancelled unless the attending physician states in writing that such delay would constitute a hazard to the patient. The Chairman of the Surgery Department or the Director of the Surgery Department shall be empowered to ensure the staff compliance with these requirements.

Section 6. Policies and procedures for day surgery shall be consistent with those applicable to inpatient surgery, anesthesia, and post-operative recovery.

Section 7. In the event that a patient is undergoing a surgical procedure within the operating room by a non-physician (i.e. podiatrist or dentist), a physician must be present within the facility and available to the operating room.

ARTICLE XXI: Professional Practice Evaluation Committee (PPEC)

Section 1. The Vice Chairs for each department will serve on this committee in addition to a member at large. The committee will also be able to request assistance from other members of the medical staff on an as needed basis. Members of the MEC will not be eligible to serve on this committee. The PPEC will review cases forwarded from the clinical specialty reviewers and Leadership Council. The PPEC will also review the determinations from prior levels of review to ensure consistency, support interventions and support Clinical Specialty Reviewers. Behavior reports will be reviewed with the PPEC committee for intervention or advancement of report to the MEC.

In addition, the PPEC will consist of the following support staff:

Section 2. Professional Practice Evaluation (PPE) Support Staff: Currently the Quality office serves as peer support staff. This will remain the same with the creation of the Professional Practice Evaluation Committee (PPEC). Charts for peer review will continue to be identified through department triggers, reported concerns, sentinel events, litigation risks and patient complaints. Staff will prepare charts for the clinical specialty reviewer. PPE Support Staff will log each case into a central spreadsheet to track cases sent for review. Quality care manager will prepare any behavior reports for review.

Section 3. Leadership Council: Plan will be initiated to formalize the Leadership Council which will include CAO, CNO, Chief of Staff, Vice-Chief of Staff, Quality Care Manager, and Immediate Past Chief of Staff. Optional member: PPEC Chair. Peer review may be discussed with the Leadership Council for direction. Leadership Council may refer a case to the PPEC. This council will also review behavioral reports and forward to the PPEC as needed.

Section 4. Clinical Specialty Reviewer: Currently the department chairmen serve as our Clinical Specialty Reviewers. We will observe the current policy in respect to sending peer reviews to reviews outside the facility for cases of competitors and partners, or at the direction of the Leadership Council. This will remain the first step of review in the new process with the creation of the PPEC. Rather than using the current categories for peer review 1-4, classification of “No Concern” or “Some Concern” will be implemented in the future. If the case has been determined to have “Some Concern” regarding practice, it will be forwarded to the PPEC committee for further review.

Approved by Covenant Board: September 22, 2022