PROVIDENCE
Sacred Heart Medical Center
Sacred Heart Children's Hospital
Holy Family Hospital

Medical Record Completion and Suspension Policy

Original Date: *09/2015; updated MEC 03/2018; updated MEC 09/2021*

Medical Record Policies

All practitioners shall utilize the hospital's electronic health record according to hospital and medical staff policy. (See medical staff policy: *Epic Use and Training*.) Practitioners must use system-approved electronic order entry through the EMR. The hospital and its providers delegate clinical order set development, review, revision, and approval to Providence Health &Services System and affiliate clinical expert collaboration groups, such as Clinical Program Services institute focus groups and clinical decision teams. Clinical practice guidelines and standardized order sets are considered approved by the hospital's medical staff upon approval by designated review expert groups. When a new/revised order set has been approved, PH&S is responsible to communicate these updates to clinical caregivers. If the MEC has concerns or feedback regarding order sets, the MEC or designee can communicate with clinical expert collaboration leaders for consideration.

History and Physical

This policy amplifies the Medical Staff Bylaws and complies with requirements of CMS and The Joint Commission (TJC).

TJC states:
The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (PC.01.02.03)

Medical Staff Bylaws state:
The admission history and physical (H&P) examination shall be completed by a member of the Medical or Allied Health Professional Staff with privileges to do so. A medical history and examination that was completed within 30 days prior to inpatient/observation admission may be accepted, but this must have an update performed by the attending physician or his designee within 24 hours after admission or registration but prior to a procedure requiring anesthesia services. This update may be noted as a history and physical update, an interval-note, or a progress note. For patients admitted prior to the date of surgery, a progress note dated the same day of surgery, but entered prior to the surgery/procedure will suffice as an H&P update.

Policy:

A history and physical is required for all patients within 24 hours of registration or admission and prior to any operative or other high risk procedure (chemotherapy is considered a high risk procedure).

Required elements of a complete H&P are: Chief complaint, details of present illness, relevant past history appropriate to the patient's age, drugs, allergies, assessment of body system (including heart and lungs), conclusion/impression, and plan of care. (If drug and allergy documentation is provided elsewhere in the EHR, they do not need to be documented in the H&P.)

The admitting physician or practitioner performing a surgery or procedure is responsible to assure completion of the history and physical examination. Nurse Practitioners and Physician Assistants are approved to complete H&Ps; H&P must be countersigned by a physician sponsor within 48 hours OR prior to a procedure requiring anesthesia services. (Certain outpatient procedures may be performed by nurse practitioners and physician assistants. No countersignature is required from a physician sponsor if the nurse practitioner is credentialed to perform the procedure and is the provider completing the procedure.)

The physician or his representative is responsible to ensure the H&P is part of the hospital encounter in the EHR. This may be by computerized entry, dictation, voice-recognition, templates, and similar methods to provide legible and searchable text.

In addition to the above requirements, psychiatric patients will have a complete neurological examination at the time of the admission physical examination.

A history and physical exam performed within the prior 30 days, and which meets the required elements may be accepted from a referring licensed independent practitioner within Washington State, provided it receives the required review and update from a member of the Medical or Allied Health Professional Staff with privileges to do so. The admitting physician must:

- Review the history and physical documents
- Conduct a second physical assessment to confirm the information and findings
- Update any information and findings, as necessary, including a summary of the patient's condition and course of care during the interim period, and the current physical/psychosocial status; and
- Document the above in the EHR.

Oral surgeons and podiatrists may be credentialed to perform the H&P. If not specifically credentialed, an H&P by a physician or allied health professional, as above, will be required.

Surgical/procedural patients with anesthesia services

This category contains any high-risk procedure ~~and/or any procedure~~ that may involve moderate, deep, general, or regional anesthesia and may cause a lack of protective reflexes requiring extended pre-or post-procedure monitoring. Protective reflexes are defined as the ability to maintain a patent airway and to clear the airway of occlusions such as secretions or emesis without aspiration, and the ability to maintain spontaneous and effective ventilation effort.

Procedures such as, but not limited to the following are included in this category:

Any invasive procedure with moderate sedation or above

Percutaneous visceral aspirations or biopsies (excludes skin, bone marrow, muscle, breast, thyroid, paracentesis, thoracentesis, lymph nodes, etc. if these are performed with less than moderate sedation)

Gastrostomy placements

Cardiac and vascular catheterizations

Angioplasties

Discograms

Dilatation and curettage

Diagnostic imaging exams and procedures with moderate or higher levels of IV sedation

Endoscopies

Implantations

1. For patients who have been admitted prior to the date of surgery, and who have a complete H&P in the inpatient electronic health record (EHR), a progress note recorded within 24 hours prior to surgery will suffice as the update/interval note. The anesthesiology assessment will also suffice as the update/interval note when the H&P is reviewed by the anesthesiologist.

2. Same-day admissions for inpatient and outpatient surgery must have either:
    a. A complete history and physical document performed within the prior 30 days and an update/interval note prior to the procedure. The provider will document 'no changes' in the patient condition or provide a summary of the changes noted in the patient's condition. The anesthesiology assessment will also suffice as the update/interval note when the H&P is reviewed by the anesthesiologist.

        OR

    b. If the history and physical document provided from the physician's office is over 30 days old, a history and physical must be performed prior to the surgery and contain all of the required elements. Note that the physician may not document 'refer to the prior history and physical' if that history and physical is over 30 days old. Physicians are encouraged to work with

Clinical Informatics to develop a custom Epic template for the required H&P elements.

In an emergency, a written progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis recorded before surgery will suffice.

Non-operative and other low-risk procedures

Per TJC (MS.03.01.01 EP 19) the medical staff can identify specific patients to whom the assessment requirement would apply, in lieu of a comprehensive medical history and physical examination. The assessment must include

-patient age, diagnosis, the type and number of surgeries and procedures to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure

-Nationally recognized guidelines and standards of practice for assessment of specific types of patients prior to specific outpatient surgeries and procedures

-applicable state and local health and safety laws

This category includes non-admitted patients referred for diagnostic MRI examinations who require sedation under the direction of anesthesia, to include anxiolysis through general anesthesia. These patients will have no invasive or additional procedures performed during this encounter.

In addition. Procedures such as, but not limited to, the following are included in this category:

Diagnostic imaging with or without IV sedation, lumbar punctures, amniocentesis, arthrography, sinograms, voiding cystourethrogram, myelograms, paracentesis, thoracentesis, PICC placement, injections, gastric feeding tube and non-implanted IV access device removal, and ophthalmologic laser procedures without sedation.

Non-operative and other low-risk procedures do not require a complete H&P, but at a minimum, require a procedural note. A radiology imaging report or result in the chart suffices.

Continuing Ambulatory Care Services (Series patients*)

This category includes outpatients receiving infusions, and chemotherapy (chemoembolization/Y-90 ablations).

An initial H&P meeting the bylaw requirements must be documented in the medical record prior to the initiation of the treatment. The H&P may remain valid for one year but must be updated on an as needed basis as the underlying medical condition of the patient changes. Hospital staff receiving the patient will notify the ordering physicians of any identified changes in the patient's condition.

*Note: Dialysis patients sent to the hospital for fistulogram or declot are usually managed under moderate sedation. Their assessment, management and documentation are governed by CMS regulation. The most recent H&P and any updates by the attending provider and nursing notes from the dialysis center will be obtained and reviewed by the provider prior to the procedure.

Home dialysis patients must have most recent H&P and office notes available from nephrologist office.

References:

Centers for Medicare/Medicaid Interpretive Guidelines (CMS): S&C-08-12. 'The medical history and physical exam must be completed and documented by a physician as defined in CMS section 1861R -- a doctor of medicine or osteopathy, doctor of dental surgery or of dental medicine, doctor of podiatric medicine, doctor of optometry and chiropractor.' (Note that the PHC urban hospitals do not credential optometrists or chiropractors.)

The Joint Commission (TJC): PC 01.02.03 'The patient receives a medical history and physical exam no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.' (Note: anesthesia services are defined as moderate sedation or above.)

Also see TJC Standards MS.03.01.01 (6-11) and the following posted TJC Frequently Asked Questions (FAQ)

- Credentialing Non-Medical Staff member - Licensed Independent Practitioners Who Order Tests and Treatments from a Joint Commission Accredited Organization 11/24/2008
- Medical Students Doing H&P 11/24/08
- Delegation of the History and Physical Examination 11/24/08
- History and Physical for Hospital Outpatient Procedures 11/24/08
- Podiatrists and Dentists Performing the Entire History and Physical for Inpatient and Outpatient Care (11/24/08)
- Permission to Administer Moderate Sedation (2/11/09)

The Joint Commission (TJC) (PC.01.02.13 EP6)

Also reference the following hospital policies

- Sedation for Adults and Sedation for Pediatrics –these provide definitions of sedation.
- Non-staff practitioners ordering tests and procedures
- Resident Scope of Practice

Verbal Orders:

Guiding Principles:

- Keep patients at the center of our care
- Keep patients safe
- Address patients' needs promptly, using a collaborative inter-professional approach to care
- Manage conflict away from the patient

Guidelines for order entry:

- Providers are encouraged and expected to use Epic order entry to place the majority of their orders – particularly admit, peri-operative and discharge order sets.
    - Rationale: Routine orders do not exist in Epic in the manner we have been accustomed to. Physicians/Providers can set up preferences in Epic that function similar to routines, but nursing cannot implement the physician preferences so the nurse would have to enter each order individually as the physician gives it and read back for accuracy which is very time consuming and prone to errors.
- There are, however, appropriate circumstances where a telephone/verbal order is necessary to provide timely care and nurses will have the training needed to do so. Examples include:
    1. The provider is inextricably engaged in direct clinical care or a procedure.
    2. The provider is NOT within reasonable proximity of a computer.
    3. The provider is driving.
    4. The urgency of an order supersedes the time it would take the provider to log on and place an order

General guideline for who should enter the order from inside the hospital:

For orders originating inside the hospital, the care team member initiating the call (and generally the one looking at the patient chart) is expected to enter the order. For example, if the RN initiated the call to the provider, the RN would enter the order as a telephone order. If the provider initiated the call, the provider would enter the order.
If there are concerns about practice, our expectation is we will do what is necessary to provide safe, timely, collegial care to patients and discuss concerns in private or by using the normal chain of command.

Progress Notes:
Progress notes shall be recorded by the attending physician or his designee at the time of observation, at least daily, and shall be sufficient to allow continuity of care and transferability. The patient's clinical problems shall be identified and correlated with specific orders, results of tests and treatment. Rounding and progress note entry for patients who are medically stable and on custodial care, as designated by hospital policy, while awaiting placement for non-acute services will be seen at least every seven (7) days. Rounding may be more frequent if medical issues arise

Consultation:
Consultations by qualified practitioners shall be obtained for patients who have or develop conditions that are beyond the approved privileges of the attending practitioner. Emergency treatment can be initiated at any time. The medical record shall show evidence of timely review by the consultant and documentation of the consultant's findings and recommendations. While the patient has active issues pertaining to the consultant's area of expertise, the consultant will be continually available to the patient, the patient's family and the attending of record and shall document his or her input with regular progress notes. Should the patient's active issues pertaining to the consultant's area of expertise become quiescent, the consultant may formally sign off the case by documenting this in the medical record.

Consultation requests shall be made by personal contact from provider (physician or AHP1) to provider (physician or AHP1). (Exceptions to this may include policies and protocols for patient management as approved by the MEC.)

Operative Notes:

If an operative or procedure note is immediately entered into the electronic health record (by voice recognition or template) before the patient moves to the next level of care, a brief post-procedure note is not required. If the operative or procedure note is dictated, an immediate post-procedure note must be completed and shall contain a description of the findings, the technical procedure used, the specimen removed (if any), the estimated blood loss (if any), the post-operative diagnoses, the name of the primary surgeon or operator and the name/s of any assistant/s. Specifically, interventional radiology and cath lab cases do not require documentation of specimen removed and estimated blood loss.

Operative and procedure reports should be completed immediately after surgery or invasive procedure, but in no case later than 24 hours following the procedure. The dictated transcription shall become part of the medical record as soon as it is available. See the Medical Records Completion and Suspension Policy approved by the MEC which outlines progressive consequences for failure to abide by this bylaw requirement

Discharge Summary

Discharge summaries should be completed within 24 hours of discharge, but in no case later than 72 hours from time of discharge. See the Medical Records Completion and Suspension Policy approved by the MEC which outlines progressive consequences for failure to abide by this bylaw requirement.

Medical record suspension will occur when:

- Any portion of the patient's health record remains incomplete for more than 31 days. Records that are incomplete because of missing dictation/diagnoses/signatures of a supervising physician's extender* (PA, ARNP, etc.) will be included in the delinquencies of the supervising physician. (The supervising physician is the physician attributed to the specific case, not necessarily the sponsoring physician of record.)
- Any discharge summary or discharge note (admission for 60 hours or less) is not completed within 72 hours.
- Any operative or procedure report is not completed within 72 hours of the procedure.
- Any physician query is not responded to within 35 days of the query being sent by Coding.

*Physicians are responsible to assure medical record completion by their sponsored mid-level providers. The sponsoring physician of record will be included in all communications from the MEC regarding repeat suspensions. The sponsoring physician is required to participate in development of all plans to improve the documentation of a physician extender and to endorse in writing all plans for improvement.

Medical record suspension will suspend the suspend privileges and ability to work in the medical center until medical records have been brought current. The providers is responsible for arranging for coverage for his/her hospitalized patients and for arranging coverage for the E.R. on-call schedule if that physician has been assigned call any time during the period of the suspension.

Excused Absence: Excused absences are defined as an illness or a leave that keeps a medical staff member or other privileged provider away from the hospital for five (5) or more days. Except in circumstances beyond the provider's control, an excused absence must be requested in advance.

- For an excused absence, the provider must provide notification to the Medical Staff.
- The Medical Staff Office will communicate medical staff member and provider absences to Health Information Management (HIM) via email.
- Upon return from an excused absence, the medical staff member and privileged provider must complete all deficient medical records by or before the first Monday after their return date.
- When an excused absence has not been requested in advance, the medical staff member and privileged provider has the ongoing responsibility for completing all medical records without pause. In the circumstance that medical records become delinquent, automatic suspension will be processed.

Emergency Case Exemption: A 24-hour exemption from medical record suspension of privileges may be granted to a physician who is managing an emergency-situation (or a physician extender assisting with an emergency-situation). The exemption will be for the emergency-situation only and will not extend to other hospitalized, scheduled, or non-emergent patients. The physician is responsible to obtain authorization for the emergency exemption from the Chief Medical Officer or his designee.

Personal Emergency: Providers may also be granted an emergency exemption for a personal or family emergency; this may be arranged through medical records. Records of these exemptions will be maintained by HIM and reviewed by medical leadership if there is a pattern of concern.

When all delinquent records have been completed, the provider will be automatically returned to the status that was in effect prior to the suspension, and all privileges (admitting and clinical) will be reinstated.

Repeat medical record suspensions

Providers with four (4) or more medical record suspensions, or three (3) consecutive month suspensions, in one rolling 12-month period will receive a letter from the MEC president and Department Chair or service chief requiring that all records be complete by a specified date (letter will include a copy of this policy), and the provider must provide a satisfactory written plan to MEC leadership for managing their medical record obligations. The plan should include information related to how they will remedy the current situation, as well as plans to prevent further medical record suspensions. The MEC leadership group may accept the plan and, if accepted, provide a copy of the plan to the practice manager and practice medical director (and physician sponsor, if

applicable), as the provider is in imminent danger of a full suspension of all privileges, which will affect his/her partners, call group, and/or physician sponsor.

After a plan is in place, if two additional medical record suspensions occur within one rolling 12-month period, the MEC leadership will notify the provider (with copy to group leader/president and sponsor, if applicable) that:

- A one-week suspension will occur in the following month, with date to be determined by the MEC leadership. This full suspension prohibits any, and all practice, within the hospital for the specified dates, emergent or otherwise. The suspension is in effect at all Providence facilities.
- The suspension will be noted in the provider's credentials file and will be released to subsequent hospitals as an official action taken by the medical staff.
- A formal Performance Improvement Plan (PIP) must be developed with the provider which will outline clear expectations for continued currency with medical record documentation. The provider (and sponsor, if applicable) will be required to sign the PIP. The PIP will state that any subsequent full suspension will be for 31 days, and thus will be reported to the NPDB, and that if five (5) suspensions occur in a rolling 12-month period that his/her medical staff privileges will expire with no recourse to a fair hearing.
- If a provider refuses to agree to the PIP, the MEC will begin the process of terminating privileges, and the provider will have rights to a Fair Hearing.

- The provider has the option to present his/her case before the MEC leadership group, or the full MEC, if he or she desires. (In the case of a physician extender, the physician sponsor is required to attend with the physician extender.)

Performance Improvement Plan (PIP).
PIP's will be considered the same as a Focused Professional Practice Evaluation (FPPE) and will be monitored for a minimum of one year.

Refusal to enter into a Performance Improvement Plan (PIP)
If the provider refuses to enter into a plan to improve his or her performance to comply with the Medical Staff Bylaw requirements for documentation, the MEC will begin the process of terminating privileges according to the Fair Hearing Plan.

Failure to meet requirements of a Performance Improvement Plan (PIP)
Unless there are significant extenuating factors, failure to comply with agreed upon requirements of a PIP will result in termination of privileges with no recourse to a Fair Hearing.