CENTRACARE – MELROSE HOSPITAL

525 W Main Street
MELROSE, MINNESOTA

MEDICAL STAFF RULES AND REGULATIONS

MEDICAL RECORD RULES

Adopted by Medical Staff: 2/19/2024

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Section A – Medical Record Requirements

A.1 Medical Record Requirements

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

A.1.1 All entries in the medical record must be dated, timed and authenticated.

A.1.2 The attending provider shall be responsible for the preparation of a complete and legible medical record for each patient to whom he/she provides care. Its contents shall be pertinent and accurate. This record shall be compiled by the hospital using interactive entry into CentraCare's Epic Health record and shall include, as appropriate to individual patient: identification data, complaint, personal history, family history, history of present illness, physical examination, provisional diagnosis or diagnostic impression, diagnostic and therapeutic orders, diagnostic and therapeutic procedures and test results, medical or surgical treatment, operative and invasive procedure reports, pathological findings, progress notes, consultation reports, discharge summary or discharge note (including final diagnosis, condition on discharge, discharge disposition and discharge instructions), code status and decisional capacity and autopsy report when applicable. All medical records must be complete and will not be filed until complete except at the direction of the Medical Record Committee.

A.1.3 All records are the property of CentraCare – Melrose Hospital and shall not be removed from the premises except by a subpoena, court order, statute or order of the Governing Body. In case of patient readmission, all previous records shall be available for use by the attending physician. This shall apply whether the patient is attended by the same physician or another. Unauthorized removal of electronic or paper charts from the hospital is grounds for suspension of Medical Staff privileges and/or membership of the practitioner for a period to be determined by the Executive Committee of the Medical Staff.

A.2 History and Physical

A.2.1 A complete history and physical (H&P) examination shall be completed and documented for each patient no more than thirty (30) days before or 24 hours after admission, but prior to surgery or a procedure requiring anesthesia.

A. History and physicals must include:
1. patient identification;
2. chief complaint;
3. history of present illness;
4. review of systems;
5. personal medical history, including medications and allergies;
6. family medical history;
7. social history, including any abuse or neglect;
8. physical examination to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
9. data reviewed;

10. assessments, including problem list;
11. plan of treatment; and
12. If applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion, which will be documented in the plan of treatment.
13. in the case of a pediatric patient, the history and physical examination report must also include:
    a. Length or height; and
    b. Weight

A.2.2 When an H&P has been completed within thirty (30) days before admission, an updated medical record entry must be completed and documented in the patient's record within twenty-four (24) hours after admission. In all cases, the update must be documented prior to surgery or a procedure requiring anesthesia. The update of the history and physical examination must

A. Reflect any changes in the patient's condition since the date of the original H&P was that might be significant for the planned course of treatment; or
B. State that there have been no changes in the patient's condition.

A.2.3 Obstetrical records shall include a complete prenatal record, which may be legible copies of the attending physician's office records transferred to the Hospital prior to admission.

A. Prenatal records must be signed and dated
B. A complete H&P is required on all obstetrical cases delivered via scheduled cesarean section.
C. For those obstetrical cases that result in vaginal delivery, the prenatal record may be substituted for the H&P if the last prenatal visit occurred within two weeks of admission.
    1. An interval admission progress note must be written that includes pertinent additions to the history and subsequent changes in the physical findings.
D. If no prenatal record is present, a complete history and physical is required except in emergency cases.

A.2.4 In cases for which moderate sedation, deep sedation or anesthesia will be utilized, a current history and physical must be available for review prior to the procedure.

A.2.5 Those patients that are found to require emergency surgery/invasive procedures will not require an H&P prior to the procedure. The licensed practitioner will be required to document a brief note regarding the patient's condition and planned procedure prior to the induction of anesthesia. The complete H&P must be documented post-procedure. The Emergency Record may be used in lieu of an H&P in this situation provided all required components of the H&P are included.

A.2.6 A transfer summary may be used in lieu of an H&P provided all required H&P components are included for those patients admitted and promptly transferred to another hospital.

A.2.7 Cancellations, Delays, and Emergency Situations

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

B. In an emergency situation, when there is no time to record a complete history and physical, the attending physician may utilize the Emergency Department note, which shall meet the documentation requirements in Section A.10 by recording an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's condition, heart rate, respiratory rate, blood pressure and diagnosis. Immediately following the emergency procedure, the attending physician is then required to complete and document a full history and physical examination.

A.3 Short Stay Documentation Requirements

For ambulatory or same day procedures, a Short Stay History and Physical Form, approved by the Medical Executive Committee, may be used. These forms shall document the chief complaint or reason for the procedure, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings.

A.4 Informed Consent

Informed consent is required for all cases of invasive/surgical procedures requiring anesthesia. CentraCare – Melrose uses the Minnesota Alliance for Patient Safety (MAPS) Informed Consent. Physicians shall discuss the risks and benefits of the procedure, including any risks associated with not performing the procedure, and shall sign the consent form as documentation of the consent. The patient's signature on the consent form indicates understanding of the discussion.

A.5 Operative/Delivery Reports

A.5.1 Any procedures requiring sedation/anesthesia must have the following seven elements in the immediate post-op/procedure note and the full procedure/operative report:

A. Name(s) of the licensed independent practitioner(s) who performed the procedure and his/her assistants;
B. Name of the procedure performed;
C. Description of the procedure;
D. Findings of the procedure (including complications);
E. Estimated blood loss;
F. Specimens removed, if any; and
G. Postoperative diagnosis.

A.5.2 Operative and Delivery reports shall be completed immediately after the procedure. In cases where these reports are dictated, a brief operative or delivery note must be documented in the record to provide information until the transcribed report is available in the record.

A.5.3 An operative report is required for all cesarean section deliveries.

A.5.4 Before moderate or deep sedation or anesthesia, a pre-sedation or pre-anesthesia evaluation shall be completed and recorded in the patient's record. Immediately before administering moderate or deep sedation or anesthesia, the patient is re-evaluated with conclusions recorded. A post anesthesia evaluation is completed and recorded after any procedure requiring anesthesia.

A.5.5 Obstetrical epidurals only require a procedure note that includes the reason for procedure and procedure findings.

A.6 Progress Notes

A.6.1 Progress notes shall be recorded at the time of interaction. Progress notes should give a pertinent, chronological report of the patient's course in the Hospital and should reflect any change in condition and the results of treatment. Documentation of patient evaluation shall be at least done every 24 hours by the physician(s) or designated clinically privileged licensed health care provider actively involved in the patient's care. Swing bed patients shall have progress notes documented at least every seven days.

A.6.2 The attending practitioner is required to document the need for continued hospitalizations; failure to do so shall be brought to the attention of the Chief of Staff.

A.7 Discharge Summaries (aka: Clinical Resumes)

A.7.1 Discharge summaries will be completed by the medical physician discharging the patient and will briefly recapitulate the significant physical and laboratory findings, procedures performed and treatment rendered, final diagnoses (reason for hospitalization), patient condition on discharge and the specific instructions and arrangements for future care, including physical activity, limitations, medications, diet and follow-up care.

A. Discharge summaries are required on all medical and surgical cases with length of stay more than 48 hours.

B. Discharge summaries are required on the following cases regardless of length of stay: Cesarean Sections, Deaths (excluding Hospice patients who are on Alternative Care Bed or Respite status), and Transfers to other Acute Care Facilities. A transfer summary may be used in lieu of a discharge summary provided all required components of the discharge summary are included.

C. A final progress note may be substituted for a discharge summary in cases with hospitalization of less than 48 hours and for normal newborn infants. The final progress note must include the following:

1. Final diagnosis
2. Outcome of hospitalization
3. Disposition of case
4. Provision for follow-up care including any instructions given to the patient and/or family.

A final progress note may not be substituted in cases described in A.7.1(B).

A.8 Autopsy Reports

A.8.1 When an autopsy is performed, provisional anatomic diagnosis should be documented in the medical record within 3 days and the complete report should be made part of the medical records within 30 business days unless additional time is required for results of special testing, etc.

A.9 Outpatient

A.9.1 Surgery and/or invasive procedures requiring anesthesia require a history and physical as described in Section A.2 of this document.

A.9.2 Operative/procedure reports shall be documented immediately following the event as noted in A.5.

A.9.3 Outpatient therapeutic and diagnostic services must include adequate clinical information to verify the purpose and appropriateness of the requested service. Orders must be signed, dated and timed.

A.9.4 Records of outpatient services are integrated into the patient's medical record with results communicated to the ordering provider. The ordering provider retains responsibility for communicating the results and any recommendations for follow-up examination or further treatment to the patient.

A.10 Emergency Records

A.10.1 The emergency record shall be documented within 48 hours following discharge/transfer of the patient from the Emergency Department. The emergency record shall include:

A. adequate patient identification;
B. information concerning the time of the patient's arrival, means of arrival and by whom transported;
C. pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to his/her arrival at the hospital;
D. description of significant clinical, laboratory and imaging findings;
E. diagnosis and treatment given;
F. condition of the patient on discharge or transfer, and
G. final disposition, including instructions given to the patient and/or his/her family, relative to necessary follow up care

A.11 Documentation Requirements for Other Patient Classifications:

A.11.1 Alternative Care Bed (ACB): A pre-arranged hospital stay that does not qualify for hospice and does not meet the medical necessity requirements for hospitalization.

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

A.11.2 Respite Hospice: Short-term temporary respite care to those needing intermediate to skilled nursing service.

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

A.11.3 Outpatient Observation: Services furnished to evaluate an outpatient's condition to determine the need for possible admission as an inpatient.

A. Documentation Requirements:

1. Provider order for Observation Services
2. Admission documentation of the medical necessity for observation services including the monitoring and treatment to be administered during the outpatient observation period
3. Progress notes documented at least daily along with a final progress note including the final diagnosis, summary of the patient's condition and care received once the patient is stable for discharge or requires admission as an inpatient.

Section B - Completion Requirements

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

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

B.1 Histories and Physicals not present on admission must be completed within 24 hours of patient admission by the admitting/attending provider.

B.2 Consultations

B.3 Operative or Procedure Reports (including Delivery Reports)

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

B.4 The total record, including signatures, shall be completed within 30 days of discharge. Days absent for illness, vacation, etc are not counted when calculating delinquency. It is the responsibility of the provider to notify Health Information Management of vacation plans or other absences. The provider must complete their medical records within 72 hours of their return to work.

Section C - Medical Record Completion Enforcement Procedure

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

C.1 Physicians or other licensed independent practitioners with incomplete records in the time periods outlined above shall be notified in accordance with the Delinquent Documentation Policy. Failure to complete the records within the required timeframe (30 days) shall result in action up to, and including, automatic suspension of privileges pursuant to the CentraCare – Melrose Hospital Medical Staff Bylaws. Suspension will be activated by the Medical Staff Office.

C.2 The Chief of Staff (or designee) shall notify the individual physician(s) or other licensed independent practitioner affected when privileges are suspended.

C.3 The Manager of Credentialing and Privileging (or designee) shall notify the following persons and departments of the physicians or other licensed independent practitioners whose privileges have been suspended:

A. Chief of Staff
B. Director – Patient Care
C. Patient Access, Emergency Department, Surgery Department
D. Clinic of the suspended Provider if they cover call

C.4 Health Information Management Department shall communicate the status of the incomplete records with the Medical Staff Credentialing and Privileging office.

C.5 If dictation has been completed on an incomplete record but the record has not been available for signature, the provider will be allowed one week grace period before being suspended.

C.6 Reinstatement of privileges is automatic upon completion of delinquent records. Failure to complete the medical records within 30 days following notice of suspension will result in automatic resignation from the Medical Staff or APP/AHP Staff.

C.7 Six suspensions in the past 12 months may result in automatic resignation from the Medical Staff or APP/AHP Staff. The Medical Executive Committee will review for disciplinary action.

SECTION D – Emergency Medical Screening Examinations

D.1 QUALIFIED MEDICAL PERSONNEL

D.1.1 Patients who present with a potential emergency medical condition will have a medical screening examination performed by an Emergency Medicine physician or any other privileged physician, physician assistant or nurse practitioner each acting within the scope of his/her privileges