



**MOUNT CARMEL**

**MOUNT CARMEL HEALTH SYSTEM**

**RULES AND REGULATIONS**

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## **ABORTIONS AND STERILIZATIONS:**

The Medical Staff of Mount Carmel must abide by *The Ethical and Religious Directives for Catholic Health Care Services*. Any questions will be addressed by the System Mission Department. The System Mission Department has a process for consideration of sterilization based on medical necessity, to be evaluated on a case by case basis.

## **ADMISSIONS:**

A patient may be admitted to the Hospital only by a Physician or Practitioner who is a Member of the Medical Staff and has been granted Privileges in accordance with the Bylaws and Credentials Policy Manual. All Physicians and Practitioners shall be governed by and comply with the policies of the Hospital.

No patient shall be admitted until a provisional diagnosis or valid reason for admission has been stated, except in a medical emergency. In a medical emergency, such statement shall be recorded on the patient's record as soon as possible.

No patient shall be transferred to another institution without the approval of the responsible Physician, Practitioner, or his or her designee.

- Admission of All Patients

Mount Carmel West, Mount Carmel East and MCSA – No patients under the age of 18 shall be admitted except on Obstetrics, where no age limit applies, and for Trauma patients at a designated Trauma Center, where no patient is admitted under the age of 16.

- (a) Patients with psychiatric disorders may be admitted to a designated Psychiatric Unit only by a psychiatrist who retains primary responsibility for the care of the patient.
- (b) Patients admitted for Cardiac procedures including Cardiac Cath and open-heart surgeries will comply with standards from Ohio Department of Health

Mount Carmel New Albany – No patients under the age of 13 shall be admitted

## **CERTIFICATES:**

Death Certificates shall be signed by the attending physician within 48 hours or by the coroner, if applicable. (Ohio Revised Code 3705.16)

## **Acute Dialysis Unit Guidelines:**

### **DEFINITIONS**

1. Emergency refers to a dialysis emergency treatment and must meet ALL criteria.
  - a) Patient is acutely ill.
  - b) Patient's condition is likely to worsen if dialysis is not administered immediately.
  - c) Requires the presence of a physician.
2. Physician refers to Nephrologist
3. Working day is defined as Monday through Saturday.

### **ORDER ENTRY**

- a) All dialysis orders must be entered electronically by the physician. Verbal orders will be accepted only when the physician is not in the premises.
- b) Patients 'out-patient' chronic dialysis orders will not be accepted. Every treatment will require an individual, specific order.
- c) Standing orders for future treatments cannot be given.
- d) Orders such as 'follow previous order' will not be accepted.

### **PRESCRIPTION**

- a) Elements of prescription: The following elements of treatment must be specified with every treatment:
  - Duration
  - Blood Flow
  - Dialysate Flow
  - Bath potassium and bicarbonate
  - Medications if any
  - Anticoagulation
  - Dialyzer
  - Fluid removal or target weight
  - Access
- b) Guidelines on fluid removal: A target fluid removal/target weight must be specified. An order such as 'fluid removal per critline' will not be accepted as it requires the nurse to complete the prescription. Limits on ultrafiltration may be prescribed based on critline.
- c) Sliding Scale orders for dialysate bath will not be accepted.

### **NEW PATIENTS**

For patients unfamiliar to the physician/group, physician evaluation will be required before initiation of the first dialysis treatment. In emergency situations, dialysis can be initiated but the physician must be present at some portion of the treatment. For New Starts see PHYSICIAN COVERAGE below.

## **PHYSICIAN COVERAGE**

- a) Physician must be present in house at some portion of the patient's treatment, if the patient is a new start, acute or chronic.
- b) Physician must return call within 15 minutes.
- c) A "Stat" page must be returned immediately.
- d) Every physician must arrange to provide alternative coverage if he/she is unable to return the call within the specified time. If the physician does not return the page within 15 minutes, the alternate physician will be paged. If alternate physician does not return the call within 15 minutes, the nurse will call the Medical Director (currently Dr. Venkataraman). If unable to reach him, the nurse will call the appropriate Vice President of Medical Affairs for assistance in locating a nephrologist. Instances of non-responsiveness from primary and covering physicians will be tracked and reported as appropriate to the medical staff leadership.

## **SCHEDULING**

Electronic orders for scheduling must be entered before 3 PM. For any orders written after 3 PM, the treatment will be provided the following working day, unless it is an emergency.

## **LATE ROUNDERS**

Order entry before 3 PM is required unless it is an emergency. The physician must accommodate the patients need for timely treatment.

## **DISCHARGES:**

Patients will be discharged from the Hospital only on the direct order of the Attending Physician (or his/her designee). At the time of discharge, the attending Physician or designee shall complete the depart summary (or, at MCNA, the discharge summary). The discharge diagnosis, medication reconciliation, and discharge order must be complete at the time of discharge.

Patients who leave the Hospital without approval of the Attending Physician shall be requested to sign a statement that they are leaving against medical advice (AMA), and that they release both the attending Physician and the Hospital from all further responsibility. If the patient leaves before a statement is signed, or refuses to sign such a statement, the patient's nurse shall make an appropriate notation, dated and timed, in the nursing notes to this effect. More detailed information is available in the Administrative AMA Policy.

# MEDICAL RECORDS

## POLICY:

Each member of the medical staff will be responsible for the timely, legible and complete preparation of his/her portion of the medical record for which he/she is responsible on each of his/her patients. The medical record will contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

## RECORD COMPLETION

- Each member of the medical staff is expected to maintain an adequate, current medical *record for each patient.*
- The attending physician shall be responsible for the preparation of a complete medical record for each patient within 10 days following assignment of a discharged patient's medical record regardless of patient type.
- A complete medical record is defined as one that has all entries, dictation and signatures completed.

In the event a medical record remains incomplete by reason of death, resignation or inability of a staff member to complete the record, the Health Information Management Department may request that the Department Chair consider the circumstances and approve the record for closure via placement of a signed Administrative Closure Letter in the medical record describing such reasons.

## CONTENTS

The medical record contains information that reflects the patient's care, treatment, services, course and results of care, treatment and services.

All entries must be legible, timed, dated and authenticated. Each patient record shall include:

### Demographics:

- Patient name, address, and date of birth, and the name of any legally authorized representative; the patient's sex; the legal status of any patient receiving behavioral health care services; the patient's communication needs, including preferred language for discussing health care. If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative are documented in the medical record.

### Clinical Information:

- Reasons for admission or treatment
- Complaint/symptoms
- Personal history
- Family history
- History of present illness, including care provided prior to arrival, if any

- Physical examination
- Conclusions or impressions drawn from the medical history and physical exam including admitting diagnosis.
- Treatment goals, plan of care and revisions to plan of care, including evidence of Advance Directive
- Progress notes stating medical or surgical treatment and patient's response to care
- Informed consent
- Pre- and post-anesthesia notes, including pre-induction assessment, pre- and post-sedation notes
- Operative/invasive procedure note immediately post op
- Operative/invasive procedure report – dictated/fully described electronic note
- Physician's diagnostic and therapeutic orders
- Physician's orders for discharge from post anesthesia care unless discharge is according to criteria approved by the medical staff
- Special reports
  - Consultations
  - Clinical laboratory results
  - X-ray reports
  - Anesthesia reports
  - Pathologic report
  - Other test results
  - Autopsy report – dictated
  - Death summary
- All relevant final principal and secondary diagnoses, complications and procedures performed, written without use of symbols and abbreviations
- Conclusions at termination of hospitalization
- Discharge instructions to the patient and family
- Medications ordered and administered including strength, dose, and route.
- Adverse Drug reactions
- Discharge summaries, final note or transfer summary; including reason for hospital admission, significant findings, procedures performed, and treatment rendered, the patient's condition at discharge and patient discharge disposition

<b>HISTORY &amp; PHYSICAL (H&amp;P)</b>
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The History & Physical (H&P) must be completed no more than 30 days before or 24 hours after registration or inpatient admission but prior to any surgical procedure or procedure requiring anesthesia services (except in emergency situations). Obstetric records must include comprehensive prenatal information. A durable, legible original or reproduction of the office or clinic prenatal record is acceptable as an H&P with an update note at the time of admission.

- If the H&P was completed within 30 days prior to admission, an update is required within 24 hours of admission but prior to any inpatient or outpatient surgery or procedure requiring anesthesia services or procedural sedation. This H&P update documentation must indicate that the patient was re-examined and that the update was performed, regardless of whether any changes were identified. The note must include that:
  - The H&P was reviewed

- The patient was interviewed and re-examined
- Either no changes were noted or changes as listed were noted since the H&P was completed.
- The H&P and update notes must be performed by a physician, maxillofacial surgeon, advanced practice registered nurse, physician assistant or appropriately trained podiatrist.
- If a licensed practitioner who is not a member of the medical staff performed the H&P within 30 days of admission, an updated H&P must be documented as outlined above.
- If the H&P has been dictated but not yet recorded in the patient's chart, there must be documentation to that effect and an electronic admission note entered in the record by the admitting physician. This note must contain any relevant history and physical examination findings pertinent to the admission or surgery planned.

**History and Physical Content:** At a minimum, the history (obtained from the patient whenever possible) and physical examination shall include the following:

- Chief complaint
- History and details of present illness including assessment of the patient's emotional, behavioral and social status, when appropriate.
- Pertinent past medical, surgical, social and family histories, including allergies and current medications.
- An appropriate review of systems.
- Examination of circulatory and respiratory systems and any body part or body system placed at risk by the planned procedure.
- A statement of the conclusions or impressions drawn from the admission history and physical examination and the course of action planned for the patient is required. This statement should include the principal reason for admission and conditions present on admission and must contain information to justify the admission and continued hospitalization.

<b>SUMMARY LIST</b>
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Ambulatory care records maintained in hospital affiliated clinical settings providing continuing services must have a summary list created for by the third (3) visit for each patient.

The summary list shall include:

- Known significant medical diagnoses and conditions
- Known significant operative and invasive procedures
- Known adverse and allergic drug reactions, and
- Known current medications, over-the-counter medications and herbal preparations
- Entries must be signed, dated and timed
- The patient's summary list is updated whenever there is a change in diagnoses, medications, or allergies to medications, and whenever a procedure is performed.
- The summary list is readily available to practitioners who need access to the information of patients who receive continuing ambulatory care services in order to provide care, treatment and services.



## **INFORMED CONSENT**

Documentation of informed consent obtained by the physician will be placed in the medical record prior to the procedure or treatment. Informed consent consists of:

- The procedure to be performed including any laterality if applicable
- Name of individual(s) who will be performing the procedure
- The nature and purpose of the procedure
- What the procedure is expected to accomplish
- Likelihood of success, including likelihood of patient achieving his/her goals and potential problems during recuperation
- Reasonably known risks (including side effects), benefits and reasonable alternatives
- Risks, benefits, and side effects related to alternatives
- Risks related to not receiving the proposed care, treatment, and services
- Discussion regarding patient questions.
- Entries must be signed, dated and timed.

Informed consent is required for all procedures as listed in the hospital administrative policy.

## **ORDERS**

- All orders for treatment shall be signed, dated and timed.
- Orders for resuscitation must be signed within 24 hours.
- Restraint orders require daily signature.
- Current members of the medical staff may sign records for a covering physician or designated staff alternate for record completion at the discretion of the responsible practitioner.
- All orders for treatment, including but not limited to verbal, telephone, restraint, post-operative, admission, or discharge, shall be signed and dated by a licensed physician, dentist, or podiatrist.
- House physicians and licensed resident physicians, under the direction of a staff member, may enter and sign any order, verbal or written, without any requirement for countersignature by the attending physician.
- Post-op orders shall be entered upon completion of surgery, before the patient is transferred to the next level of care.
- Admission orders shall be entered by the attending physician or his/her designee. An admission to a critical care bed should always be seen and evaluated by an admitting or consulting physician.

## **VERBAL OR TELEPHONE ORDERS**

Verbal or telephone orders are to be limited and restricted to:

- Emergent situations

- Clinical situations where it is impractical for orders to be entered into EMR (Electronic medical record) or written on the appropriate form for non-EMR sites.
- Situations when physicians do not have access to remote computer devices or the patient chart.
- Verbal or telephone orders accepted by a licensed healthcare professional (as defined by the Hospital Administrative Policy) as allowed within their respective legal scope of practice must be signed and dated by a licensed physician, dentist, or podiatrist.
- Verbal or telephone orders should be authenticated by the prescriber no later than 30 days from the initiation of the order, with the exception of restraint and resuscitation status which must be authenticated within 24 hours.
- Verbal orders for Total Parental Nutrition, chemotherapy (as defined by the American Society of Hospital Pharmacists pharmacological classification system) and non-authorized non-Formulary medications are not permitted.

### Medication Orders

- Medication orders must contain the name of the medication, dosage, route, and frequency for administration.
- As needed, “PRN” orders must have indications for administration included in the order. If two or more medications in the same classification are ordered, indications or sequence of administration must be indicated to avoid therapeutic duplication.
- Blanket orders such as “continue previous meds”, “resume preoperative meds”, or “discharge on current meds” are not authorized.
- Range orders (medication orders with more than one variable) will not be accepted without dosing parameters or indications.

### OPERATIVE NOTE AND REPORT

- All operations/procedures performed shall be fully described in the medical record by the attending physician.
- A pre-operative diagnosis is recorded before surgery by the licensed independent practitioner responsible for the patient.
- **Immediate Post Op note:** Immediately post-op, before patient is transferred to next level of care, an operative note is entered in the medical record and shall include, at minimum:
  - name of the primary surgeon(s) and assistant(s)
  - estimated blood loss (Note: In procedures where blood loss is not expected to occur, such as, but not limited to, cardiac catheterizations, endoscopy, or minor bedside procedures, documentation of blood loss is required only when blood loss actually occurs.)
  - findings
  - technical procedure used
  - specimens removed
  - Pre- and post-op diagnosis
  - Entries must be signed, dated and timed
- Additional post-operative documentation includes the patient’s vital signs and level of consciousness, medications (including intravenous fluids), blood and blood components, any unusual events or postoperative complications, and management.

- Completion of a full operative report, electronic or dictated, is required within twenty-four (24) hours.

## **ANESTHESIA ASSESSMENT & ADMINISTRATION DOCUMENTATION**

- The medical record of any outpatient/same-day surgery patient having moderate or deep sedation will contain:
  - A history and physical examination, diagnostic test results, anesthesia, drug and allergy information and preoperative diagnosis.
  - A pre-sedation or pre-anesthesia assessment, including anesthesia risk (i.e. ASA score and/or Malampati classification).
  - Documentation of patient's candidacy for the planned anesthesia.
  - Re-evaluation of patient status documented immediately before moderate or deep sedation use and before anesthesia induction.
  - Perioperative documentation including unusual events, physiologic readings, treatments and responses to treatments.
  - Documented assessment of post-operative status on admission to and discharge from post-anesthesia recovery area.
  - Entries must be signed, dated and timed.

## **PROGRESS NOTES**

- Pertinent progress notes shall be recorded at the time of each patient observation.
- Progress notes shall be entered into the electronic medical record daily by the attending physician or physician designee on all patients.
- Progress notes must be read for accuracy, signed, dated and timed by the author.
- Final progress notes are to be completed prior to discharge.

## **DISCHARGE SUMMARY / FINAL NOTE**

- In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following:
  - Active/ final diagnosis(es) and impressions
  - The reason for hospitalization
  - Hospital course/care, treatment and services provided
  - Procedures performed
  - The patient's condition and disposition at discharge
  - Information provided to the patient and family
  - Provisions for follow-up care
- A discharge summary may be dictated or created using the Electronic Medical Record (EMR) discharge summary template including the components listed above. If the paper record is used, the summary must be signed at the time of discharge.
- A discharge summary is required for all inpatient and observation admissions regardless of final length of stay (except as noted below).

- Exception: If the observation visit is less than 24 hours, and patient's course is uncomplicated, the final discharge summary can be created as a final progress note. It must include at a minimum:
  - Outcome of hospitalization
  - Final diagnoses/impression
  - Disposition of the case
  - Provisions for follow-up care
- Completion of a discharge summary is required within ten (10) days of the patient's discharge and within ten (10) days of assignment of the patient's record to the practitioner.
- Any significant change in condition occurring after the discharging summary is completed but prior to actual discharge should be noted as an addendum to the discharge summary.

## **CONTINUITY OF CARE SUMMARY**

At the time of patient's discharge from our facility to another hospital, an extended care or rehabilitation facility, or to home with assistive services, the hospital informs other service providers who will provide care, treatment or services to the patient about the following:

- Reason for the patient's discharge or transfer
- Patient's physical or psychological status
- A summary of care, treatment and services provided to the patient
- The patient's progress toward goals.
- The Continuity of Care summary is to be completed prior to transfer. The related discharge summary is to be completed within ten (10) days of the patient's discharge and within ten (10) days of the medical record being assigned to the practitioner.

## **DEATH SUMMARY**

In the event of death, a dictated death summary is required. This summation should include:

- Reason for admission
- Findings and course in the hospital
- Event leading to death
- Time and date of death
- Death summary is to be completed within ten (10) days of the patient's death and within ten (10) days of the medical record being assigned to the practitioner.

## **DEATH CERTIFICATES**

Death certificates are to be completed and signed within 48 hours of availability.

## **AUTHENTICATION**

- All entries in the medical record must be signed by the person making the entry with an authorized signature facsimile (written signature, computer entry). Authentication includes date and time of signature.
- Computer signature must be used with personal signature password protection.
- Authenticate all electronic notes as quickly as possible to release them as “final” to become part of the patient’s legal medical record. Saved notes are not final notes.
- Current members of the medical staff may sign records for a covering physician or be designated a staff alternate for record completion at the discretion of the responsible practitioner.
- Inappropriate use of passwords violates the Policies and Procedures of the Medical Staff and staff members may be subject to sanctions by the Medical Executive Committee.
- The provider’s signature shall serve as attestation that the information, (whether the content is original or copied) is accurate, and that any copied information is current and represents the provider’s services for that date of service.

## **COPY / PASTE**

All entries in the EMR must be patient and visit specific and contain the actual data collected by the provider based on medical necessity and personally rendered services. Providers may reference other providers’ entries in the patient’s record (by date and time), for example, when the information is pertinent to the reason for the visit, the patient’s history, test or imaging results, etc.

If any information is imported or copied forward from prior documentation or e-documentation created by the Provider, once the information is added, the Provider shall review the content, confirm pertinence, accuracy, and medical necessity for the new, current note and update as appropriate.

Physicians must abide by the Mount Carmel Health System Administrative Policy regarding copy/cloning.

## ABBREVIATIONS

- The following abbreviations are prohibited from use in all documentation, handwritten or electronic including information from outside sources incorporated and used as part of the patient's hospital record:

DO NOT USE	USE
Lack of leading zero example .5 mg	Write "0.5 mg" - Always use leading zero
Trailing zero example 1.0mg	Write "1 mg" - Never use trailing zero except in lab or imaging studies or catheter/tube sizes
U or u	Write "units"
Q.D. or QD or q.d. or qd	Write "daily"
QOD or Q.O.D. or qod or q.o.d.	Write "every other day"
IU	Write "international units"
MS or MSO4 or MgSO4	Write "morphine sulfate" or "magnesium sulfate"

- Names of medications cannot be abbreviated.
- Use of personally created abbreviations for the purpose of shortening documentation entered into the medical record is prohibited.
- Other abbreviations may be used provided they can be located in reference materials specifically published to define symbols, abbreviations, terms etc. used in professional documentation:
  - All standard symbols for chemical elements and compounds are approved.
  - All standard abbreviations for professional titles are approved.
  - All Standard English language abbreviations (reference: Webster's New Collegiate Dictionary) are approved.
  - All standard medical abbreviations found in standard Medical Dictionaries or Medical Texts like Stedman's, Tabers or Neil M. Davis are approved.

## DOCUMENTATION CLARIFICATION / CODER QUERY

- The attending physician must document the reason for hospitalization at the time of admission; significant secondary diagnoses and/or significant findings that reflect the patient's severity of illness and risk of mortality; and all final diagnoses and any complications at the time of discharge.
- When documentation is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent, a Documentation Clarification or Coder Query will be submitted online to the physician.

- The physician is expected to review the document and provide additional documentation, amended documentation, or a timely response to the documentation clarification/query prior to the discharge of the patient.

## **CONFIDENTIALITY**

- A practitioner's access to patient information is limited to necessary use in the treatment of patients, scientific study, or peer review activities.
- All practitioners are required to maintain the confidentiality of patient information and abide by all relevant local, state and federal laws related to confidentiality and security of patient information.
- Improper use or disclosure of patient information may be grounds for sanction by the Medical Executive Committee.

## **FAILURE TO COMPLETE MEDICAL RECORDS**

Records must be completed according to medical staff policies, hospital policies and regulatory requirements.

## **DELINQUENT MEDICAL RECORD MONITORING POLICY**

### REQUIREMENTS

Records are to be completed according to documentation requirements as outlined in the Medical Staff Rules and Regulations. Availability of the EMR remotely provides daily opportunities for timely record completion. Practitioners and Allied Health Professionals are expected to check the electronic medical record system on a regular basis (not less than once a week) to determine the completion status of their patients' medical records

- Final operative/procedure reports must be completed within 24 hours post procedure.
- Final progress notes and transfer summaries must be completed prior to discharge.
- Death certificates must be completed within 48 hours of availability.
- Birth certificates must be completed within 72 hours of availability.
- ED notes must be completed within 48 hours post discharge.
- Discharge summaries on patients discharged or transferred must be completed within ten (10) days post discharge and within ten (10) days of the medical record being assigned to the practitioner.
- Death summaries must be completed within ten (10) days post discharge and within ten (10) days of the medical record being assigned to the practitioner.

### DEFINITIONS

**A complete chart has all documentation and signatures completed.**

For the purpose of monitoring record completion timeliness, a record will be deemed in **delinquent** status if it remains incomplete greater than 10 days post date of discharge, or if it is missing a final operative/procedure report greater than 10 days post procedure date, and has a delinquency assigned to the practitioner for at least ten (10) days. This includes inpatient, observation, ambulatory surgery, interventional procedure, and emergency department records which are incomplete for dictation, PowerNote completion, final diagnosis, and/or signature.

## MONITORING PROCESS

Every Wednesday morning, the Health Information Management Department will compile a list of physicians who will receive a delinquency if documentation and signatures on delinquent records are not completed by the following Monday (MCHS holiday Mondays excluded) at 10:00 A.M. A courtesy reminder notice will be emailed by HIM directly to practitioners to prompt record completion and indicate the potential for delinquency status if records are not completed by 10:00 A.M. the following Monday. This email will be the only communication warning of impending delinquency.

Every Monday morning (MCHS holiday Mondays excluded) at 10:00 A.M., the Health Information Management Department will compile a list of practitioners who have incomplete records that are now delinquent. Notification of first delinquency/warning or suspension will be emailed directly to practitioners after the Monday compilation of delinquent medical records. The Medical Staff Office, physician leadership, and hospital leadership will also be notified of the delinquencies and/or temporary suspensions via email.

Practitioners can avoid vacation-related delinquencies by notifying the Health Information Management Department in advance of any vacation time and keeping current with record completion. When practitioners plan to be absent from their practice for more than seven (7) days, they must complete all records available within the electronic record message center up to the date prior to leaving. Incomplete records in a delinquent state must be completed upon return prior to Monday at 10:00 A.M., to avoid incurring a delinquency.

Email notices will be sent using email addresses maintained by the Medical Staff Services office. Practitioners are responsible for notifying Medical Staff Services and the HIM Department of any changes to their email address.

## FIRST DELINQUENCY/WARNING

A first delinquency will be imposed Monday after 10:00 AM (MCHS holiday Mondays excluded) when a practitioner has a delinquent medical record:

- One or more medical records with an operative or procedure report missing >10 days post procedure date; or
- One or more incomplete records > than 10 days post date of discharge; and
- The record(s) in question have been assigned to the practitioner for at least 10 days.



## TEMPORARY SUSPENSION

Temporary suspension will be imposed Monday after 10:00 A.M. (MCHS holiday Mondays excluded) when a practitioner has a delinquent medical record and has previously incurred a first delinquency:

- One or more medical records with an operative or procedure report missing >10 days post procedure date; or
- One or more incomplete records > than 10 days post date of discharge; and
- The record(s) in question have been assigned to the practitioner for at least 10 days.

Suspension shall occur according to the following status:

- For the first occurrence/delinquency in the calendar year (January 1 – December 31), the physician will receive a warning letter. A copy will be sent to the department chair.
- Automatic temporary suspension will be initiated if the delinquency is still not addressed by the subsequent Monday and will remain in place until all the assigned delinquencies are resolved.
- Once the practitioner has addressed all existing medical record delinquencies and/or been removed from suspension, the next delinquency encountered during that calendar year will result in another temporary suspension.

Practitioners in a suspension status will not be permitted to perform new elective procedures, schedule new procedures, or electively admit patients during the period of automatic suspension. When in suspension status, the attending physician may continue to provide care for all inpatients already assigned to his/her care *as of the date of suspension*, take call or emergency cases, see consults, and complete previously scheduled cases. Suspension will not be reported to the National Practitioner Databank.

When a practitioner receives a temporary suspension due to medical records delinquencies, key department contacts will be notified to prevent scheduling. Temporary suspension for delinquent Medical Records will be lifted after HIM Department verification of completion of all existing delinquent records. Verification and lifting of temporary suspension for delinquent Medical Records will only be performed by HIM during hours of operation Monday through Friday, 8:00 A.M. to 4:30 P.M. and key department contacts will be notified of reinstatement.

Appeals may be submitted in writing to the Medical Staff Services office within two weeks of the warning/suspension. Any appeal will be forwarded to the Medical Staff President for review, and the practitioner will receive a written response within two weeks after the appeal has been received by the Medical Staff President. An appeal will not alter the immediate temporary suspension, but if the appeal is upheld on review, the suspension will be expunged.

Timely completion of medical records is essential to provide safe, effective patient care. Any practitioner who incurs two or more temporary suspensions or a continuous suspension four or more weeks within any twelve-month calendar period (January 1 through December 31) will be referred to the appropriate Multidisciplinary Peer Review Committee for consideration of further action.

## **PATIENT CARE RESPONSIBILITIES AND COVERAGE:**

- (a) Every admitted or observation patient will be managed by an attending physician who must be a member of the medical staff with approved privileges. If the patient has no primary physician, he/she will be assigned to a staff member on unassigned call in the appropriate department to serve as the attending physician
- (b) When a general internal medicine patient, who has been admitted to the hospital in the last 30 days, presents to the ED for a subsequent admission, to preserve continuity for this subsequent admission, the ED physician will proceed as follows:
  - (1) the ED physician will contact the primary care physician's coverage (if one exists)
  - (2) if no coverage exists then the patient will be admitted to the physician of record (or their designee) for the most recent admission within the previous 30 days.
- (c) In the event of an overwhelming volume of patients requiring admission from the Emergency Department (e.g. mass casualty incident, pandemic flu), the President of the Medical Staff (or his/her designee) will identify a process to equitably assign patients to all credentialed members of the medical staff.

## **ORAL SURGEONS, DENTISTS, AND PODIATRISTS:**

A patient admitted for dental or podiatric care is the dual responsibility of the dentist or podiatrist and a physician member of the Medical Staff, except oral surgeons who have been credentialed to perform history and physical examinations.

- The **oral surgeon** may be the sole admitter if the patient has no medical complications.
- The **dentist** is responsible for dental history of disease and oral examination, completion of operative reports, progress notes and summary.
- The **podiatrist** is responsible for the history of podiatric disease and examination, operative report, progress notes and summary.
- The **physician** is responsible for medical history and physical examination and supervision of general health while in the hospital.

## **TRANSFER OF CARE:**

**Levels of care:** This designation is defined by the intensity of care required and is divided into four (4) categories: intensive care (highest intensity), step down care (intermediate intensity), med-surg or similar units (lowest intensity), and transfer or discharge.

### **Transfers between different levels of care**

When a physician primarily responsible for a patient requests that the patient be transferred to another physician at a **different level of care**, the accepting physician at the different level of care must agree to the transfer of primary responsibility for the patient. The accepting physician must document in the medical record that he/she agrees to the transfer. The accepting physician assumes responsibility for the patient as soon as:

- (a) the change in level of care order is written by the transferring physician; and
- (b) the acceptance by the accepting physician is documented in the medical record.

When a patient transfers to a higher level of care, it is the responsibility of the physician accepting the patient into the higher level of care to reconcile both medication and non-medication orders. When a patient transfers to a lower level of care, it is the responsibility of the physician transferring the patient to the lower level of care to reconcile both medication and non-medication orders.

### **Transfers between the same level of care**

When a physician primarily responsible for a patient requests that the patient be transferred to a different physician at the **same level of care**, the accepting physician must agree to the transfer of primary responsibility for the patient. The accepting physician must document in the medical record that he/she agrees to the transfer. Any acute or ongoing issues regarding the need for changes in order or medications will become the accepting physician's responsibility as soon as:

- (a) the order for the transfer of care is written by the transferring physician; and
- (b) the acceptance by the accepting physician is documented in the medical record.

When a patient transfers to the same level of care, it is the responsibility of the physician accepting the transferring patient to reconcile both medication and non-medication orders.

### **Transfers or discharges**

When a patient is discharged from any level of care to another facility (e.g. long term acute care, skilled nursing, extended care) or home, it is the responsibility of the physician at the time of transfer or discharge (transferring physician) to perform discharge medication reconciliation and enter any needed discharge orders.

### **ALTERNATE PHYSICIAN COVERAGE:**

Each member of the Medical Staff shall have a substitute equivalent practitioner who is a member in good standing of the Medical Staff available to care for the practitioner's patients in the Hospital in the practitioner's absence and is able to respond in a timely manner (*refer to Medical Staff Credentials Policy – Article 2 (2.A.1) (j)*). *A physician's alternate will be designated on the initial Medical Staff Application, and subsequently on the Medical Staff reappointment application forms.*

The Chairman of the practitioner's department, the campus VPMA, the President of the Medical Staff, or his designee shall have the authority to call any member of the Medical Staff should the attending practitioner and the alternate be unavailable.

## **PATIENT CONSENT:**

### **Patient Consent**

1. The policy of the Hospital with respect to informed consent is that all patients are entitled to be advised by the responsible Practitioner about his/her diagnosis, the nature and purpose of the proposed course of treatment/procedures, and the reasonably known risks, complications, expectations, benefits, and alternatives of the treatment/procedure. The consent must be dated, timed, and signed by the responsible practitioner. The consent will be valid for thirty (30) days from the date signed by the patient.
2. The patient should be advised of sufficient information so as to be reasonably able to make a competent decision with respect to consenting or refusing the administration of the treatment/procedure.
3. The patient should consent to the treatment/procedure by signing the appropriate "consent form," acknowledging that such disclosure of information has occurred and that all questions asked about the treatment/procedure have been answered in a satisfactory manner. If the patient's written consent cannot be reasonably obtained, the Physician should document the verbal "consent" given in the Physician's Progress Notes.
4. Informed consent shall be obtained by the responsible Practitioner for all invasive procedures other than minor lab and routine blood testing, and for those involving anesthesia or sedation. More extensive and detailed information on informed consent and procedures requiring informed consent is included in the Mount Carmel Administrative Policy: "Informed Consent for Surgery or Invasive Procedure."
5. Informed consent is to be obtained by the responsible Practitioner for non-emergent transfusion of blood/blood products prior to transfusion of such products. Documentation requirements for potential blood transfusion are included in the Mount Carmel Administrative Policy: "Consent for Non-emergent Transfusion of Blood/Blood Products."
6. Obtaining informed consent is the responsibility of the responsible Practitioner. It is recommended that the Physician record a dated and timed progress note in the medical record or in a written consultation setting forth that informed consent has been obtained.
7. House Staff and nursing personnel may witness patient signature or next of kin signature for informed consent pursuant to physician order assuring that the form has been completed before the administration of preoperative sedation and the release of the patient from the Nursing unit. Further, the Nursing Department will assure that the consent form is a part of the patient's medical record and contact the Physician if the form is not present in the record prior to the administration of sedation or the performance of the treatment/procedure.
8. For emergent situations where the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient, for emergencies involving a minor, an

unconscious patient, or an incompetent patient in which consent for surgery cannot be immediately obtained from parents, guardian, or next of kin, these circumstances should be fully explained in the patient's medical record. The medical record should indicate the efforts made by the Hospital and the Physician in emergencies to obtain the necessary consent. The Hospital should render treatment to a non-consenting person only after taking reasonable steps to obtain consent, and only then if the intervention is an emergency.

9. Documentation requirements for VBAC consent are included in the OB/GYN Department policies.

### **Legal Representation for Patients and Minors**

To aid in determining the appropriate individual to provide informed consent for medical treatment or surgical procedures in circumstances where the patient is incapable of making a competent informed consent or informed refusal, or in circumstances involving a minor child, the following shall apply:

1. A minor who is married and a competent individual under the age of eighteen (18) years may be considered to be emancipated and may consent to medical and surgical care for themselves and their children.
2. A competent minor afflicted with venereal disease or suffering from drug use or dependency may also consent to related medical or surgical treatment.
3. An emancipated minor can consent to medical treatment for himself or herself.
4. A parent, legal guardian, or other legally authorized person may consent to treatment and medical care for their minor children.
5. In an emergency, when a Physician is faced with a situation where immediate action is necessary to prevent death or serious impairment of the patient's health, the Physician may act without consent.
6. If a person is incapable of giving their own consent, their spouse, legal guardian, or other legally authorized person may consent for them.
7. An incompetent person may only give consent through their guardians or next of kin. If no guardian has been appointed by the Court and the incompetent person is a minor, the parents can consent. However, unusual medical procedures for incompetent adults or for minors cannot be undertaken without judicially approved permission.

## PHYSICIAN CONSULTATIONS

Responsibility of physician requesting consultation:

- The patient's attending physician has the responsibility of requesting consultations.
- The consulting physician must indicate, in the medical record, the reason for requesting the consultation.
- The requesting physician will designate if consult is STAT, ASAP (Urgent), or routine. STAT and ASAP (Urgent) consultations require direct physician to physician communication. STAT consultation is reserved for life or limb-threatening circumstances.
- Consultation required:
  - In certain situations, by Ohio's Durable Power of Attorney and Living Will laws and the physician shall follow Hospital policies in these situations.
  - For procedures by which a known or suspected pregnancy may be interrupted, except in an emergency, per Hospital policies.

Responsibility of the consulted physician

- Consultation includes examination of the patient and of the medical records. A written opinion signed, dated and timed by the consultant must be added to the medical record.
- Time requirements for consults:
  - A STAT consult shall be seen within one hour. STAT consultation is reserved for life or limb-threatening circumstances. If the consult cannot be seen within that timeframe, please notify the requesting physician so they can consider other options.
  - An ASAP (Urgent) consult shall be seen within four hours of the time the consulted physician is notified.
  - A routine consult shall be seen within 24 hours of the time the consulted physician is notified.
  - If a consult is requested in preparation for an operative procedure, the consultation note, except in emergency, shall be recorded prior to the operation.
- The consulted physician may request additional consultations with notification of the attending physician. IF the consulted physician does not feel competent to evaluate the patient, he/she needs to contact the requesting physician to discuss.
- If the consulted physician has had a prior encounter with the patient that would uniquely complicate the requested consultation process or interaction with the consultant, the physician should contact the requesting physician so they can identify other alternatives. Members of the medical staff may not decline consults on the basis of patient personal characteristics or economic status.
- Members of the medical staff may not decline consults on the basis of a patient's insurance coverage. If the consulted physician believes that performing the consult will cause the patient a significant and avoidable cost, the physician should contact the requesting physician so they can identify other alternatives.
- Refusal to see an appropriate consult is subject to review by Medical Staff Peer Review.

- If a requested consultant is not a member of the Medical Staff and is asked to provide direct treatment or orders, she/she must apply for and be granted temporary Privileges pursuant to the Medical Staff bylaws.

#### Responsibility of consulted resident physicians

- Consultations that are part of the training program shall be valid when reviewed and approved in writing by a member of the teaching staff in the consulted specialty.
- Other consultations may be made only in urgent situations and shall be reviewed by a member of the medical staff who would otherwise have been called as a consultant for the patient. They may be made preliminarily at the direction of a consultant who will be responsible for any opinion or action arising from the preliminary consultation and will confirm or modify the preliminary consultation and sign, date, and time the final version.

#### Consultation by medical staff leadership

- Under unique circumstances in which consultation is advisable for safe and effective patient care, medical staff leadership (department chair, medical staff president, medical staff president-elect, VPMA) may request consultation.
- The attending physician will be promptly notified of such circumstances.

#### Consultation by and to Allied Professional Practitioners

- Consultation by and to Allied Health Practitioners will be governed by the parameters of this document and their collaborative agreement.

### **PHYSICIAN ORDERS**

- All patient care orders, including but not limited to verbal, telephone, restraint, post-procedural, admission, or discharge shall be authenticated by signature, date, and time by a physician, dentist, podiatrist, or allied health practitioner (i.e. a privileged practitioner) with appropriate privileges at the hospital to which the patient is admitted.
- Verbal and Telephone Orders:
  - Verbal or telephone orders may be accepted by a licensed healthcare professional (e.g. registered nurse, registered pharmacist, licensed physical therapist, etc.) who is employed by the hospital or has been granted privileges by that hospital's medical staff. Accepted verbal or telephone orders should be related to the scope of the healthcare professional's practice.
  - Verbal or telephone orders should be authenticated by the prescriber no later than 30 days from the initiation of the order, with the exception of restraint and resuscitation status which must be authenticated within 24 hours.
- Physicians in Training:
  - Resident physicians (including interns) and Fellows may issue and authenticate orders without countersignature by an attending, consulting, or faculty physician.
  - Medical students may not issue orders under any circumstance.
- Allied Health Practitioners:

- Allied Health Practitioners with prescriptive authority and appropriate privileges may issue and authenticate orders.
- All Allied Health Practitioners without prescriptive authority, or without appropriate privileges, must have any issued order countersigned by their supervising physician.
- Change in level of care:
  - All pre-existing orders on a given patient are automatically cancelled when that patient changes a level of care (e.g. transferred into or out of a critical care unit, taken to surgery or upon completion of a procedure). Orders must be re-issued at that time.
- Standardized Orders:
  - All standardized order sets or pre-printed orders are considered as any other order. They must contain the patient's name and other identifying information per hospital policy, and be authenticated by signature, date, and time.
- Orders regarding patient type must be authenticated by the attending physician prior to patient discharge. Allied Health Practitioners and Physicians in training may not authenticate patient type orders.

**UTILIZATION:**

Regulatory and payor requirements pertaining to patient care shall be observed.

(a) Designation of Patient Type:

A physician shall determine the patient type for all hospitalized patients by order at the time of admission. A physician order is required for any change of patient status during hospitalization.

**Approved:**

MCSA MEC	January 28, 2022
MCH MEC	January 28, 2022
MCNA MEC	February 1, 2022
Credentialing Sub-Committee of the Quality & Safety Committee of the MCHS Board of Trustees	February 2, 2022

MCNA and MCSA MEC	May 17, 2021
MCH MEC	May 18, 2021
Credentialing Sub-Committee of the Quality & Safety Committee of the MCHS Board of Trustees	May 24, 2021

MCNA and MCSA MEC	10/23/2019
MCH MEC	10/21/2019
Credentialing Sub-Committee of the Quality & Safety Committee of the MCHS Board of Trustees	10/21/2019



Approved:  
MCNA and MCSA MEC  
MCH MEC  
Credentialing Sub-Committee of the Quality & Safety Committee  
of the MCHS Board of Trustees

June 19, 2017  
June 20, 2017  
June 26, 2017

MCH MEC  
MCNA and MCSA MEC  
Credentialing Sub-Committee of the Quality & Safety Committee  
of the MCHS Board of Trustees

September 15, 2015  
September 21, 2015  
May 26, 2017

Medical Records Policy Revision  
Approved:  
MCH MEC  
MCNA and MCSA MEC  
Credentialing Sub-Committee of the Quality & Safety Committee  
of the MCHS Board of Trustees

November 15, 2016  
November 21, 2016  
November 28, 2016

# MOUNT CARMEL