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Medical Staff Rules and Regulations of CentraCare-Monticello

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CentraCare adopts the following Policy/Procedure for:

CentraCare - Monticello

A. GENERAL

1. PREAMBLE

The Medical Staff shall adopt such rules and regulations as may be necessary to

implement more specifically the general principles found within the Medical Staff Bylaws, subject to the approval of the Operating Committee. These rules and regulations shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Hospital. The rules and regulations shall be part of the Medical Staff Bylaws and any changes made to the rules and regulations shall become effective when approved by the Operating Committee.

Applicants and members of the Medical Staff and others holding clinical privileges shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the Medical Staff Bylaws and the Rules and Regulations, the Bylaws shall prevail.

Violation of these rules and regulations shall be grounds for disciplinary action in accordance with the Medical Staff Bylaws.

2. DEFINITIONS

Terms defined in the CentraCare - Monticello Hospital Medical Staff Bylaws shall have the same meaning when used in these Rules and Regulations

3. EFFECT

These rules and regulations shall be adopted and remain effective after action by the Medical Staff and Board of Directors as described in Medical Staff Bylaws Article 8.B.

4. CODE OF CONDUCT

The Medical Staff complies with the Code of Conduct and medical staff policies.

B. ADMISSION, CARE AND DISCHARGE OF PATIENTS

1. The Hospital may accept patients for admission with all types of diseases or conditions, subject to the limitations of the Hospital's facility, personnel and the medical services it provides.
2. A patient may be admitted to the Hospital only by a practitioner with appropriate admitting privileges.

   A physician with appropriate clinical privileges shall be responsible for the care and treatment of each patient in the Hospital as the attending physician. He or she shall see and evaluate or arrange for another qualified member of the medical staff, to see and evaluate the patient in a timely manner after admission, as appropriate to the nature and seriousness of the condition for which the patient was admitted, but in no event later than 24 hours after admission. The attending physician shall also be responsible for:

a. completing, or arranging for the completion of the history and physical in a timely manner as required by these Rules and Regulations.

b. the prompt completion and accuracy of the medical record.

c. the issuance of any necessary special instructions.

d. Seeing, or arranging for another practitioner to see the patient.

3. Any practitioner who, due to his/her license or other reason, cannot or will not assume all of the responsibilities of the attending physician shall admit patients only with another practitioner who can and will assume such responsibilities.

4. Each practitioner shall arrange coverage for each of his or her patients in the Hospital consistent with patient needs and Medical Staff requirements. Practitioners must refrain from delegating care of their patients to any practitioner who lacks the qualifications or privileges to undertake this responsibility. Practitioners are responsible for assuring that the covering practitioner:

    a. is qualified and will be available to assume responsibility for care of their patients during their absence, and

    b. is aware of the status and condition of each patient he or she is to cover.

5. In case a patient's attending physician, or his or her designated alternate is not available, the Chief of the Medical Staff or designee shall have authority to call any practitioner with appropriate clinical privileges to assume care of the unavailable practitioner's patient.

6. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. The admission order shall specify the patient status as inpatient, observation, or outpatient, based on the practitioner's evaluation of the patient's diagnosis, plan of care and expected length of stay. In the case of an emergency, such statement shall be recorded as soon as possible.

7. Special Admission Considerations

    The following principles are to be met in the care of the potentially suicidal patient for the protection of patients, Medical and Nursing staff, and the hospital:

    a. Any patient known or suspected to be suicidal, shall not be admitted to any unit of the hospital, unless admission criteria for the Geriatric Behavioral Health Unit is met. Appropriate referrals to suitable facilities will be provided.

        If, in the judgment of the physician, serious medical problems exist of a higher priority than the underlying psychiatric problem, the patient should

be admitted to the appropriate nursing unit and put on one-to-one nursing care.

b. It is recommended that any patient known or suspected to be suicidal should have consultation by a professional that is trained in mental health evaluations for suicide.

c. The attending physician shall be held responsible for giving such information to others involved in the patient's care as may be necessary, to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patient might be a source of danger from any cause whatsoever.

d. In the event the patient or others cannot be appropriately protected in the general acute care service, arrangements shall be made to transfer the patient to a facility where care can be appropriately managed.

C. RESPONSE TIME

1. On call physicians must respond to an emergency within 30 minutes. If requested to evaluate an emergent situation, the on-call physician must perform face-to-face evaluation (either in person or via acceptable telemedicine technologies) of the patient in the hospital within 60 minutes.
2. All ICU patients must be seen by a practitioner within 2 hours of admission.
3. All other admissions are seen by a practitioner within 24 hours.

D. DISCHARGE OF PATIENTS

1. Patients shall be discharged only on an order of the practitioner. It shall be the responsibility of the practitioner to discharge his or her patient in a timely manner.
2. If a patient indicates intent to leave the Hospital before the completion of treatment or contrary to the advice of the patient's attending practitioner, the nursing staff shall contact the patient's attending practitioner or designee to arrange for the patient to discuss his or her plan with the attending practitioner or designee before the patient leaves. The attending practitioner or designee shall discuss with the patient the implications of leaving the Hospital against medical advice, including the risks involved and the benefits of remaining for treatment, as necessary to meet the standard of informed refusal of treatment.
3. The patient who insists on leaving against medical advice shall be asked to sign a release acknowledging that they are leaving against medical advice and their understanding of the medical risks and possible consequences of refusing continued treatment at the Hospital. If the patient cannot be located or refuses to

sign the form, the nursing staff who witnessed the refusal shall sign the form and document in the patient's medical record the facts surrounding the patient's departure.

4. A patient who leaves the Hospital without notifying any health care worker prior to departure is considered to have eloped. In the Emergency Department, this applies to any patient who has been seen by the Triage Registered Nurse, had a triage assessment initiated and/or been placed in a treatment area but left prior to completion of an evaluation in the Emergency Department. Documentation of the circumstances, time and date of the incident shall be documented by the nurse in the medical record.

E. DEATH OF PATIENTS

1. In the event of a patient death at the Hospital, death shall be pronounced within a reasonable time by the attending practitioner or his or her representative. Nursing personnel may also pronounce death in accordance with policy. The body shall be released following an entry of pronouncement of death in the medical record of the deceased by a physician or per nursing policy. Policies with respect to release of deceased bodies shall conform to local law. The attending practitioner or his or her representative is responsible for notifying the next of kin in all cases of patient death. The attending practitioner or designee shall report all patient deaths to the coroner/death investigator, or to other agencies as required by law (e.g., in the event of death while under restraint).
2. If the basis for pronouncement of death is "brain death" (i.e., the total and irreversible cessation of all functions of the entire brain, including the brain stem), death must be pronounced by a physician, and a second, independent physician must confirm the determination of brain death. Both physicians must document their findings in the patient's record. The patient's family must be informed of the patient's death. If the family objects to terminating treatment or contests the accuracy of the diagnosis, Hospital Administration shall be advised and consulted before medical interventions (e.g., ventilator) are discontinued.
3. If the patient or the patient's family indicates that the patient has, or will contribute anatomical gifts, consent shall be secured in accordance with applicable law. The patient's attending practitioner shall comply with the Hospital protocol for identifying potential organ and tissue donors.
4. It shall be the duty of all staff members to secure meaningful autopsies whenever appropriate, consistent with applicable law and Hospital policy. An autopsy may be performed only with a written consent of a relative or legally authorized agent, signed in accordance with State law.

F. TRANSFER OF PATIENTS TO ANOTHER FACILITY

In the event of a patient requiring transfer to another facility, it shall be the responsibility of the treating practitioner attending the patient to arrange the transfer. All patients being transferred must be seen (either in person or via acceptable telemedicine technology) by a practitioner prior to transfer. No patient shall be transferred or discharged from CentraCare - Monticello to another health facility unless arrangements have been made in advance, and in compliance with applicable federal and state emergency service laws and Hospital policies and procedures.

G. ORDERS, THERAPIES AND TESTS

1. All orders shall be timed, dated, recorded clearly, and authenticated by the ordering practitioner. All outpatient orders must include diagnosis or reason for the therapy and/or test.
2. All orders for medications must include the name of the medication, dosage, route and duration and shall be authenticated by the ordering practitioner.
3. Verbal orders may be accepted by an authorized licensed professional in emergency situations and telephone orders may be accepted when the ordering practitioner is unavailable and does not have access to the patient record to enter the order. If the ordering practitioner is in the Hospital and able to enter the order, verbal and telephone orders shall not be accepted. Verbal orders shall be accepted only as follows.
    a. Within the scope of their practice and subject to other legal requirements and provisions of these rules and regulations, the following categories of licensed professionals are authorized to receive verbal orders:
        i. Registered nurses
        ii. Nurse practitioners
        iii. Pharmacists
        iv. Respiratory therapists (for treatment within their scope of practice)
        v. Physical and occupational therapists (for treatment within their scope of practice)
        vi. Laboratory technician
        vii. Imaging technician
        viii. Registered dietitians (for diets, tube feedings and nutritional supplementation).
        ix. CRNA

x. Paramedic/EMT
xi. Physician assistant
xii. Certified Medical Assistant
xiii. Licensed Independent Certified Social Worker

b. Under no circumstances may the Health Unit Coordinator (HUC) or other non-licensed personnel accept verbal orders.

c. Verbal orders for medications shall be received and recorded only by health care professionals whose scope of licensure authorizes them to receive medication orders. Such orders shall be recorded promptly in the patient's medical record, noting the name of the person giving the verbal order, signed and dated by the individual receiving the order.

d. Verbal orders given over the telephone or in person shall be recorded promptly in the patient's medical record, noting the name of the person giving the verbal order, and signed and dated by the person receiving it.

e. Verbal orders must be promptly dated, timed and countersigned by the ordering practitioner. The practitioner who is responsible for the care of the patient and authorized to give such orders may countersign the ordering practitioner's verbal orders. A practitioner who countersigns a verbal order for another practitioner in such a situation assumes responsibility for the order as being complete, accurate and final.

f. To be accepted, verbal orders must be recorded and read back to the ordering practitioner, who must verify the accuracy and correctness of the information before the conversation is ended. Orders dictated *over* the telephone to a recording machine or through any unauthorized person as an intermediary of the practitioner, are not acceptable.

4. Unless previously documented in the medical record or in Advanced Directives, Do Not Resuscitate (DNR), "No Code" or other orders to withhold or withdraw life-sustaining treatment must be entered into the patient record and accompanied by appropriate documentation describing the patient's medical condition and the discussions with the patient and/or patient's family on which the order is based.

5. All practitioners are responsible for adhering to the Hospital's policies and procedures regarding the ordering and use of restraints.

6. Dietitian Orders:

    a. Registered Clinical Dietitian will review diet orders on assigned patient care unit(s).

    b. After nutritional assessment, Registered Clinical Dietitian may:

i. Initiate and modify diet order
ii. Modify diet texture
iii. Initiate or change a calorie level
iv. Initiate or change enteral feeding after a provider referral for tube feeding
v. Initiate or modify therapeutic diet order
vi. Registered Clinical Dietitian may not order or discontinue or change a fluid restriction
vii. Initiate or change oral nutritional supplements (see Nutrition Services: Nourishments and Supplements policy)
viii. Conduct nutrition education/counseling
ix. Initiate referrals to outpatient nutritional services

H. COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE) USE AND ENFORCEMENT

1. CentraCare - Monticello has established CPOE as the mechanism for placing orders. Practitioners are expected to use CPOE. To optimize patient care, it is recognized that cause may exist to not use CPOE. Specific cause may include, but not limited to:
    a. Orders given for emergent care where the need for immediate care must supersede the mechanism of order entry.
    b. Situations where extraordinary volume and urgency requires expediting the order process.
2. All order sets will be reviewed and approved by the Medical Staff Executive Committee.

I. INFORMED CONSENT

1. No elective procedure or special diagnostic or therapeutic procedure may be performed in the Hospital unless a signed informed consent, meeting applicable legal requirements, has been obtained from the patient or the person legally responsible for the patient. Refer to the Informed Consent for Procedures Policy.
2. It is the treating practitioner's responsibility to obtain informed consent. Hospital personnel may assist in providing the information necessary to secure the patient's informed consent. It is the final responsibility of the treating practitioner to review this information, answer questions and obtain informed consent.

3. The practitioner who obtains the informed consent of the patient or legal representative shall document their conversation in the patient's medical record.
4. Should the patient and/or responsible party not agree to some aspect of this regimen, the practitioner should explain the nature and benefits of the recommended treatment, and the medical risks and possible consequences of refusing such treatment, including any options to the treatment being refused. The patient and/or responsible party shall then sign a form acknowledging their understanding of the medical risks and possible consequences of refusing the recommended treatment.
5. The informed consent must specifically name the procedure(s) to be performed and the name(s) of the practitioner(s) performing the procedure(s). This includes the name and description of the surgical tasks of practitioners other than the primary surgeon who performs important parts of the procedure(s), such as harvesting grafts, implanting devices, or dissecting, removing or altering tissues. The consent must include the date and time of obtaining informed consent and the signature of at least one witness who verifies the signature is that of the patient or the patient's representative, and that the form was signed prior to the procedure.
6. Except in medical emergencies where the patient lacks the capacity to give informed consent, and no legal representative is available, such that informed consent may be presumed as described in paragraph "4" of this section, explanations must be given, and informed consent obtained before the patient receives any sedative or narcotic preoperative medication that might alter the level of consciousness.
7. Informed consent for medical or surgical treatment may be obtained by telephone, or by other means such as e-mail, facsimile (fax), or via video conference or telemedicine, only if the person having legal capacity to consent for the patient is not otherwise available. In such instances, the responsible practitioner must, to the extent possible given the circumstances and the technology utilized, provide the patient's legal representative with the information he would disclose if the person were present. Telephone or video conferencing/telemedicine is preferable to e-mail or facsimile when informed consent is needed. The following must be obtained prior to surgery:
    a. Hospital staff must verify that the patient's legal representative and the treating practitioner have discussed the patient's condition and the recommended treatment, and that the patient's representative has in fact, given informed consent.
    b. Telephone discussions between the patient's legal representative and the person obtaining the representative's consent should be witnessed by an additional responsible hospital employee. The exact time and nature of

the informed consent given should be carefully documented and signed by both employees. The patient's representative must be informed that the second person will be listening to the discussion.

c. When informed consent is given by telephone or video conferencing/ telemedicine, immediate steps should be taken to procure a confirmation of informed consent by facsimile, e-mail or letter whenever possible.

d. If facsimile or electronic scanning is available, informed consent forms can be transmitted to the representative for signature, and when signed, returned by facsimile or email, with the original to follow by mail.

e. In limited situations, e-mail may be a means of communicating with the person who is legally able to consent for a patient. Informed consent for basic hospital services and medical treatment that do not require documented informed consent may be obtained by requesting an e-mail confirming the informed consent given. If informed consent is required, the responsible practitioner should make the request for informed consent by sending a message stating, to the extent practical, the information necessary to obtain such consent (e.g. the reason for and nature of the treatment, the risks, benefits, alternatives, etc.)

8. In case of emergency, when the patient or responsible party is unable to give informed consent and there is no evidence that the patient or the patient's legal representative would refuse the treatment (such as a known religious belief), the following procedure shall be followed.

    a. The patient's practitioner must determine if:

        i. the patient has a condition that could lead to death or serious disability if not immediately diagnosed and treated, or

        ii. immediate services are required to alleviate severe pain.

        If such an emergency condition exists and there is no evidence that the patient would refuse the treatment, informed consent is implied by law, and treatment for the emergency condition may be provided.

    b. In no case shall any procedure specifically refused by the patient or responsible party be performed.

J. CONSULTATIONS

1. It is the duty of the Medical Staff and the Medical Staff Executive Committee to see that members of the staff do not fail in the matter of obtaining consultations

as needed. Where circumstances justify such action, the Chief of Staff or designee may request, or require a consultation.

2. Requests for consultation should be made by the attending practitioner to the consulting practitioner. The attending practitioner must document the consultation request and is responsible for supplying the consultant with all available and relevant information regarding the patient and the need for the consultation. The attending practitioner's responsibility for his or her patient does not end with a request for a consultation.
3. Any qualified practitioner with clinical privileges can be called for consultation within his/her area of expertise and within the limits of clinical privileges that have been granted.
4. Essentials of a Consultation - A satisfactory consultation includes examination of the patient and the medical record as requested by the attending practitioner. A dictated and/or written opinion signed by the consultant must be included in the medical record. This documentation should include evidence of review of the patient's record, pertinent findings on examination of the patient, the consultant's opinion and recommendations. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation. (Unless the surgeon is the one who performed the H&P).
5. Except in an emergency, consultation is recommended, but not limited to the following instances:
    a. When the patient is not a good risk for an operation or treatment.
    b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.
    c. Where there is doubt as the choice of therapeutic measures to be used.
    d. In unusually complicated situations where specific skills of other practitioners may be needed.
    e. When requested by the patient or a surrogate decision-maker.

K. CONFLICT OF OPINION

In the event that there is a conflict of opinion between nursing staff and an attending practitioner or between treating physicians, regarding care of the patient, the attending practitioner will first be contacted by the responsible director, manager or administrative supervisor in an attempt to resolve the issue. If the issue cannot be resolved, the appropriate Medical Director, Chief of Staff or Chief Medical Officer may be contacted by the attending physician, director, manager or administrative supervisor to assist in resolving the problem.

L. REQUEST BY PATIENT FOR A CHANGE IN PRACTITIONER

A patient requesting a change in practitioner is responsible for securing a new practitioner. The attending practitioner shall continue to be notified of the patients request to change practitioners. The attending practitioner shall continue caring for the patient until a new attending practitioner has been identified and accepted the patient. The Medical Director, Chief of Staff or Chief Medical Officer may need to provide or delegate medical coverage during the interim period.

M. MEDICAL RECORD RULES

1. MEDICAL RECORD REQUIREMENTS

These Rules and Regulations regarding Medical Records shall be interpreted to apply to all versions of the Medical Record, including but not limited to, electronic or paper forms of the record, and shall include the use of electronic signature.

A. All entries in the medical record must be dated, timed and authenticated

B. The patient's attending practitioner and each practitioner involved in the care of the patient shall be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current. The record will include:

I. Identification data
II. Chief complaint and history
III. Personal History
IV. Physical Examination
V. Special reports; e.g., diagnostic reports, consultations, clinical lab
VI. Provisional diagnosis
VII. Medical and surgical treatment
VIII. Pathological findings
IX. Progress notes
X. Final Diagnosis
XI. Condition on discharge
XII. Discharge, transfer or death summary
XIII. Code status and decisional capacity
XIV. Follow up and autopsy reports as applicable
XV. Discharge disposition

2. PROGRESS NOTES:

A. After visiting the patient, the physician must provide the required documentation:

I. Med/Surg: OB; Observation; and ICU at least once every 24 hours.

II. Swing Bed: at least every seventh day.

B. The attending practitioner is required to document the need for continued hospitalizations; failure to do so shall be brought to the attention of the Medical Staff Executive Committee.

3. HISTORY AND PHYSICAL (H&P)

A. The content of the H&P examination should be based on information considered clinically pertinent by the clinical service. An H&P examination should include, but is not limited to:

i. A clear description of the presenting complaint(s).

ii. Thorough medical history describing significant medical conditions, previous significant surgeries and other procedures, current medications and allergies.

iii. Significant social factors and family history that may have impact upon medical condition(s), treatment plan and ongoing post-discharge care.

iv. Review of systems in sufficient detail to identify additional symptoms that relate to presenting illness, may require additional evaluation and management, or may impact current treatment episode.

v. Physical examination that includes, at a minimum, an overall assessment of patient status, recording of vital signs, exam of major organ systems, and additional body systems that relate to presenting illness.

vi. Initial clinical impression(s) and/or differential diagnosis.

vii. Management plan that includes additional diagnostic studies to confirm clinical impression and treatment plan.

viii. An abbreviated H&P is acceptable in certain situations (as noted later in the policy; also see Appendix A see below) and consists of, at a minimum, the following documented elements:

a. Chief Complaint and/or Reason for Procedure

b. Current medications and dosages

c. Known allergies, medication reactions

d. Statement of patient's general medical condition, including pertinent co-morbid conditions, cardiopulmonary status and other conditions that

affect the patient's ability to tolerate sedation/analgesia/anesthesia (including any previous reaction to anesthesia/sedation)

e. Relevant physical findings (must include exam of heart, lungs, airway, and anatomic assessment of area involved in procedure)

f. Sedation plan based on assessment

g. Anesthetic risk and/or ASA classification

h. **PRE-SEDATION ASSESSMENT:**

i. Lung Exam

ii. Heart Exam

iii. Mallampati Airway Classification

iv. Comment(s)

v. ASA Classification

Appendix A

Type	Full H&P*	Abbreviated H&P*	At MD discretion
Any Inpatient Admission	**X**		
Outpatient with General Anesthesia, Regional Anesthesia or Monitored Anesthesia Care (MAC), or deep sedation	**X**		
Outpatient Procedure with moderate Sedation/ Analgesia		**X**	
Outpatient Invasive Procedure with or without Local Anesthesia			**X**
Outpatient Non-Invasive Procedure without Sedation/Analgesia/Anesthesia			**X**

ix. History & Physical (H&P) Timing Requirements:

a. Inpatients:

i. A full H&P is to be completed and documented in the medical record up to 30 days before or 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services (e.g., general anesthesia, monitored anesthesia care or regional anesthesia care).

ii. For H&P's completed within 30 days prior to admission, an H&P update documenting any changes in the patient's condition and physical exam is also completed within 24 hours after admission, but prior to surgery or procedure requiring anesthesia services.

b. Outpatients with Invasive Procedures with Sedation/Analgesia:

i. Outpatients having surgery or invasive procedures with general anesthesia, regional anesthesia, monitored anesthesia care or deep sedation must have a full H&P completed within 30 days prior to the procedure.

ii. Outpatients having procedures requiring moderate sedation/ analgesia (conscious sedation) must have at least an abbreviated H&P 30 days prior to the procedure. Refer to Sedation policy.

c. Outpatient procedures, invasive, with or without local anesthesia; non-invasive, without sedation, analgesia, or anesthesia:

i. The performance of an H&P is at the discretion of the physician or licensed independent practitioner performing the procedure.

ii. There must be at least a chief complaint or reason for the procedure listed.

x. CANCELLATIONS, DELAYS AND EMERGENCY SITUATIONS

a. When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, endoscopy, colonoscopy, bronchoscopy, radiological procedures with sedation, and procedures performed in the Emergency Department), the operation or procedure will be canceled or delayed by the Surgical Services Manager or Anesthesiologist until a complete history and physical examination is recorded in the medical record, **unless** the attending physician states in writing that an emergency situation exists.

b. In an emergency situation, when there is no time to record a complete history and physical, the attending physician may utilize the Emergency Department note, which shall meet the documentation requirements in Section M.5. by recording an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's condition, heart rate, respiratory rate, blood pressure, and diagnosis. Immediately following the emergency procedure, the attending physician is then required to complete and document a full history and physical examination.

4. OPERATIVE REPORTS

A. Operative reports shall be recorded or dictated immediately after surgery and will be entered into the patient record as soon as possible, but not longer than 24 hours after the procedure.

i. Operative Reports shall include:

a. Patient name and medical record number

b. Date of surgery

c. Preoperative diagnosis

d. Procedure(s) performed

e. Names of the licensed independent practitioners who performed the procedure and assistants

f. Description of the procedure

g. Findings of the procedure

h. Estimated blood loss

i. Any complications

j. Any specimens removed; and

k. Postoperative diagnosis.

ii. If the full operative report is not immediately documented after surgery, an immediate procedure/operative progress note is recorded in the medical record before the patient transfers to the next level of care. The progress note shall include:

a. The name of the primary surgeon and assistants

b. A description of the surgical findings (including complications)

c. Procedures performed

d. Specimens removed

e. Estimated blood loss

f. Pre and Post-op diagnoses

g. Type of anesthesia administered

h. Grafts or implants (may indicate where in chart for detail)

iii. Before moderate or deep sedation or anesthesia, a pre-sedation or pre-anesthesia evaluation shall be completed and recorded in the patient's record. Immediately before administering moderate or deep sedation or

anesthesia, the patient is re-evaluated with conclusions recorded. A post anesthesia evaluation is completed and recorded after any procedure requiring anesthesia.

iv. Obstetrical epidurals only require a procedure note that includes the reason for procedure and procedure findings.

B. In all surgery cases, the staff member with surgical privileges will be responsible for the number and qualifications of his/her assistants. In any surgical procedure with unusual hazard to life, the assistant must be a physician who is present and scrubbed.

5. DISCHARGE SUMMARY

A. A discharge, transfer or death summary shall be dictated or recorded for all patients at the time of this event. The discharge, transfer or death summary shall be completed, authenticated by the responsible practitioner and placed in the medical record as soon as possible. It shall include:

i. Final diagnosis

ii. Reason for hospitalization

iii. Procedures performed

iv. Care and treatment of services provided

v. The condition and disposition at discharge including physical activity, psycho-social status, medication, diet and arrangements for follow-up care

vi. Documentation of a physical exam at time of discharge

All patients require a discharge/transfer or death summary, including newborns, unless otherwise noted.

B. A final discharge note may be used instead of a discharge summary for non-complicated patients that stay less than 48 hours, excluding newborns.

A final discharge note will include the following:

i. Outcome of hospitalization

ii. Disposition of case

iii. Provision for follow-up care

C. For swing beds: The information sent to the receiving provider also includes the following:

i. Contact information of the practitioner responsible for the care of the resident.

ii. Resident representative information, including contact information.

iii. Advance Directive information

iv. All special instructions or precautions for ongoing care, when appropriate.

v. Comprehensive care plan goals.

6. OBSTETRICAL RECORDS

A. Obstetrical records shall include

1. A complete (signed and dated) prenatal record that includes a documented visit within 30 days of admission with an interval admission note written within 24 hours of admission, to include pertinent addition to the history and subsequent changes in physical findings. If a provider visit was not completed within 30 days of admission, a full history and physical will be required except in emergency cases. Cesarean section deliveries will require a full history and physical prior to surgery. The complete prenatal record, may be a legible copy of the attending physician's office records transferred to the hospital prior to admission.
2. A labor and delivery summary shall be completed for every delivery.
    i. A discharge summary is not required for OB patients with normal term delivery without complications (endometritis, hemorrhage, thrombophlebitis, wound infection, etc.)
    ii. If a final discharge summary is not required, a progress note on the day of discharge with final diagnosis will be required.
    iii. An operative note and discharge summary is required for patients who have a cesarean section. A complete history and physical is required for elective cesarean sections.

7. NEWBORN RECORDS

A. Newborn records must include a physical exam within twenty-four (24) hours of birth.

B. A final discharge summary on the day of discharge will be required. (See discharge summary requirements).

8. EMERGENCY DEPARTMENT RECORDS

A. The medical staff shall adopt a method of providing medical coverage in the

emergency services area, consistent with the hospital's basic plan for delivery of such services.
Patients who present with a potential emergency medical condition will have a medical screening exam (MSE) performed by an Emergency Medicine physician, or any other privileged physician acting within the scope of his/her privileges; or any Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Certified Nurse Midwife (CNM), Licensed Psychologist (LP), or Clinical Nurse Specialist (CNS) practicing within the scope of his/her functions and who has been approved by the Medical Staff and Operating Committee of the Board of Directors.

B. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital records, if such exists. The record shall include:
    i. Adequate patient identification;
    ii. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
    iii. pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his/her arrival at the hospital;
    iv. description of significant clinical, laboratory and imaging findings;
    v. diagnosis and treatment given;
    vi. condition of the patient on discharge or transfer; and
    vii. final disposition, including instructions given to the patient and/or his/her family, for any necessary follow up care.

9. GERIATRIC BEHAVIORAL HEALTH UNIT RECORDS

A. A medical assessment will be completed within 23 hours of admission by a physician or APP.

B. An admitting diagnosis must be made on all patients admitted to the psychiatric unit.
    i. All psychiatric patients must be admitted with a principal psychiatric diagnosis.
    ii. The admitting diagnosis must include the medical diagnosis, other disease diagnoses, if any, and the psychiatric diagnoses.
    iii. The reasons for admission must be clearly documented as identified by the patient or others significantly involved with the admission, or both.

C. A complete neurological examination, if indicated, must be documented at the time of admission to the psychiatric unit.

D. Each patient must receive a psychiatric evaluation by a psychiatrist or APP within sixty (60) hours of admission to the psychiatric unit. The psychiatric evaluation must include the following:

   i. Medical history;

   ii. Assessment of mental status;

   iii. Description of the patient's attitudes and behavior;

   iv. Assessment of intellectual and memory functioning and orientation; and,

   v. Description of the patient's personal strengths, i.e., knowledge, interests, skills, aptitudes, personal experiences, education, talents, and employment status in descriptive, not interpretive language.

E. Progress Notes: A psychiatrist will document a weekly progress note at a minimum.

10. DOCUMENTATION REQUIREMENTS FOR OTHER PATIENT CLASSIFICATION

a. Alternative Care Bed (ACB):

A pre-arranged hospital stay that does not qualify for hospice and does not meet the medical necessity requirements for hospitalizations.

Documentation Requirements: An H&P is not required. Nursing progress notes shall be documented but no rounding from a provider will occur during an ACB stay.

b. Respite Hospice:

Short-term temporary respite care to those needing intermediate to skilled nursing service.

Documentation Requirements: An H&P or an update to an H&P done within the last 30 days must be completed within 24 hours of admission for respite care.

c. Outpatient Observation:

Services furnished to evaluate an outpatient's condition to determine the need for possible admission as an inpatient.

Documentation Requirements:

i. Provider Order for Observation Services
ii. Admission documentation of the medical necessity for observation services including the monitoring and treatment to be administered during the outpatient observation period

iii. Progress notes documented at least daily along with a final progress note including the final diagnosis, summary of the patient's condition and care received once the patient is stable for discharge or requires admission as an inpatient.

d. Outpatient in a Bed:

Outpatients that need additional care, but do not require admission to the Hospital as Inpatient or Observation.

Documentation Requirements:

i. Documentation to include the plan of care
ii. Progress notes at least daily with a final progress note to include the discharge plan.
iii. Documentation of any procedures performed is required as specified in the Operative Reports section of these Rules & Regulations.

11. COMPLETION REQUIREMENTS

All medical record documentation for inpatient and outpatient visits will be completed no later than 48 hours after patient contact. Documentation not completed within 48 hours will become delinquent in accordance with the Delinquent Documentation Policy.

Federal Regulations dictate that these types of documentation must be completed within 24 hours, they will be considered deficient if incomplete at 24 hours and delinquent if not completed within 48 hours:

A. Histories and Physicals not present on admission must be completed within 24 hours of patient admission by the admitting/attending provider.

B. Consultations

C. Operative or Procedure Reports (including Delivery Reports)

Reports of operation or delivery shall be documented by the physician performing the procedure immediately following the operation/procedure/delivery. If the report is dictated, a brief descriptive note which summarizes the procedure must be documented in the record immediately following the procedure to provide information prior to the final report being available. Dictated operative reports must be completed within 24 hours of the operation. Physicians who electronically document their operative/procedure/delivery reports at the conclusion of the event need not complete this interim note.

D. The total record, including signatures, shall be completed within 30 days of discharge. Days absent for illness, vacation, etc are not counted when calculating delinquency. It is the responsibility of the provider to notify Health Information

Management of vacation plans or other absences. The provider must complete their medical records within 72 hours of their return to work.

12. MEDICAL RECORD COMPLETION ENFORCEMENT PROCEDURE

Procedure to be followed when patient records are not completed within the specified time period:

A. Physicians or other licensed independent practitioners with incomplete records in the time periods outlined above shall be notified in accordance with the Delinquent Documentation Policy. Failure to complete the records within the required timeframe (30 days) shall result in action up to, and including, automatic suspension of privileges pursuant to the CentraCare – Monticello Hospital Medical Staff Bylaws. Suspension will be activated by the Medical Staff Office.

B. The Chief of Staff (or designee) shall notify the individual physician(s) or other licensed independent practitioner affected when privileges are suspended.

C. The Manager of Credentialing and Privileging (or designee) shall notify the following persons and departments of the physicians or other licensed independent practitioners whose privileges have been suspended:
   i. Chief of Staff
   ii. Director – Patient Care
   iii. Patient Access, Emergency Department, Surgery Department
   iv. Clinic of the suspended Provider if they cover call

D. Health Information Management Department shall communicate the status of the incomplete records with the Medical Staff Credentialing and Privileging office.

E. If dictation has been completed on an incomplete record but the record has not been available for signature, the provider will be allowed one week grace period before being suspended.

F. Reinstatement of privileges is automatic upon completion of delinquent records. Failure to complete the medical records within 30 days following notice of suspension will result in automatic resignation from the Medical Staff or APP/AHP Staff.

G. Six suspensions in the past 12 months may result in automatic resignation from the Medical Staff or APP/AHP Staff. The Medical Executive Committee will review for disciplinary action.

N. PERIODIC REVIEW

Outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants will be periodically reviewed. A sample of records to be reviewed for the aforementioned practitioners will be determined by the

Medical Executive Committee.

O. OWNERSHIP OF MEDICAL RECORDS

All records are the property of CentraCare - Monticello and shall not be removed, except by court order or subpoena. Prior to removal, a copy of the documents released will be made by the Hospital. Release and review of records will be carried out in compliance with the hospital wide policies on Patient Privacy and Confidentiality, and Release of Information.

P. VALIDATION OF RESIDENT MEDICAL RECORDS

To assure that all legal, regulatory, and liability issues involving chart documentation are addressed when residents prepare reports.

To provide guidelines for institutional determination of the physician and/or advanced practice provider (APP) responsible for countersigning resident medical records.

As part of their education, residents are expected to prepare history and physicals, progress notes, discharge summaries, operative reports, and consultations. These various reports (and this list is not exhaustive) are prepared on patients who are admitted under the name of a member of the medical staff. This physician and/or the practitioner designated by the admitting physician, has the legal, regulatory (Joint Commission), and liability responsibility for the patient. Resident will document in each note/narrative, the name of the practitioner that is supervising the care of the patient.

Residents can hold one of two types of medical license in Minnesota. Until they have completed one year of postgraduate training, residents are issued a license that limits their medical practice to activities within the residency. After successful completion of the first year for US medical graduates and the second year for International medical graduates, they are encouraged to apply for a regular license. This allows them to carry on employment activities outside the residency if approved by the program director. However, their patient care activities when working as a resident are still required to be supervised. Supervising practitioners may differ in the degree of latitude granted residents to independently issue orders on patients. A frank discussion between the practitioner and the resident early in their interaction may reduce the possibility of misunderstandings.

Because they hold valid licenses, residents may enter orders or give verbal orders. Waiting for a supervising practitioner's co-signature before carrying out an order would delay care and be difficult to manage, and thus is unnecessary.

Medicare regulations stipulate what involvement the supervising practitioner needs to have to properly bill for services to Medicare patients and avoid criminal fraud charges.

1. Every resident sees patients at CentraCare - Monticello under the supervision of a credentialed practitioner, except when working independently within an employment agreement outside of their residency contract.

2. Supervising practitioners, in their discretion, may delegate the responsibility of patient recordkeeping to a resident physician. Validation of a patient's record of care remains the responsibility of the supervising physician. Validation is required for H&P's, Progress Notes, ER Record or Note and Discharge Summaries. When an APP supervises a resident, the APP's documentation is the only information that can be utilized for billing purposes.
3. To help distinguish who the supervising practitioner is at any particular time, residents will include the practitioner's name as part of their narratives.
4. The supervising practitioner and the resident will discuss the resident's independent issuing of orders at the start of each rotation.
5. Orders, either written or verbal, initiated by a resident do not need to be co-signed.
6. The residency program will develop educational programs and written materials to help the attending staff comply with Medicare regulations regarding resident supervision.
7. Participation in the teaching program is voluntary for members of the Medical Staff. Non-participation with the program will not affect the practitioner's Medical Staff appointment or privileges.

Q. ADOPTION AND AMENDMENT

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within the Medical Staff Bylaws, subject to the approval of the Operating Committee. These rules and regulations shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Hospital. The rules and regulations shall be part of the Medical Staff Bylaws and any changes made to the rules and regulations shall become effective when approved by the Operating Committee.

Applicants and members of the Medical Staff and others holding clinical privileges shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the Medical Staff Bylaws and the Rules and Regulations, the Bylaws shall prevail.

Violation of these rules and regulations shall be grounds for disciplinary action in accordance with the Medical Staff Bylaws.

These Rules and Regulations may be amended only in accordance with procedures set forth in the Medical Staff Bylaws. These Revised and Restated Rules and Regulations of the Medical Staff shall be communicated at a regular or special meeting of the Medical Staff, or via electronic communications, and shall replace any previous Rules and Regulations, and shall become effective when approved by the Operating Committee.

Approval Signatures

Step Description	Approver	Date
Operating Committee	Karleen Janssen: MONT EXEC ASST TO ADMINISTRATOR EX	06/2023
Medical Executive Committee	Karleen Janssen: MONT EXEC ASST TO ADMINISTRATOR EX	06/2023
Chief Medical Officer and QRA Director	Caryn Bommersbach: CCH DIR QUAL ASSUR & MED STAFF COMPLIANCE EX	06/2023
Chief Medical Officer and QRA Director	John Hering: CCH PRESIDENT/ CMO CC MONTICELLO EX	06/2023
Document Owner	Karleen Janssen: MONT EXEC ASST TO ADMINISTRATOR EX	06/2023