Pender Memorial Hospital
an affiliate of New Hanover Regional Medical Center

Rules and Regulations
Medical Records Committee Review Function

I. Preamble

The medical record for each patient of this Hospital should contain sufficient information as to identify the patient, support the diagnosis(es), justify the treatment, document the management and results as well as facilitate the continuity of care. Accordingly, the Medical Records Committee conducts quarterly analyses of medical records, or representative samples thereof, so as to assure the propriety and integrity of the medical records for the patients who seek treatment at this institution. This committee may initiate those action steps or recommendations in order to improve the timely completion, accuracy, and completeness of these records.

II. Protection of the Medical Record

All medical records are the property of the Hospital and are maintained for the benefit of each patient and for the healthcare providers. Records may be removed from the hospital's jurisdiction only as pursuant to an appropriate court order, subpoena, or statute. In the case of re-admission of the patient, previous records may be available upon request for use of the attending physician. Except for current inpatients, all records which are removed from the Medical Records Department should be returned by 5 p.m. each day.

III. General Medical Record Requirements

All physician entries into the medical record (e.g. orders, notes, operative notes, history and physicals) shall be timed and dated.

A legible identifier for services provided/ordered is requested. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation. Facsimile of signatures is acceptable.

IV. Orders

The Standing Rules of the Medical Staff stipulates the manner in which orders shall be documented and authenticated. Rules 301 and 302 of the Standing Rules state,

In order to comply with CMS and DNV requirements and NC statutes, verbal/telephone orders for medications should be countersigned by a physician or physician extender within 5 days from when the order is made. Other verbal/telephone orders should be countersigned by a physician or physician extender within fourteen (14) days from the date of discharge.

A. Verbal/telephone orders shall be taken only by a duly authorized person within the scope of their practice. These persons include:

Cardiac cath technologists I & II;
Certified nurse midwives;
Certified occupational therapy assistants;
Certified phlebotomists;
Certified respiratory therapists;
EEG technicians;
Electrophysiology technologists;
EMTs - intermediate;
Home care social workers;
Licensed practical nurses;
Medical technologists;
Nurse practitioners;
Occupational therapists;
Paramedics;
Pharmacists;
Physical therapists;
Physical therapy assistants;
Physician assistants;
Polysomnagraphics technologists;
Registered dietitians;
Registered nurses;
Registered radiology technologists;
Registered respiratory therapists;
Speech language pathologists

B. Verbal/telephone orders for <u>medications</u> shall be taken only by the following within the scope of their practice:

Certified nurse midwives;
Certified respiratory therapists;
EEG technicians;
EMTs - intermediate;
Licensed practical nurses;
Nurse practitioners;
Paramedics;
Pharmacists;
Physical therapists;
Physician assistants;
Polysomnagraphics technologists;
Registered nurses;
Registered respiratory therapists

C. Verbal and telephone orders shall be dated and recorded directly in the patient record and must include the date & time written and the name of the person who gave the order. The individual accepting the order must sign the order using his/her full signature which includes first name, last name, and title.

D. Medication orders for certain classes of drugs will be reviewed at periodic intervals as designated by the Pharmacy and Therapeutics Committee. Other drugs as stipulated by the Pharmacy and Therapeutics Committee will be subject to automatic stop orders. All medication orders must be rewritten at the time of transfer from an intensive care unit and after a surgical intervention or surgical procedure.

V. Ambulatory Patient Records

Records for patients who receive ambulatory care on an ongoing basis should contain a summary list of known, significant diagnoses and known medications. The outpatient portion of the chart should also be available when a patient returns to the Hospital for treatment.

VI. Admission Note

As soon as possible but within twelve (12) hours, all patients must have a written admission note in the medical record. The admission note should contain (a) reason for admission, (b) provisional diagnosis(es), (c) statement regarding the initial assessments of the patient including candidacy for a surgical procedure, where appropriate, or any other procedure which involves a degree of risk. The record of any patient who undergoes a surgical procedure in the operating room must contain an adequate pre-anesthesia evaluation.

VII. Medical History and Physical Examination

A relevant medical history and physical examination shall be recorded or updated within twenty-four hours following the admission of the patient and prior to any operative or invasive procedure requiring general anesthesia or major regional anesthesia. If a relevant, but thorough, History and Physical has been performed within thirty (30) days prior to the admission, then a durable, legible copy of the report may be included in the patient medical record provided that there is an interval update note stating there are no changes or a note detailing any changes that may have occurred.

A. The admitting inpatient H&P shall include:
   1. Elements that are immediately pertinent to the chief patient complaint or presenting problem;
   2. The history of present illness; relevant past medical history, significant operative or invasive procedures; medications; and known allergies;
   3. Review and examination of systems as pertinent to the chief complaint or presenting problem;
   4. Additional elements necessary for the safe and effective treatment of the patient.

B. An outpatient H&P shall include:
   1. Elements that are immediately pertinent to the chief patient complaint or presenting problem (i.e., history or physical examination of the area of interest for the planned procedure and surrounding systems/structures, if applicable), medications and known allergies; missing History of Present Illness;
   2. Examination of the heart, lungs, and neurological status. If neurological status is pertinent, it can be performed by the anesthesia provider and incorporated into the outpatient H&P as part of a combined activity;
   3. Additional elements as necessary for the safe and effective treatment of the patient.

C. Continual/Recurring Chemotherapy and/or Transfusions:

Initial brief History and Physical
- Patient history/indications
- Current medications
- Known allergies
- Existing conditions/problems
- Treatment plan

Interval update history and physical note every 30 days
- Status changes
- Patient's condition
- Treatment plan

D. A facsimile of the history/physical assessment is acceptable.

E. Staff Qualifications: The privilege to perform an H&P examination is automatic and need not be delineated for physician members of the medical staff. Delineated history and physical privileges must be awarded for non-physicians.

F. Examinations by Practitioners without Privileges: The hospital may accept a history and physical examination performed within 30 days prior to admission by a physician without current hospital privileges as long as practitioner with current hospital privileges endorses the findings and enters an interval note within 24 hours after admission and prior to an operative or other invasive procedure involving general or major regional anesthesia.

Exception: A clinically pertinent note, such as a medical screening examination, may be substituted for a history and physical for the purpose of emergency surgery or prior to other urgent interventions involving general or major regional anesthesia.

G. Interval Note: An update or interval note must be entered in the medical record whenever the history and physical examination was performed prior to admission or registration for surgery.

1. This update or interval note shall document any significant changes reported by or observed in the patient since the pre-admission history and physical examination.
2. The note shall be documented in the medical record:
    - Within 24 hours following admission and
    - Prior to any operation or invasive procedure requiring general or major regional anesthesia (whichever occurs first).

H. Examples: The following examples fully comply with this policy. They are not intended as a comprehensive listing of all possible approaches to compliance.

1. An H&P examination is recorded in the physician's office within 30 days prior to admission. An interval note is entered within 24 hours following admission. The patient undergoes a surgical procedure involving general anesthesia three days after admission. Routine progress notes between the admission and surgery provide sufficient updates to the patient's condition.
2. The pre-sedation assessment for patients undergoing moderate or deep sedation serves as a comparable equivalent of a history and physical examination.

VIII. Legible Documentation and Co-signatures

All discharge summaries must be legibly recorded if not dictated. Documentation is to be by the physician, except as permitted by the hospital and the medical staff with regards to paramedical persons including certified or licensed physician assistants and licensed nurse practitioners may document discharge summaries provided such dictation is authenticated by the responsible attending physician and provided this duty for the physician assistant and/or Nurse Practitioner has been approved by the Credentials Committee.

IX. Operative / Procedure Notes

A. For inpatient/major invasive procedures:

The operative note should be fully described by the operating physician in a standardized format and should include:

- Date of surgery
- Preoperative diagnosis(es)
- Post operative diagnosis(es)
- Name of surgical procedure(s)
- Name of primary surgeon and assistant(s)
- Identity of anesthetic techniqueDescription of Procedure(s) performed
- Operative findings
- Specimens removed (if not implied by the name of the case)
- Estimated blood loss
- Description of any intra-operative complications and resultant action taken

B. For Ambulatory Procedures (Including Endoscopies , Cardiac Caths, Blocks, Radiology with Sedation, Bronchs, ECT's))

The operative note should be fully described by the physician performing the procedure and include:

- Date of Surgery
- Preoperative Diagnosis (es)
- Postoperative diagnosis
- Name of technical procedure (s) used
- Description of Procedure(s) performed
- Names of physician performing procedure and assistant(s)
- Identity of anesthetic technique
- Description of Findings
- Specimen(s) removed (if not by the name of the case)
- Estimated blood loss
- Description of any intra-operative complications and resultant action taken

C. For Minor Outpatient Procedures (Including bone marrows, transfusions, non-stress test, lumbar punctures, Opthalmic Yag Lasers)

The procedure/progress note should be fully described by the physician performing the procedure and include:

- Date of procedure
- Findings
- Patient disposition/condition

D. Brief Operative Note:

The brief operative note should be described by the operating physician and should include:

- Name of physician performing procedure and assistants (s)
- Name of technical procedure used
- Description of findings
- Estimated blood loss
- Specimen(s) removed (if not by the name of the case)
- Postoperative diagnosis

The brieft operativenote for high risk procedures shall be written immediately upon completion of surgery, before the patient is transferred to the next level of care (e.g. before the patient leaves the post anesthesia care area). Exception, if the surgeon accompanies the patient from the operating room to the next unit or area of care, the operative/procedure progress note can be written in that unit or area of care.

High Risk procedures are defined as:

- Inpatient procedures under general/deep sedation
- Same Day Surgery
- Cardiac Catherizations
- Interventional Radiology requiring moderate sedation
- Invasive Radiology requiring moderate sedation
- Endoscopy-Inpatient

X. Consultations

Provider to provider consultation shall be requested when patient care needs differ from the Licensed Independent Practitioner's granted clinical privileges or when the attending physician values the involvement of an additional Licensed Independent Practitioner with specialized knowledge even when the privileges of the two Licensed Independent Practitioners may be the same. There should be provider to provider communication regarding a consult request whenever possible.

If a face-to-face meetings is not possible, then communication should be made through HIPAA compliant electronic means that provides direct access to the consultant (e.g. Perfect Serve or a direct phone call). The consult must be completed within 24 hours of receipt, unless the requesting physician specifically allows a longer period of time.

Regardless of how the consult is communicated, an order (verbal/written) must be placed in the patient's chart, reflecting the need for consultation and the specific physician or practice from which the consult is requested.

XI. Progress Notes

Physicians or a qualified designee should give a pertinent chronological report of the patient's course. These notes should be sufficient to describe the changes in the patient's condition or course and the results of the treatment. Progress notes should be made at least daily for patients admitted to the hospital. Abnormal results of lab, EKG, x-rays or vital signs should be addressed and resolved, explaining if they are unresolved.

XII. Discharge Summary

All patients must have a discharge summary, 24 or 48 hour note as appropriate, legibly recorded or dictated except for the following categories: routine newborn stays and uncomplicated obstetrical deliveries. Discharge summaries should be performed at the time of discharge from the hospital or as soon afterwards as possible but no later than fourteen (14) days from discharge. A discharge summary may be dictated 24 hours prior to discharge, however a progress note and discharge order must be written on the day of discharge. The discharge summary should include:

- date of admission
- date of discharge
- admission diagnoses
- final diagnosis(es) should be recorded in full, and listed in order of principal and secondary diagnoses. Symptoms should not be used unless specified as undiagnosed.
- short clinical resume which covers the course of this stay and patient outcomes(s) at discharge and follow-up instructions with regards to physical activities, diet, medications, and follow-up care.

When the patient is discharged within forty-eight (48) hours of admission the physician may enter a final progress note if the note recapitulates the reason for hospitalization, significant findings, plus the procedures or treatments given, final diagnosis(es) should be recorded in full, and listed in order of principal and secondary diagnoses. Symptoms should not be used unless specified as undiagnosed the discharge status of the patient as well as specific instructions to the patient and/or family.

XIII. Emergency Department Records

All emergency department records must contain the following information:

- Pertinent history of illness or injury including emergency care provided to the patient prior to arrival
- Physical findings including vital signs
- Diagnostic/therapeutic orders
- Clinical observations with results of treatment
- Diagnostic impression
- Final disposition/condition on discharge
- Instructions for follow-up care

XIV. Observation Status

All patients placed in observation status must contain the following information:

- Order indicating “Observation”
- Pertinent history of illness or injury
- Physical findings including vital signs
- Diagnostic/therapeutic orders
- Clinical observations with results of treatment
- Diagnostic impression
- Condition on discharge

XV. Post Mortem Examinations

When an autopsy is performed, a provisional anatomic diagnosis(es) should be recorded in the medical record within seventy-two (72) hours and a complete protocol should be made a part of the record within sixty (60) days.

XVI. Completion of Medical Records

The record of discharged patients should be completed within fourteen (14) days of the date of discharge. The Health Information Management Department will establish a mechanism for alerting physicians to their incomplete charts prior to the expiration of this fourteen (14) day window.

Physicians will be placed on the Voluntary Relinquishment of Privileges (VROP) list when he/she does not complete his/her medical records within the fourteen (14) window. In accordance with the provisions of the bylaws, the physician shall be considered to have resigned from the medical staff if he/she has not completed his/her charts sixty days from
the relinquishment of his/her respective admitting privileges. Physicians placed on the VROP list are reported to the Professional Review Committee for formal evaluation. Physicians who fail to complete records timely three times in a calendar year are reported to the North Carolina Medical Board.

Emergency Department physicians, Anesthesiologists, Radiologists and Pathologists are required to complete his/her medical records within fourteen (14) days of the date of discharge.

When a physician is absent from Wilmington more than seven (7) days, (s)he should notify the medical record manager prior to the absence and additional time for completion of records may be granted. Special consideration can also be given by the department manager for illness.

Standing Rule 102 forbids the admission of a patient to the service of another physician for the purpose of treating the patient himself/herself.

Per North Carolina General Statute, Chapter 90-14.13, physicians who fail to complete timely records three times in a calendar year are reported to the North Carolina Medical Board.

Other applicable regulations are referenced in the Standing Rules of the Medical Staff.

XVII. Retention of Record

The medical center sets the policy for the specific retention of patient records. Generally, patient records are retained in hard copy for a period of two (2) - four (4) years after which the records may be microfilmed for permanent retention. Medical records (excluding Zimmer Center Medical Records), with discharges after the implementation of the electronic medical record will be maintained electronically.

XVIII. Completion of Records When Attending Physician is Unable To Do So

In the event the attending physician is unable to complete a record, the Medical Records Review Committee will review the charts(s) in question. If the committee determines no other physician has sufficient knowledge of the case to complete the record and the attending physician is unlikely to complete the record in the judgment of the committee, the committee may declare the record complete.

XIX. Abbreviations

A. Abbreviations, acronymns and symbols are acceptable in the Medical Record if:
Context specific, and
Not included on the Pender Memorial Hospital (PMH) "Do Not Use Abbreviation List"

B. The "Do Not Use Abbreviation List" applies to all orders and all medication related documentation that is handwritten (including free text computer entry) or on pre-printed forms.

XX. Proposals for Introduction / Deletion of Chart Forms

Any patient care-related form which is proposed for inclusion or deletion from the patient permanent record must be approved by the Forms Committee. The manager of medical records will at his/her discretion refer the proposal along with his/her assessment of the proposal to the Medical Records Committee for approval if needed.

Approvals:

Heather Davis, DO Chief of Staff	Date
Ruth Glaser President	Date

Revisions:
MS February 2019
BOT February 2019