METHODIST HEALTHCARE -
MEMPHIS HOSPITALS
AND METHODIST HEALTHCARE –
OLIVE BRANCH HOSPITAL

UNIFIED GENERAL RULES & REGULATIONS

GENERAL RULES AND REGULATIONS

1.0 ADMISSION AND DISCHARGE OF PATIENTS

1.1 NON-DISCRIMINATION

Medical staff members shall comply with hospital's policies regarding the admission, transfer, and discharge of patients. All services available to Hospital and Provider-based clinic patients shall be provided in a non-discriminatory manner, without regard to age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, gender, sexual orientation and gender identity or expression.

2.0 PATIENT CARE

2.1 INSERTION OF CENTRAL LINES

A catheter checklist and a standardized protocol will be used for all central lines.

Hand hygiene will be performed prior to catheter insertion or manipulation. Standardized kits/supplies will be used for the insertion of all CVLs. Full barrier protection is to be used for the insertion of all non-emergent central lines; exceptions for emergency insertions will be appropriately documented. Chlorhexidine will be used for CVL skin prep. Standardized protocol will be used to disinfect catheter hubs. When noncompliance with the central line insertion bundle is observed, nurses and other clinicians are empowered to "Stop the Line" until the issue is corrected

All CVLs will be evaluated daily; nonessential catheters will be removed. When adherence to aseptic technique is compromised (i.e. catheters inserted during a medical emergency), replace the catheter as soon as possible, i.e., within 24 hours.

For adult patients, femoral catheters will not be used unless other sites are unavailable. If a femoral site is emergently required or no other location is available, document the justification. When an adult patient arrives with a femoral catheter site and a central line is required, relocate to an upper extremity site within 24-48 hours if medically possible.

2.2 SEDATION AND ANALGESIA ORDERS FOR ADULT CRITICAL CARE PATIENTS

All patients on mechanical ventilation requiring sedation and analgesia will be placed on the Sedation and Analgesia standardized orders appropriate for the patient's condition.

2.3 HOSPITAL/FACILITY/PROVIDER-BASED CLINIC POLICIES

Policies regarding patient care should be followed at all times including but not limited to:

1. Patient Identification and Armband Use Policy - to ensure the accuracy of patient identification and delivery of safe, effective patient care
2. Consents and Authorizations - to define and describe responsibilities for obtaining and documenting consents or authorizations for conduct of patient care and supporting programs.
   The medical staff has specified and approved the procedures that require a properly executed informed consent form; the list is appended to the hospital informed consent policy.
3. Universal Protocol, Site Marking, Time Out - to promote patient safety by providing guidelines for verification of correct patient, correct procedure, and correct site for invasive/surgical procedure(s)
4. Medication Reconciliation Policy - to avoid therapeutic duplication, drug-drug interactions, and interactions between treatments/procedures and medications
5. Restraint Policy- to ensure the patient's rights, dignity, and safety are maintained when protective restrain is necessary to protect the patient from harm and prevent interference with his/her treatment plan
6. Incorrect Surgical Counts - In the event of an incorrect count, which includes lap sponge, instrument, needle or any other counted item; the current hospital policy will be followed, including x-ray requirements as per policy.

2.4 SLEEP APNEA GUIDELINES - ADULT

Patients with known or suspected sleep apnea presenting for surgery may require special postoperative considerations. The severity of the OSA, the nature of the planned surgical procedure, and the effectiveness of home CPAP (if prescribed) all factor into the patient's postoperative course.
Patients are typically stratified across three criteria:

- the severity of the OSA
- the available and effective use of home CPAP
- the nature of the procedure (airway surgery or procedures that typically result in significant postoperative pain).

In general patients with an apnea hypopnea index greater than 30 or a BMI greater than 35, or oxygen saturations less than 90% in PACU are at increased risk. Patients meeting any of these increased risk criteria should, at a minimum, undergo prolonged PACU and SDS observation prior to discharge. Strong consideration should be given to overnight telemetry observation for any patient with somnolence, borderline oxygen saturations, or poor pain control.

Patients with OSA undergoing airway surgery (to include pharyngeal, laryngeal, or jaw advancement) should be, at a minimum, monitored overnight in a telemetry bed. Patient with severe or poorly managed OSA undergoing airway surgery may (at the discretion of the anesthesiologist or surgeon) require overnight ICU monitoring.

2.5 SLEEP APNEA GUIDELINES – **PEDIATRICS**

Pediatric patients (of all ages) presenting for surgical procedures and having risk factors for postoperative respiratory complications with obstructive sleep apnea syndrome undergoing an adenotonsillectomy, ENT surgery or other non-airway surgery should have surgery where

inpatient Pediatric Advanced Airway can be provided. A collaborative management plan should be developed by the involved surgeon, anesthesiologist, as well as consultants in sleep medicine and/or pediatric Pulmonology, when needed, to reduce the risk of post operative complications.

Risk Factors for postoperative respiratory complications in children with known or suspected OSAS undergoing adenotonsillectomies, ENT surgeries or other non-airway surgeries:

- Age younger than 3 years
- Severe OSAS on polysomnography
- Cardiac complications of OSAS (e.g. right ventricular hypertrophy)
- Failure to thrive
- Obesity
- Prematurity
- Recent respiratory infection
- Craniofacial anomalies*
- Neuromuscular disorders*

Severity of OSA and the nature of the planned surgical procedure all factor into the patients Perioperative course and can be assessed by a sleep study to decide the Perioperative anesthetic management of a patient. The sleep laboratory assessment (none, mild, moderate, or severe) should take precedence over the AHI (the number of episodes of sleep disordered breathing per hour).

Severity of OSA	**Adult AHI**	**Pediatric AHI**
None	0-5	0
Mild OSA	6-20	1-5
Moderate OSA	21-40	6-10
Severe OSA	> 40	>10

*Guidelines apply for pediatric patients of all ages; however, there are increased risk factors noted in the table above for children < 3 years of age.

2.6 NEUROLOGIC ADMISSIONS FOR PATIENTS LESS THAN 18 YEARS

The following suspected neurologic diagnoses/conditions exclude children less than 18 years (except NICU transfers) from admission to any MLH facility other than Le Bonheur Children's Hospital:

1. status epilepticus of any type
2. new onset partial seizure
3. acute myelopathy
4. stroke(thromboembolic or hemorrhagic)
5. suspected inflammatory polyneuropathy
6. head trauma with or without LOC
7. suspected CNS or PNS infection of any kind
8. neurologic condition requiring mechanical ventilation

9. acute or evolving focal neurologic deficit of brain or spinal cord
10. known or suspected intracranial or intraspinal space occupying lesion
11. acute onset of altered mental status
12. neurologic condition with associated risk of progressive respiratory failure
13. suspected acute or chronic shunt malfunction

2.7 REMOVAL OF INDWELLING URINARY CATHETERS

A standardized protocol will be used for patients with indwelling urinary catheters (foley). Foleys will be removed per protocol to prevent Catheter Associated Urinary Tract Infections. Evidence-based guidelines direct management of foleys to prevent hospital associated infection.

Physicians order the insertion and maintenance of indwelling urinary catheters. Nurses will perform assessments and will remove catheters per protocol unless the patient has an acceptable and documented indication to continue the foley:

- Physician order to continue, including a documented acceptable indication
- Post-op surgery less than 24 hours ago
- s/p OB or Gynecologic surgery
- s/p Urologic surgery
- s/p Colorectal surgery
- s/p kidney, pancreas, or liver transplant
- s/p surgery on structures surrounding the genitourinary tract
- Spinal fusion, scoliosis w/prolonged immobilization
- Patient paralyzed, on a ventilator, requires a catheter and an external "condom" catheter is not appropriate
- Strict urine output monitoring in a critical care patient
- Continuous bladder irrigation or Medication instillation
- Acute urinary retention
- Bladder outlet obstruction
- Open sacral or perineal wound w/ urinary incontinence.
- Epidural in place
- Strict 24 hour urine collection and incontinence
- Hospice care (for patient comfort)
- Chronic history of indwelling or suprapubic catheter

3.0 EMERGENCY DEPARTMENT CARE

3.1 PREGNANT PATIENTS PRESENTING TO EMERGENCY DEPARTMENT

Pregnant patients presenting to the Emergency Department shall be treated in the following manner.

1. A pregnant patient over twenty (20) weeks gestation with obstetrical problems shall be seen in the emergency department, evaluated, and further treatment provided in the labor and Delivery area as needed.
2. A pregnant patient over twenty (20) weeks gestation with non-obstetrical problems will be evaluated in the emergency department and the patient's obstetrician or the obstetrician on call will be notified.

3. A pregnant patient under twenty (20) weeks gestation will be seen by the Emergency Department provider and an appropriate care plan developed for the patient's disposition.

3.2 PRONOUNCING DEATH FOR ADULT INPATIENTS & SIGNING DEATH CERTIFICATES

A. **Pronouncing Adult Inpatients**

This process is intended to be used during hours when the admitting physicians depend on the emergency department physician to pronounce any patients who expire during those hours. Typically these will be patients who are not candidates for resuscitation.

If the patient's admitting physician is not available, the patient is placed on a cardiac monitor and the rhythm is transmitted to the ED workstation. In order to maintain flow of information to the family, the Administrative Supervisor will be notified; and he/she will be the one to explain this process to the family who might be in attendance.

The primary care nurse of the patient who has expired, if an RN, or the PCC will review with the ED physician or RN – MRT (as applicable) a comprehensive report. This report will include the patient's name, PCP, consults, and clinical status (vital signs, rhythm on the cardiac monitor, neurological status, circulatory status and respiratory status). Additional information may be required, such as: admitting diagnosis and any subsequent events which may be pertinent to the patient's demise. This report and the rhythm strip, which is transmitted to the ED physician is used to determine that the patient has expired. The patient's chart is then delivered to the ED, where the ED physician documents in the chart, "Pronounced dead at …" and gives the order to discharge to the funeral home.

The ED physician may pronounce the patient; however, the death certificate will be completed by the patient's admitting physician.

The RN – MRT (medical response team) may pronounce death in the above situations, if the death was anticipated or the patient was receiving palliative care, and the attending physician has agreed in writing to sign the death certificate. The agreement by the attending physician must be present with the deceased at the place of death.

B. **Signing Death Certificates for Adult Patients Who Expire in the Emergency Department**

The MLH Emergency Medicine Committee encourages a call to the patient's attending physician to request the attending physician to sign the death certificate. If there is a refusal from this physician, then the Emergency Department physician will consider signing the death certificate.

The following is a list of guidelines (criteria) for when the ED Physician will sign the death certificate. (This list is not all inclusive):

- Patients without an attending physician or one not identified
- Out of state patients/ no attending physician within the Facility's state
- Patients from the nursing home with or without advance directives
- Age greater than sixty-five years of age at physician discretion
- Patients with chronic debilitating conditions including conditions such as heart disease, chronic lung problems, or end stage renal disease.
- Obvious cause of death including life-threatening dysryhthmia, heart attack, and stroke

The following is a list of guidelines for when the ED Physician should NOT sign the death certificate:

- All patients that had surgery or trauma within three months of death
- Any trauma patients
- Deaths of suspicious origin
- Any request from the family, the attending physician, or ED physician for an autopsy
- Any case that involves police intervention other than a routine interaction with the emergency department
- Recent hospitalization within 3 months.

4.0 PERIOPERATIVE CARE

4.1 "NO EMERY HOUSE" PATIENTS: ANESTHESIA, SURGICAL CARE AND INVASIVE PROCEDURE CARE

Patients with advanced directives, including no emery house (NEH), and other orders which limit treatment, who develop complications during the anesthesia and the peri-operative period will be treated as medically and ethically appropriate.

If the patient or surrogate decision maker does not desire this suspension, his/her specific wishes of exception must be clearly delineated in the progress notes, entered as a physician order and discussed with the anesthesiologist prior to the induction of anesthesia.

4.2 ORDERS ENTERED BY CRNAs/GRNAs

Orders entered by CRNAs/GRNAs shall be reviewed and co-signed by a supervising anesthesiologist prior to the patient's transfer from the perioperative area.

4.3 SPECIMEN REMOVAL

All specimens removed during a surgical procedure should be sent to the pathologist for evaluation except for exempt specimens as determined by the Facility's Department of Surgery and Anesthesia.

5.0 GENERAL RULES AND REGULATIONS

5.1 NO EMERY HOUSE

A physician may document in the medical record, a “No Emery House” in accordance with the policy “Guidelines for Withholding or Withdrawing of Life Sustaining Treatment”.

5.2 DAILY VISITS OF PATIENTS

A. Every patient admitted as inpatient or placed in observation status will be visited by an attending/admitting physician designated substitute physician at least once a day in accordance with the requirements set forth below.

1. On the first day of patient admission, the attending/admitting physician or designated substitute provider must examine the patient, place a progress note, develop a care plan, and write appropriate orders within the following timeframes:
    - Med-Surg/Tele within 12 hours;
    - Stepdown within 6 hours; and
    - Intensive Care within 4 hours.

2. Each day after the day of admission, the attending/admitting physician or designated substitute physician must visit the patient and complete a progress note at least once every 24 hours except on the day of planned discharge.

B. An exception to the daily physician visit requirement may be made for patients admitted to the MLH Behavioral Health unit. This exception may be utilized only if the attending psychiatrist visits the patient on the days of admission and discharge. On days other than admission and discharge, the psychiatric nurse practitioner may round on behalf of the psychiatrist, but for no more than three consecutive days without the psychiatrist seeing the patient.

C. Newborns should be examined initially by the calendar day after birth and daily thereafter. Once the infant is discharged by the physician, no further visits are required, even if the infant remains with the mother in the hospital. The physician remains responsible for care until the infant leaves the hospital.

D. Repeat failure to abide by the requirements set forth above will be forwarded for review under the Professionalism Policy, the PPE Policy, and/or the Credentials Policy.

5.3 PHYSICIANS TREATING FAMILY MEMBERS

In accordance with the AMA Code of Medical Ethics, section 8.19, "Self- Treatment or Treatment of Immediate Family Members," members of the medical staff shall avoid performing elective surgical procedures (including the administration of general anesthesia) upon members of their immediate families.

They shall avoid serving as admitting, attending or consulting physicians for the medical care of first degree relatives (parents, children, siblings or spouses) in the hospital or as primary physician in provider-based clinics. They shall exercise prudence when observing procedures done by other physicians on family members in order to avoid disruption.

This regulation shall in no way be construed to prohibit emergency care of family members.

5.4 MEDICATION ORDERING GUIDELINES

Medication ordering guidelines shall apply to physicians and LIPs in hospitals and provider-based clinics.

A. Elements of a Complete Medication Order

A complete medication order will include the following:

- Date of order
- name of drug (either generic or brand)
- time of order
- dose
- dosing interval or frequency
- route of administration
- conditions for use if relevant (i.e. "for headache" for a PRN drug)
- Legible signature of prescribing practitioner and his/her Methodist ID#, or appropriate electronic signature.

B. Medication Ordering Guidelines

In the interest of minimizing errors, the following guidelines will be followed when documenting medication orders:

- Medication orders must be dated and timed
- The metric system is used for all medications (Apothecary symbols are not acceptable, e.g. grains, minims, etc.)
- Unapproved abbreviations must not be used
- Drug names must not be abbreviated
- Use a leading zero when dose is less than a whole unit
- Do not use a trailing zero
- Orders must clearly state administration times or time interval between doses

The indication or purpose for drug use should be included for all "PRN" orders; for other orders (except antibiotics), the medical history/course should provide sufficient information to support use of the medication. If multiple "PRN" orders are documented for the same indication (e.g. pain), the prescriber should provide qualification to help caregivers determine which drug or dose to choose (e.g. Tylenol for mild pain, Morphine for severe pain).

Range orders shall only be used in accordance with the hospital clinical policy for medication range orders.

"On Call" medication orders must be qualified by addition of the conditions for the call for the medication.

For drugs where the name might be confused with other medications, the alternate name (i.e. brand or generic) should be documented in order to minimize the risk of error.

If a medication order is incomplete or illegible, the prescriber will be contacted in order to clarify the order. If the prescriber cannot be identified or contacted, an alternate physician caring for the patient will be contacted.

C. Antibiotic Orders
The indication for antibiotic must be selected

D. Computerized Provider Order Entry (CPOE) and other EMR Requirements
CPOE is required when and where available and implemented. Appropriate training must be completed and competency established prior to a practitioner's use of CPOE. Current medical staff members (except Affiliate members) and AHP staff must complete all mandatory EMR training and competencies as required.

As new functionality becomes available in the EMR, additional mandatory training and use of that functionality when applicable may be required as defined by the MEC. By way of example, this includes electronic Medication Reconciliation and Transfer Orders Process. Failure to complete training and use the functionality within the time period specified by the MEC (typically within 30 days after implementation of functionality at a practitioner's hospital) may result in privileges being held in abeyance until training is completed and the new functionality is utilized when applicable.

5.5 CONSULTS

A. Except in an emergency, consultation is required when:
    1. The diagnosis is obscure
    2. A question exists as to whether or not a specific surgical procedure or proposed method of therapy is appropriate
    3. The patient has failed to respond to therapeutic measures over an extended period of time.
B. Consults should be answered/seen within 24 hours.
C. The specialty physician/group on call for ED coverage is responsible for responding to, and is expected to see, inpatient consults if one is placed for that physician/group on call. Those patients will be seen by the physician on ED call for that specialty, regardless of payor status or insurance plan. The ED call physician will be responsible for seeing all consults received by him/her during the time on ED call.
D. In non-emergent circumstances, a physician should examine and evaluate the patient before an elective consult.
    An emergency consultation will involve physician to physician communication.

5.6 EMERGENCY DEPARTMENT CALL COVERAGE

A. Each department or section shall provide a list of on-call physicians for patients who do not have a private physician. The on-call physician must be readily available and, if for any reason he/she is unavailable, he/she is responsible for supplying adequate coverage and informing the emergency department.
B. Each hospital/Facility will identify the specialties that provide call coverage on a 24/7 basis, partial basis and those services that are not available at its facility. A call coverage system will be designated at each facility for treatment of emergent patients. If a patient presents to the ED at a facility where the needed specialty does not have coverage, the patient will be stabilized and transferred to a facility that provides coverage. This may include a transfer to a facility outside of MH-MH or MHOBH.

5.7 PATIENT CARE AND PHYSICIAN NOTIFICATION (ED)

A. Notification Call: On call physicians should respond within 30 min. If after 30 minutes of placing a notification call there has been no response from a physician, the emergency medicine physician shall use his/her judgment for stabilization and disposition of the case, per Facility policy.

B. All patients presenting to the ED for care will receive a medical screening exam. If additional assessment and/or treatment is needed, the patient will be seen by either an emergency physician, on call physician, their private physician, dentist (as appropriate), or a qualified provider (nurse practitioner or physician assistant).

C. When a physician needs an ED physician to evaluate an inpatient, he/she must communicate with the ED physician directly.

D. If the ED physician feels that the medical situation so indicates, he/she shall use his/her discretion to obtain the most available physician to care for this emergency until his/her private physician or on-call physician arrives.

E. If the patient does not have a private physician, the disposition of the case shall be at the discretion of the ED physician. If a referral is necessary, the ED physician will use the on-call list.
Patients with co-morbidities and without established physician relationships, who require admission after an ED evaluation, should be admitted to one of the following specialties, as available at Facility:
- Internal Medicine
- Cardiology
- OB/GYN
- General Surgery
- Neurosurgery
- Pediatrics

F. A physician may not sign out to the ED for care of his/her patients.

G. Whenever the on-call physician or his/her designee is requested by the ED to come see a patient either in the ED or in another area of the hospital to which the patient has been admitted, including but not limited to the ICU or CCU, the physician or designee shall comply with the ED physician's request and be in attendance in a timely manner.

H. If the physician or designee refuses to come see the patient or is not timely in his/her attendance, the ED physician may call another physician and should call the Department Chair involved immediately. If he/she cannot reach the Department Chair or cannot resolve the matter, the ED physician should call the Facility Chief of Staff, Associate Chief of Staff (as applicable), and/or the President of the Medical Staff.

I. For all ED patients being admitted to ICU, the ED physician will call all consultants for notification purposes. Physicians are expected to return appropriately placed phone

calls and pages from hospital personnel within 30 minutes of the time the call/page is made.

5.8 ON CALL COVERAGE

A credentialed physician can provide on-call coverage (including making hospital rounds) for a credentialed sub-specialist as long as the credentialed physician does not exceed his/her level of approved privileges. During the period in which the credentialed physician provides on-call coverage the credentialed sub-specialist must be available (immediately by phone and within 30 minutes to the applicable Methodist Healthcare location) to ensure appropriate subspecialty coverage if needed.

5.9 PHYSICIAN RESPONSE TO PHONE CALLS/PAGES

Physicians are expected to return appropriately placed phone calls and pages from hospital personnel within 30 minutes of the time the call/page is made. Physicians in provider-based clinics shall address inquiries from patients seeking clinical advice within the guidelines established for the practice.

5.10 AUTOPSY POLICY

Autopsies may be performed in deaths where clinical questions are unanswered. An autopsy is not required for non-reportable situations. Reportable deaths (as defined by jurisdictional law) will be handled by the medical examiner*.

The Facility, in conjunction with the attending physician, attempts to secure autopsies in all cases of unusual deaths and of medical, legal, and educational interest, and informs the appropriate medical staff of autopsies that the hospital intends to perform.

When the autopsy is ordered by the attending physician, he/she should contact the pathologist directly to discuss the case and outline pertinent clinical questions to be answered by the examination.

* Reportable situations are defined in the MLH Clinical policies.

5.11 HIPAA VIOLATIONS

Violations of MLH's policies regarding PHI shall be handled in the following manner:

All complaints/reports of possible violations will be investigated by the Privacy Officer in collaboration with the HIM Director at the appropriate facility. If deemed a violation, the Privacy Officer will present the occurrence to the Peer Review Oversight Committee (PROC). The PROC will ratify the violation status and determine the severity according to the guidelines and make a recommendation to the MEC.

6.0 MEDICAL RECORDS

6.1 CONTENTS OF A MEDICAL RECORD

The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient, including observation patients. Its contents shall be current and pertinent. The record shall include:

A. Identification Data

Include:

1. identification number
2. name
3. date of birth
4. gender
5. address
6. telephone number
7. emergency contact data
8. next of kin
9. legal status of patients receiving mental health services
10. contact data for any legally aurthorized representative

B. History

C. Physical Examination

D. Impression/working diagnosis

E. Plan of care

F. Reports of tests and their results

Report of all:

1. diagnostic or therapeutic examinations
2. evaluations and procedures
3. laboratory
4. radiology
5. EEG
6. EKG

G. Progress notes/clinical observation

H. Consultation reports: Consultation which renders an opinion after examination of the patient and review of the medical record.

I. Anesthesia record(s)

J. Report of operation

K. Medication administration records

- All medications the patient was receiving prior to admission will be listed.
- Every medication ordered or prescribed for an inpatient, or dispensed to an ambulatory patient or discharged patient will be documented.
- Each dose of medication administered will be included.

L. Pathology Report: Every operated case with surgical specimen.

M. Evidence of informed consent

N. Diagnostic and therapeutic orders

O. Discharge summary: to include conclusions at termination of hospitalization.

P. Final diagnosis without abbreviations

Q. Autopsy report

- Preliminary report of the gross pathologic diagnosis to the record within a reasonable time (two working days if possible)
- Final autopsy report submitted to the record within a reasonable time (thirty working days for routine cases and three months for complicated cases).

R. Advance directives

S. Discharge instruction to the patient or family

T. Records of any donation and receipt of transplants or implants

U. Emergency care: emergency care provided to the patient prior to arrival, if applicable

V. Prenatal records
W. Problem List

C. HISTORY AND PHYSICAL

The physician assessment should be relevant and should include sufficient information necessary, as determined by the physician, to provide the care and services required to address the patient's conditions and needs and may vary by setting or level of care, treatment, or services. Therefore, the specific data could be different for populations, setting of care, treatment or services.

6.2 PHYSICIAN ASSESSMENT

A. REQUIRED LEVELS OF PHYSICIAN ASSESSMENT

1. Minor Procedures requiring only minimal sedation

   Patients undergoing minor procedures with oral anxiolysis (no moderate or deep sedation) require a clinical assessment completed prior to the procedure and a pre-procedure note.

   Examples may include:

   - Bone marrow biopsy
   - Wire localization
   - Myelogram
   - Lumbar Puncture

2. High Risk Procedures

   a) High-risk procedures are defined as procedures that frequently require moderate or deep sedation and may be performed in areas outside of the operating room. These procedures require a physician assessment and a procedural sedation note.

      The physician assessment will include:

      - Assessment of previous anesthesia/sedation complications
      - History of difficult airway
      - Mallampati score
      - History of sleep apnea
      - Pregnancy Status (as appropriate)
      - Assignment of ASA classification
      - Current medications
      - NPO status
      - Focused physical examination

   b) The procedural sedation note should be documented in the hospital's EMR.

   c) Examples include procedures that may be performed in the following areas:

      - Cardiac cath lab
      - Interventional radiology
      - Endoscopy lab
      - Emergency department
      - Critical care

3. Patients Undergoing Procedures Performed in the Operating Room, and All Patients Undergoing Procedures Requiring General Anesthesia

   Patients undergoing procedures in the Operating Room, patients undergoing general anesthetic (in any setting) require a documented, history and physical and a

procedure note. **Exception**: Anesthesia evaluations will provide the appropriate level of physician assessment for diagnostic procedures requiring general anesthesia where no interventions are required (such as diagnostic MRIs).

4. SDS Patients (Same Day Surgery Patients)
   Patients undergoing surgical procedures in the Operating Room with a planned same day discharge require a history and physical exam but may have a more focused physical exam to include Heart, Lungs and a limited examination of the affected body area or organ system.

5. Summary of Assessment requirements prior to operative and high risk procedures
   The following table indicates the scope of the practitioner assessment prior to the operative and other invasive procedures. Additional physician notes as to the patient's pre-procedure condition, if any, may be recorded separately (before or after the procedure) or included in the procedure note.

Procedure	**Procedural Sedation Assessment**	**Anesthesia Evaluation**	**H & P**
Surgical procedures in the operating room		✓	✓
Interventional Procedures involving general anesthesia regardless of location.		✓	✓
Other procedures involving moderate or deep sedation	✓ or ✓		
Procedures without moderate or deep sedation or general anesthesia	Clinical assessment and pre-procedure note		

6. Inpatients
   All patients admitted to the hospital require a documented history and physical.

B. GME ASSESSMENT AND SUPERVISION REQUIREMENTS (if applicable)
   1. New admissions and consultations will be seen by the teaching service attending within 24 hours and this will be documented in the medical record.
   2. All housestaff (residents/fellows) H&Ps and consults will be verified in the medical record by the attending supervising credentialed physician (SCP) within 72 hours.
   3. All teaching service patients will be seen daily by the attending SCP on admission services and every 72 hours at a minimum on consult services (daily if in ICU).
   4. H&Ps and consults will be documented / dictated by housestaff with their own physician/ dictation number with the name of the attending supervising credentialed physician (SCP) documented within the body of the document. The housestaff will forward these to the attending for verification/attestation.
   5. In addition to H&Ps and consultations, all housestaff dictated reports will be under the resident/fellow's own number: discharge summary, operative and procedure reports, etc.

C. HISTORY AND PHYSICAL

1. Responsibility for History and Physical (H&P) Performance/Completion

The attending physician is responsible for ensuring the completion of the H&P. Although the physician may delegate the medical history to other practitioners, the attending physician is responsible for validating the medical history and must sign for and assume all responsibilities for these activities.

Physician employed RNs who are authorized to render services may perform nursing histories for the supervising physician. The physician must validate the history, sign for it within 24 hours and assume responsibility for this history.

Nurse Practitioners and Certified Physician Assistants who are credentialed as Allied Health Professionals may perform the H&P for their supervising physician. The supervising physician shall make a personal review of this H&P information within the time period specified within the credentialing policies and so certify by signature.

2. Title of H&P; Identification of the H&P

The History and Physical/Physician Assessment should clearly identify the document as the location of the history and physical elements. This is best accomplished by entitling the document as "History and Physical." Synonyms acceptable include Admission Note, Comprehensive Assessment, Initial Assessment, Consult History and Physical, or similar titles.

Additionally, the H&P may reference other detailed clinical information; but this information must be summarized in the history and physical and easily traceable to the H&P.

3. Elements of H&P

a. History:
Chief Complaint/Reason for Admission
History of Present Illness
Relevant Past Medical History*
Relevant Family History*
Relevant Social History*
Relevant Review of Systems*

b. Physical Exam to Include:
Relevant Physical Exam*
To include, at a minimum:
- Heart
- Lungs
- Examination of the affected body area or Organ System(s)

*If not present or documented, the physician has determined this element as not relevant or non-contributory.

c. Impression and/or documentation of medical decision-making

d. Plan of Care

4. Obstetrical H&P

The history and physical for admitted Obstetrical patients shall be completed electronically in the hospital's EMR.

5. H&P Timeframes/Updates

If a H&P Examination has been performed and documented within thirty (30) days of the patient's admission to the Hospital or admission for a scheduled operative or invasive procedure, an electronic version of that H&P examination may be used in the patient's medical record provided that an update is performed by an licensed independent practitioner or designee with privileges to perform H&Ps, and documented prior to the start of the operative procedure. If a patient is admitted to the hospital, this update must occur at the time of or within 24 hours of the inpatient admission. This updated H&P Examination should:

a) Address the patient's current status and/or any changes in the patient's status (if there are no changes in the patient's status, this should be specifically noted);
b) Include an appropriate physical examination of the patient to update any components of the exam that may have changed since the prior history and physical;
c) The current and/or updated history and physical should be viewable in the patient's medical record prior to the operative/ high-risk procedure, or at the time of or within 24 hours of an inpatient admission.
d) In an emergency, when there is no time to record the complete H&P examination, a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis is recorded in the medical record before the emergency surgery.

6. Delinquency / Incomplete
An H&P deemed delinquent or missing after the first 24 hours of an inpatient admission or incomplete will trigger an HIM suspension at that time.

Incomplete is defined as missing a required update or one of the required elements.

Required Elements
- Chief Complaint
- History of present illness
- Exam-Heart, Lungs & affected body system(s)
- Impression
- Plan of care

D. PROBLEM LIST
Every provider is expected to add, modify, correct, or remove problems as necessary to maintain a clinically relevant and concise problem list. The Problem List is updated at every ambulatory encounter, at admission, at discharge and as needed during an inpatient stay.

6.3 POST OPERATIVE/HIGH RISK PROCEDURE REPORT AND NOTE

A. Operative Report/Procedure Report

An operative report describing techniques, findings, tissues removed/altered shall be dictated or documented, viewable in the patient's record, and authenticated in its entirety by the surgeon immediately following surgery and before the patient leaves the post anesthesia care/recovery area.
This report shall include:

- Patient name and FIN
- Date & times of the surgery
- Names of the surgeon, assistants and other practitioners performing surgical tasks
    - The specific significant surgical tasks conducted by practitioners other than the primary surgeon/practitioner should be delineated (examples include: opening and closing, harvesting grafts, dissecting or removing tissues, implanting devices, altering tissues)
- Pre and post op diagnosis
- Name of the specific surgical procedure(s) performed
- Type of anesthesia administered
- Complications (document "no complications" if none encountered)
- Description of techniques, findings and tissues altered
- Any specimens/tissues removed and if sent to pathology (document "no specimens/tissues removed" if none removed)
- Prosthetic devices, grafts, tissues, transplants, or devices implanted (document "none" if none are implanted)
- Estimated blood loss
    - Blood administered (document "none" if none administered)
- Patient's condition at termination of procedure

B. Immediate post op/post procedure note

In the event that an operative or procedural report cannot be available and viewable in the patient's record before transfer to the next level of care (before the patient leaves PACU/recovery area), an immediate post op/post procedure note should be documented in the hospital's EMR.

This note shall include:

- Surgeon/proceduralists and assistants
- Pre and post op diagnosis
- Procedure(s) performed
- Findings
- Specimen removed and if sent to pathology (document "no specimens/tissues removed" if none removed
- Estimated blood loss
    - Blood administered (if none, document "none")
- Complications (if none encountered, document "none")
- Type of anesthesia
- Grafts or implants (if no grafts or implants, document "none")

C. Delinquency

Operative reports should be dictated or created online in the electronic medical record within 24 hours of the procedure or they will be considered delinquent. If still lacking, a suspension will be issued after post discharge chart analysis

6.4 PROGRESS NOTE

A. Pertinent progress notes shall be recorded chronologically, dated, timed and signed. Progress notes shall be sufficient to permit continuity of care. They should document the patient's

course in the hospital, reflect the results of treatment and report any change in condition. There should be a progress note to reflect each visit by a physician. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

B. The physician primarily responsible for the patient's care shall document a progress note at least daily to include reassessments and plan of care revisions. Although the attending physician (primarily responsible for the patient's care) may delegate this activity to other practitioners, the physician is responsible for validating the progress note and must sign for and assume all responsibilities for these activities.

C. Physician employed RNs authorized to render services may enter portions of the progress note to include relevant symptomatic observations and results of diagnostic and therapeutic procedures and tests for their supervising physician. The physician must daily validate this portion of the progress note, sign for it, and assume responsibility for this portion of the progress note. Additionally, the physician must (at a minimum) provide daily documentation of reassessment(s) and plan of care revisions.

D. APRNs and certified physician assistants who are credentialed as allied health professionals may document assessments and progress notes for their supervising physician however, the supervising physician (or designated substitute physician) is also required to complete a progress note on the patient in accordance with Section 5.2 of these Rules and Regulations. The supervising physician shall make a personal review of the initial assessment/H&P within the time period specified within the credentialing policies and so certify by signature

E. The psychiatric physician primarily responsible for the patient's care shall document a progress note at least 6 days a week.

6.5 PREPRINTED AND ELECTRONIC ORDERSETS

Preprinted and electronic ordersets that have not been approved by the MEC authorized process are not permitted.

6.6 DIAGNOSTIC AND THERAPEUTIC ORDERS

All diagnostic and therapeutic orders shall be documented in the medical record and signed, dated and timed by the responsible practitioner.

A. All orders shall be recorded legibly in ink or entered directly into the electronic medical record and signed, dated and timed by the responsible practitioner. Partners and physicians covering for the ordering physician may sign in the absence of the ordering physician.
B. All orders shall be recorded in the "order" section of the medical record and shall include the date, time, name and signature of the person documenting the order and the name of the ordering physician.
C. All orders shall utilize the metric system of measurement for length, height, temperature, and weight.
D. Telephone or verbal orders may be taken only by a licensed nurse (RN or LPN), except that the following personnel, in accordance with hospital policy, may take verbal orders for medication, treatment and/or procedures within their respective

areas of practice: Cardiovascular Technologists; Certified Registered Nurse Anesthetists; Medical Technologists; Pharmacists; Physical Therapists (registered/licensed) including Occupational and Speech Therapists; Respiratory Therapists; Dietitians; Special Procedure Technologists; Radiology Technologists; MRI Technologists; Nuclear Medicine Technologists; Mammographers.

E. Physician employed registered nurses who are authorized to render services can document telephone orders only after discussing with the employing physician. The telephone orders should be read-back to the physician issuing the order and the physician should verify its accuracy. The physician employed RN should electronically authenticate the order (as "read-back"), ensuring it is timed and dated.

Once the telephone order is read-back, verified, and authenticated by physician employed RN, the physician who issued the order then has up to 14 days from the date the order was issued to authenticate the order.

F. Verbal orders (orders received in the presence of the LIP) are discouraged and only to be issued in an emergency.

All verbal orders and telephone orders should be read-back to the LIP or authorized individual issuing the order and the LIP or authorized individual should verify its accuracy. Then the individual receiving the order should electronically authenticate the order (as "read-back"), ensuring it is timed and dated.

Once the verbal/telephone order is read-back, verified, and authenticated by the individual receiving the order, the LIP or authorized individual who issued the order then has up to 14 days from the date the order was issued to authenticate the order.

The attending/primary/consulting LIP may authenticate orders issued by other members of his/her practice group or the "on call" LIP.

G. Pre-printed orders are acceptable and should be treated as all other orders.

H. All orders for diagnostic procedures, including radiology imaging, anatomic pathology, cardiology services (thallium treadmill, ETT echo, cardiac catheterization etc.) shall include "Clinical reason for Exam"

I. Upon transfer from surgery or to a "different level of care" (i.e. in/out of ICU), all previous orders will be discontinued and all orders must be specified.

6.7 SHORT SERVICE RECORD/SAME DAY SURGERY RECORD

A. A short service record may be used for outpatient stays of 48 hours or less. It may be used to record the H&P, operative report and discharge summary.

B. An initial physician order for observation status or outpatient surgery should be included.

C. A final progress note is acceptable in lieu of a discharge summary. In case of a patient's death, a discharge summary is required.

D. The same day surgery record may be used for outpatient surgeries and should include the H&P, operative report and discharge instructions.

E. If patient is subsequently admitted to inpatient status, the reason for admission must be recorded in the progress note section.

6.8 REPORTS OF DIAGNOSTIC AND THERAPEUTIC PROCEDURE

A. Pathology, Laboratory, Radiology, Anesthesia, EKG, EEG, ETC.
   1. Such reports should be completed promptly, dated, authenticated, and filed in the medical record within twenty-four (24) hours, if possible. Pathology, radiology, and laboratory reports will be available in the EMR.

B. Echocardiograms
   1. Studies will be interpreted seven days/week to include holidays.
   2. Directed studies will be interpreted within 24 hours of procedure completion. They will default to the panel readers' pool if they are not interpreted within 24 hours.

6.9 ENTRIES INTO THE MEDICAL RECORD

All entries into the medical record must be signed, dated and timed.

Consults, H&Ps, discharge summaries, and operative reports should be created in electronic form. At such time specified by each facility, all progress notes at that facility should be created electronically.

Only authorized individuals make entries into medical records. The following personnel may document in the medical record:

- Authorized Rounding Nurses
- Case Managers
- Certified Pharmacy Technicians
- Certified Physician Assistants
- Chaplains
- Authorized HIM Associates
- Dentists
- Registered Dietitians
- Exercise Physiologists
- Medical Students
- Medical Social Workers
- Medical Technologists
- Nurse Anesthetists (CRNA/GRNA)
- Nurse Practitioners
- Nurse Practitioner Students
- Nursing Personnel
- Occupational Therapists
- Pharmacists
- Physical Therapists
- Physical Therapy Assistants
- Physicians
- Physician Assistant Students
- Podiatrists
- Psychologists
- Radiology Technologists
- Respiratory Therapists

- Sonographers
- Speech Therapists

6.10 ADMIT ORDER

A status order must be provided for each patient receiving care within the hospital facility.

An admit order (Patient Status: Inpatient) must be documented for each admission prior to commencing inpatient care. The admit order should contain the following order details:

* Admitting Physician
* Admit to inpatient *("patient status: inpatient")*
* Reason for care
* Anticipated LOS
* Supervising Physician if applicable

An admit order must be documented and signed/cosigned by a physician with admitting privileges who is familiar with the patient's course of treatment within 48 hours of admission or before discharge, whichever occurs earlier.

6.11 DISCHARGE ORDER

A patient shall be discharged only on the orders of the attending physician.

Patients leaving against medical advice (AMA), do not require an order provided the AMA procedure has been followed and the appropriate form is signed and on record.

In case of death there shall be a discharge order (discharge to morgue).

6.12 DISCHARGE SUMMARY

A. At the time of discharge or transfer to another level of care, the attending physician or his/her qualified designee may dictate a discharge summary or provide an electronic summary which shall include:
    1. Reason for admission
    2. Significant findings
    3. Procedures performed, care, treatment and services provided
    4. Final Diagnosis
    5. Condition on discharge
    6. Information provided to the patient and family as appropriate
    7. Disposition, follow up care provision

B. Electronic or dictated discharge summaries will be available in the EMR

C. Physician employed RNs may dictate the discharge summary.

D. At the time of discharge, the attending physician shall see that all of his/her entries are signed.

E. If the patient expires, a death note (in addition to the summary) shall be documented in the final progress note by the physician or RN who pronounces the patient dead, which shall include the time and date of death.

F. For normal newborns with uncomplicated deliveries, a progress note may be substituted for the discharge summary.

G. For outpatient stays 48 hours or less, a progress note may be substituted for the discharge summary.

H. In the case of a discharge by a member of the house staff (GME, as applicable), the physician responsible for the discharge summary must be documented in the final progress note including hospital identification numbers. The attending staff physician shall be documented in the discharge summary.

6.13 PRINCIPAL DIAGNOSIS

The "Principal Diagnosis" is that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

6.14 RECORDING OF DIAGNOSIS (PRINICPAL AND OTHERS)

The principal and other final diagnoses shall be recorded in the medical record in full, without the use of symbols or abbreviations. It should be documented in the discharge summary or the final progress note.

The final diagnosis and/or requested additional information on the documentation clarification form must be documented and viewable 7 days after discharge or the chart will be delinquent.

6.15 SIGNATURES

Authentication may be by written signatures, initials, or electronic signature. When a written signature or initials is utilized it will be accompanied by the practitioner's Methodist ID number.

All orders and documentation entered electronically will be required to be signed with electronic signature. All documents transcribed by Methodist Healthcare transcription department will be required to be signed with electronic signature.

All verbal orders and telephone orders are required to be signed with electronic signature within14 days. These documents will be accessed through the practitioner's inbox.

The use of rubber stamps for signatures on medical records is not acceptable.

6.16 TIME LIMIT FOR COMPLETION OF MEDICAL RECORDS

A. The medical record must be completed by 7 days after discharge. This includes completing and signing all required documentation.
B. Charts with incomplete documentation as of midnight on Tuesday night will result in a temporary suspension of the responsible provider on Wednesday morning. A temporary suspension restricts the provider from scheduling elective admissions and surgery/invasive procedures. Once all incomplete documentation is complete, the suspension is immediately lifted.
C. Suspension rates (the number of weeks a provider qualified for suspension on Wednesday morning divided by the total number of weeks) are reported to the Credentials Committee.

6.17 VOLUNTARY RELINQUISHMENT OF STAFF PRIVILEGES

Failure to complete all aspects of any patient's delinquent medical record within the time frame as specified in the Facility's medical staff bylaws constitutes voluntary relinquishment of staff membership and of all clinical and admitting privileges. Re-application to the staff is allowed immediately upon completion of the delinquent record.

6.18 HOUSE STAFF MEDICAL RECORD COMPLETION (As applicable to Facility)

Attending physicians, with house staff, are responsible for ensuring that all medical records are completed in accordance with the medical staff rules & regs. The attendings are responsible for timely record completion by residents working under their supervision. Timely completion for medical records will not differ for teaching cases.

Interns and Residents Reports

When members of the house staff are involved in patient care, sufficient evidence is documented in the medical record to substantiate the active participation in, and supervision of, the patient's care by the attending physician responsible for the patient.

The attending physician is responsible for chart completion.

6.19 INTER-HOSPITAL TRANSFERS RELATIVE TO RECORDS

When patients are transferred between acute care units of Methodist Healthcare-Memphis Hospitals or Methodist Healthcare-Olive Branch Hospital, transfer order reconciliation will be performed by the receiving unit/team.

A discharge summary to include the entire stay is required. The combined chart is processed as one record and housed at the discharging unit.

When patients are transferred between an acute care unit and any specialty unit (DRG exempt, such as Behavioral Health) a transfer note (electronically documented or dictated) will be provided by the transferring physician. A copy of the history and physical may be used provided it is appropriately updated at the time of transfer, signed, timed, and dated by the attending physician. The discharge summary should include the entire stay.

When patients are transferred between MLH facilities, a complete discharge summary is required at the sending facility, and a new/appropriately updated H&P and new orders are required at the receiving facility.

6.20 ACCESS TO MEDICAL RECORDS

Members of the medical staff shall have access to all of the medical records of any patient if they are involved in the care of that patient.

6.21 RELEASE OF MEDICAL RECORD INFORMATION

Written consent of the patient or the person authorized by law to consent for the patient, is required for release of medical information to persons other than those involved in the treatment of the patient or to those authorized to review the record.

6.22 ELECTRONIC MEDICAL INFORMATION

A. Passwords shall not be shared.

B. All employees of credentialed medical staff who are given proxy access to patients' personal health information (PHI) of that medical staff member shall adhere to the privacy and confidentiality standards of MLH, including the "minimal necessary" information standard.
C. Each medical staff member shall be responsible for the actions of his/her employees to whom he/she has proxied access.
D. Violations of MLH's policies regarding PHI shall be handled according to the Facility medical staff bylaws and governance documents.

6.23 UNAPPROVED ABBREVIATIONS

The following abbreviations may not be used in any clinical documentation, including all types of orders, progress notes, consultation reports, and operative reports.

Unapproved Abbreviations
U
IU
QD
QOD
MS
MSO4
MgSO4
Doses without “Leading zero”
Doses with trailing zeros

Unapproved abbreviations cannot be used in any form, upper or lower case, with or without periods.

7.0 PROVIDER BASED CLINIC MEDICAL RECORDS

7.1 CONTENTS OF A MEDICAL RECORD

The primary physician/LIP shall be responsible for the preparation of a complete and legible medical record for each patient, for each encounter in a provider-based clinic. Its contents shall be current, pertinent, and support services performed.

A. Identification data:
    1. identification number
    2. name
    3. date of birth
    4. gender

5. address
6. telephone number
7. emergency contact data
8. next of kin
9. legal status of patients receiving mental health services
10. contact data for any legally authorized representative

B. Consent for treatment as required for initial and subsequent office visits.

C. Outpatient Encounter Documentation
   1. The physician assessment shall be relevant and include sufficient information necessary, as determined by the physician, to provide the care and services required to address the patient's conditions. Documented patient assessment/reassessment includes but is not limited to results of treatment, change in condition, orders, impression and plan of care.
   2. Needs may vary by type of provider-based clinic (primary care/specialty care). Therefore, the specific data may differ by population, care setting, treatment or services.
   3. The primary physician treating the patient in a provider-based clinic is responsible for ensuring completion of the H&P as appropriate to each patient visit. Although the physician may delegate the medical history to other practitioners, the primary physician is responsible for validating the medical history and must sign for and assume all responsibilities for these activities.
   4. Nurse Practitioners and Certified Physician Assistants who are credentialed as Allied Health Professionals may perform the H&P for the primary/supervising physician who shall make a personal review of the H&P within the Consolidated Credentials Policies and so certify by signature.
   5. Elements of Encounter Documentation
      a. History
         i. chief complaint
         ii. history of present illness
         iii. relevant past medical history, family history, social history, and/or surgical history
         iv. review of systems
      b. Physical Exam
         i. Addresses constitutional, cardiovascular, respiratory, affected body area or organ system(s).
         ii. May include review of other systems: eyes, ears, nose, mouth, throat, gastrointestinal, genitourinary, gynecological, musculoskeletal, integumentary, neurological, psychiatric, endocrine, hematologic, lymphatic, allergic, or immunologic.
      c. Impressions and/or documentation of medical decision-making
      d. Plan of care
   6. Encounters should be signed, dated, and authenticated by a physician or licensed independent practitioner

D. Reports of all tests and their results shall be reviewed, dated, timed, authenticated and included in the ambulatory medical record within 24 hours when possible. Patients should be notified of all abnormal or urgent results. Reports may include:
   1. diagnostic or therapeutic examinations

2. evaluations and procedures
3. laboratory
4. radiology
5. pathology
6. EKG
7. Reports specific to the patient population served in the provider-based clinic

E. Consultation letters or reports to referring physicians that render an opinion after examination of the patient.

F. Medications Prescribed and/or Administered
    1. Documented list of all medications prescribed to the patient, including dosage, amount, and number of refills
    2. Dose administered including the strength, dose or rate of administration, administration devices uses, access site of route, known drug allergies, adverse drug reactions and the patient's response to medication

G. Evidence of informed consent

H. Diagnostic and therapeutic orders

I. Problem list documented and updated at each encounter to add, modify, remove, or correct problems as necessary to maintain a clinically relevant and concise problem list. Includes diagnoses established during the course of the encounter.

J. Advance directives

K. Discharge instructions to the patient and/or family/caregiver

L. Referrals to internal/external providers and/or community agencies

M. Reports of diagnostic, therapeutic procedures, and treatment received from healthcare providers external to the provider-based clinic:
    1. Discharge summaries and emergency room records from recent hospitalizations
    2. Reports from recent operative and other invasive procedures
    3. Notes from home health visits
    4. Notes from specialty consultations
    5. Progress reports from intermediate nursing facilities

7.2 PERFORMANCE AND DOCUMENTATION OF HIGH-RISK PROCEDURES

The rules and regulations for REQUIRED LEVELS OF PHYSICIAN ASSESSMENT (section 6.2.A) and HIGH RISK PROCEDURE REPORT AND NOTE (section 6.3) apply to physicians who perform high risk procedures in provider-based clinics.

7.3 DIAGNOSTIC AND THERAPEUTIC ORDERS

All diagnostic and therapeutic orders shall be documented and dated, timed, and authenticated by the responsible practitioner.

A. All orders shall be recorded legibly in ink or entered directly into the electronic medical record and signed, dated and timed by the responsible practitioner.
B. Direct entry into the electronic medical record by the provider is the preferred method of documenting orders. If the prescriber completes paper orders, the provider-based clinic team member is primarily responsible for receipt and recording of physician orders and any necessary transferring onto proper forms, requisitions and computer entries. When processing paper orders, the team member must sign the order with his or her full name, title, ID#, date and time of the order, and name of the ordering physician if not entered electronically.
C. All orders shall use the metric system of measurement for length, height, temperature and weight unless the ambulatory electronic medical record does not accommodate the metric system.
D. All telephone orders require the following process:
    1. Telephone or verbal orders may be taken only by medical assistant (MA), or licensed practice nurse (LPN), or a registered nurse (RN). In addition, the following personnel may take telephone or verbal orders for medication, treatment and/or procedures within their respective areas of practice: Cardiovascular Technologists; Physician Assistants; Medical Technologists; Pharmacists; Registered or licensed Rehabilitation associates; Radiology Technologists; Registered Dietitians; and Respiratory Therapists.
    2. The order should be identified as a telephone order on the signature line for paper orders or as required in an electronic record.
    3. The team member receiving a telephone order will read back the order to the ordering physician or AHP to ensure accuracy of transcription or data entry.
    4. Electronic orders should include identifying information for the ordering physician or AHP (name, ID #) and the receiving team member's identifying information as required by the electronic record (e.g., order details, order comments, special instructions, or other defined field).
    5. Telephone orders are authenticated and signed in the following manner: the ordering physician or AHP reviews orders promptly to ensure the order is accurate, complete and final.
    6. Physicians or AHPs may sign orders given by members of their practice group or the covering physician.
E. Verbal orders given in person by credentialed medical staff or AHPs are discouraged and only to be issued in an emergency.
    1. The order should be identified as a verbal order along with the name of individual receiving the order and the name of individual giving the order.
    2. Verbal orders should be signed before the physician leaves the provider-based clinic.

F. Read back (after transcription of the order) is required to verify the telephone and verbal orders are correctly transcribed

7.4 ENTRIES INTO THE MEDICAL RECORD

All entries into the medical record must be signed, dated, and timed.

All entries shall be created in an electronic form as specified and available in the electronic medical record implemented in each provider-based clinic.

Only authorized individuals make entries into the medical records. The following personnel may document in the medical record.

1. Advanced Practice Registered Nurses
2. Case Managers
3. Certified Pharmacy Technicians
4. Certified Physician Assistants
5. Chaplains
6. Credentialed HIM professionals
7. Licensed Practical Nurses
8. Medical Assistants
9. Medical Office Assistant
10. Medical Students
11. Medical Social Workers
12. Medical Technologists
13. Nurse Practitioner Students
14. Occupational Therapists
15. Oncology Data Analysts
16. Pharmacists
17. Physical Therapists
18. Physical Therapy Assistants
19. Physicians
20. Radiology Technologists
21. Registered Dietitians
22. Registered Nurses
23. Respiratory Therapists
24. Speech Therapists

7.5 SIGNATURES

The rules and regulations for SIGNATURES (section 6.15) apply to physicians in provider-based clinics. Transcribed documents will be required to have an electronic signature when transcription is available in the clinic. Orders will be routed for electronic signature as functional and operational in any electronic medical record.

7.6 TIME LIMIT FOR COMPLETION OF MEDICAL RECORDS

A. Documentation of an encounter in a provider-based clinic shall be complete and final no later than 7 days after the patient encounter.

B. Each provider-based clinic monitors and reports deficiency rates to the Sr. VP of Physician Alignment (or his/her designee) and/or CEO (or his/her designee) to address deficiencies with the LIP.
C. The Sr. VP of Physician Alignment (or his/her designee) and/or CEO (or his/her designee) provides deficiency rates to the Sr. Director of MLH HIM as requested.

7.7 VOLUNTARY RELINQUISHMENT OF STAFF PRIVILEGES

The rules and regulations for VOLUNTARY RELINQUISHMENT OF STAFF PRIVILEGES (section 6.17) apply to physicians in provider-based clinics.

7.8 HOUSE STAFF MEDICAL RECORD COMPLETION

The rules and regulations for HOUSE STAFF MEDICAL RECORD COMPLETION (section 6.18) apply to physicians who supervise residents and fellows involved in the care of patients in provider-based clinics.

7.9 ACCESS TO MEDICAL RECORDS

The rules and regulations for ACCESS TO MEDICAL RECORDS (section 6.20) apply to provider-based clinics.

7.10 RELEASE OF MEDICAL RECORD INFORMATION

The rules and regulations for RELEASE OF MEDICAL RECORD INFORMATION (section 6.21) apply to provider-based clinics.

7.11 ELECTRONIC MEDICAL INFORMATION

The rules and regulations for ELECTRONIC MEDICAL INFORMATION (section 6.22) apply to provider-based clinics.

7.12 UNAPPROVED ABBREVIATIONS

The rules and regulations for UNAPPROVED ABBREVIATIONS (section 6.23) apply to provider-based clinics.

Unified General Rules and Regulations Amendments

Revision #	Document	Reference	Subject of Revision	Board Approved
Original	Rules and Regulations		Reformatted / streamlined	August 14, 2013
1	Medical Records	6.10 Admit Order	Revision to comply with the CMS requirement (IPPS Final Rule CMS-1599-F, Federal Register, p.50944)	Provisionally - December 18, 2013 Final – January 15, 2014
2	Medication Ordering Guidelines	5.4 B & Addition of C	A revision requiring an indication for antibiotics.	Provisionally – March 11, 2014 Final Approval – April 16, 2014.

3	Grammatical Corrections	Grammatical Corrections	Corrected capitalization and misspellings throughout document	Provisionally approve – November 19, 2014 Final Approval – December 17, 2014
4	Unification	2.7 Removal of Indwelling Urinary Catheters	• Patient paralyzed, on a ventilator, requires a catheter and an external "condom" catheter is not appropriate • Continuous bladder irrigation or Medication instillation • Strict 24 hour urine collection and incontinence • Hospice ~~or terminal~~ care (for patient comfort)	P November 19, 2014 Final Approval – December 17, 2014
5	Unification	3.2 Pronouncing Death for Adult Inpatients & Signing Death Certificate	Revised verbiage "Primary Care Physician" (PCP) to admitting physician. Changed "Charge Nurse" to PCC	Provisionally approve – November 19, 2014 Final Approval – December 18, 2014
6	Unification	5.7 Patient Care and Physician Notification (ED)	Added verbiage "as available at Facility" to the following sentence: Patients with co-morbidities and without established physician relationships, who require admission after an ED evaluation, should be admitted to one of the following specialties, *as available at Facility*: • Internal Medicine • Cardiology • OB/GYN • General Surgery • Neurosurgery • Pediatrics Removed the word "private" throughout section. • Whenever the ~~private~~ on-call physician • the ~~private~~ physician	Provisionally approve – November 19, 2014 Final Approval – December 17, 2014
7	Unification	6.16 Time Limit for Completion of Medical Records	If a medical record is incomplete for twenty one (21) days (MHOBH states 14 days) after the day of the patient's discharge, the medical record will be considered "delinquent" and the physician will be automatically and temporarily suspended from elective admitting and surgery/invasive procedure requiring conscious sedation scheduling privileges until all delinquent medical records are completed. The physician will receive a "Notice of Delinquency – Medical Records Suspension." 1. If a medical record is incomplete for twenty-eight (28) days	Provisionally approve – November 19, 2014 Final Approval – December 17, 2014

			(MHOBH states 21 days) after the patient's discharge the physician will be given a 48-hour notice. If a medical record is incomplete for thirty (30) days (MHOBH states 23 days) after discharge, the physician's staff membership and all clinical privileges will be deemed to be voluntarily relinquished.	
8	Unification	6.19 Inter-Hospital Transfers Relative to Records Addition	When patients are transferred between MLH facilities, a complete discharge summary is required at the sending facility, and a new/appropriately updated H&P and new orders are required at the receiving facility.	Provisionally approve – November 19, 2014 Final Approval – December 17, 2014
9	Medical Records	6.1 Contents of a Medical Record – Add W.	Problem List was added as an addition to the contents of a Medical Record.	Provisionally approved May 12, 2015 Final Approval – June 17, 2015
10	Medical Records	6.2 Physician Assessment Add: D. Problem List	Every provider is expected to add, modify, correct or remove problems as necessary to maintain a clinically relevant and concise problem list.	Provisionally approved May 12, 2015 Final Approval – June 17, 2015
11	1.0 Admission & Discharge of Patients	1.1 Non-Discriminatory Statement	Revised to align with system policy	Provisionally approved Feb 9, 2016 Final Approval March 16, 2016
	1.1 Non-discrimination	Addition to second sentence	All services available to Hospital and provider-based clinic patients shall be provided in a nondiscriminatory manner, without regard to age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, gender, sexual orientation and gender identity or expression.	Provisionally approved October 13, 2016. Final Approval 11.16.16
	2.3 Policies	Addition to section title	2.3 HOSPITAL/FACILITY/PROVIDER-BASED CLINIC POLICIES Policies regarding patient care should be followed at all times including but not limited to:	Provisionally approved October 13, 2016. Final Approval 11.16.16
	5.3 Physicians Treating Family Members	Addition to second paragraph	They shall avoid serving as admitting, attending or consulting physicians for the medical care of first degree relatives (parents, children, siblings or spouses) in the hospital or as primary physician in provider-based clinics.	Provisionally approved October 13, 2016. Final Approval 11.16.16
	5.4 Medication Ordering Guidelines	Addition to beginning of section	E. MEDICATION ORDERING GUIDLINES Medication ordering guidelines shall apply to physicians and LIPs in hospitals and provider-based clinics.	Provisionally approved October 13, 2016. Final Approval 11.16.16
	5.9 Physician Response to Phone Calls/Pages	Addition to section, add new sentence	Physicians in provider-based clinics shall address inquiries from patients seeking clinical advice within the guidelines established for the practice.	Provisionally approved October 13, 2016. Final Approval 11.16.16

	6.1.A Contents of a Medical Record – Identification Data	Reorder and add additional elements to correspond with new section 7.0 for Medical Records in Provider-based Clinics	A. Identification Data Include: 1. identification number 2. name 3. date of birth 4. gender 5. address 6. telephone number 7. emergency contact data 8. next of kin 9. legal status of patients receiving mental health services 10. contact data for any legally authorized representative	Provisionally approved October 13, 2016. Final Approval 11.16.16
	6.2.4.C Obstetrical H&P	Modify first	The history and physical for admitted Obstetrical patients shall be completed electronically on the PowerNote entitled OB Admission H&P.	Provisionally approved October 13, 2016. Final Approval 11.16.16
12	7.0 Provider-based Clinic Medical Records	Addition	This proposed R&R addition of "Provider-based Clinic Medical Records" complies with CMS requirements for provider-based clinics licensed under the hospital.	Provisionally Approved November 8,2016 Final Approval 12.21.16
13	2.1 Insertion of Central Lines	Revisions	If a femoral site is emergently required for line placement, providers should document justification for the femoral placement. Documenting this justification is a new CMS requirement.	Provisionally Approved December 10, 2016 Final Approval 1.19.2017
14	6.3 A&B	Revisions	This R&R has been revised to include all required regulatory components. *An Operative report including all of the required elements shall be dictated or documented, viewable in the patient's record and authenticated in its entirety by the surgeon immediately following surgery and before the patient leaves the post anesthesia care/ recovery area.*	MEC Approval 2.14.2017 Board Approval 2.15.2017 * *Note – Per Medical Staff Policies Section 1.0, 1.2, "In cases of a documented need for urgent amendment to rules and regulations, (to comply with law or regulations), the MEC may provisionally adopt and the governing body may provisionally approve."*
15	6.3 B	Revision	Revised this section to read "… *an immediate post op/post procedure note should be documented,* ***using an authorized Immediate Post OP/Procedure Cerner PowerNote."***	MEC Approval 3.14.2017 Board Approval 3.15.2017 * *Note – Per Medical Staff Policies Section 1.0, 1.2, "In cases of a documented need for urgent amendment to rules and regulations, (to comply with law or regulations), the MEC may provisionally adopt and the governing body may provisionally approve."*
16	7.4	Addition	Added "oncology Data Analysts" as authorized individuals who can document entries into the provider-based clinic	MEC Provisionally approved 4/11/17. Final approval 5/9/17.

			medical records.	QCOB approved 5/17/17.
17	6.3 A&B	Revision	Revision for the full operative report add "and tissues altered". Revision for IPPN was to include Dynamic Documentation as an authorized form of IPPN	MEC Provisionally approved 8/8/17. Final approval 9/12/17. QCOB Approved 9/20/17
18	3.1	Revision	The revisions clarify the language added to the R&R regarding treatment of obstetrical patients in the ED who are under 20 weeks gestation, over 20 weeks gestation without obstetrical problems, and those over 20 weeks gestation with obstetrical problems.	MEC Provisionally approved 9/11/18. Final approval 10/9/18. QCOB approved 10/17/18
19	6.2, Physician Assessment A. Required Levels of Physician Assessment	Revision	Revision requiring an electronically documented procedural sedation note – using the appropriate note type and title. Additionally, three elements of physician assessment (history of difficult airway, Mallampati score, focused physical exam) were added to comply with our policy and with guideline requirements.	MEC Provisionally approved 2/12/19. Final approval 3/12/19. QCOB approved 3/20/19
20	5.2 Daily Visits of Patients	Revision	Allows a psychiatric nurse practitioner to round on behalf of the psychiatrist for patients admitted to MLH behavior health unit	MEC Provisionally approved 5/14/19. Final approval 6/11/19. QCOB approved 6/19/19
21	6.16 Med Record Completion	Revision	Reduces timeline for medical record completion from 21 days to 7 days	MEC Provisionally approved 5/14/19. Final approval 6/11/19. QCOB approved `6/19/19
22	7.6 TIME LIMIT FOR COMPLETION OF MEDICAL RECORDS	Revised	Reduces timeline from 21 days to 7	Approved previously (see above) Should have been updated concurrently with Section 6.0. MEC 12/10/2019
23	6.9 Entries in the Medical Record	Administrative Change – No approval needed	HIM requested the change from "Credentialed HIM Professionals" to "Authorized HIM Associates" to align with who is actually making entries in the medical record. See MRC minutes May 2022	Administrative Change. No approval needed.
24	Entire Document	Administrative Change – No approval needed	Revised pronouns he/she, his/hers	Administrative Change. No approval needed. 02/22/2024
25	5.2 Daily Visits of Patients 6.4 D. Progress Note	Revision	The revisions state the attending physician or designated substitute provider must at a minimum examine patient, complete progress note and place appropriate orders within specific timeframes. Section 6.4 was revise to align with 5.2.	MEC Provisionally approved 7/09/24. Final approval 7/24/24. MLH Board approved 07/25/2024

26	6.2 A & C 4; 6.3B; 6.19	Revisions	Standardized verbiage to “hospitals EMR” and removed references about Cerner, PowerNote and Dynamic Documentation	MEC Provisionally approved 9/10/24. Final approval 10/8/24. MLH Board approved 10/24/2024