Stanford Health Care Tri-Valley Hospital Wide Policy	**Last Approval Date:** 6/2023
Name of Policy: Medical Staff Policy & Procedure for Medical Records	**Policy Section and Number: 70**
Departments Affected: All Departments	Page **1** of **19**

I. Purpose:

To provide guidance to the medical staff regarding medical record requirements and action in cases of delinquencies.

II. Policy:

It is the policy of Stanford Health Care Tri-Valley practitioners are responsible for complete and timely medical records. Additionally, the quality of the medical record depends on meaningful and legible content and appropriate authentication. A record is considered complete when all required contents are completed and authenticated and when all final diagnoses and any complications are documented without the use of symbols or abbreviations.

Members of the Medical Staff will be required to complete medical records in accordance with the timeframes described in this policy based upon CA Title 22 and CMS requirements. Notification of delinquency will be provided to the physician by the HIM Department. Members of the Medical Staff will be required to complete medical records within 14 days of discharge or the physician will be subject to fines and may be subject to suspension. Notice of potential suspension will be given to the physician 48 hours prior to action being taken.

III. MEDICAL RECORDS

A. Definitions

A medical record consists of medical information that is specific to the patient, that is pertinent to the patient's care and treatment, and that is in the custody of the Hospital's Health Information Management Services Department. The information contained in the medical record, and any other patient-specific information, must be treated in accordance with all applicable legal and ethical rules related to the confidentiality of patient medical information.

B. Access

Access to confidential materials by members of the Medical and other staffs of the Hospital, Hospital employees, and others is only permissible when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, Medical Staff credentialing, educational pursuit, or other specifically authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored as follows:

1. Traditional Paper Chart: prior to 3/2/2018. These charts are stored in the HIMS Livermore Dept and off-site and are retrievable by HIMS.

2. Electronic Record: legal record from 3/2/2018 to present. Any and all (electronic and/or handwritten) documents generated during a patient's stay that have been scanned or directly entered from 3/2/2018 to present. The Electronic Record is stored in EPIC.

C. Required Medical Record Elements

Elements required in a medical record include identification data; appropriate comprehensive history and physical examination; reports and consultations; clinical laboratory, radiology and other special reports; provisional diagnosis; medical or surgical treatments; operative reports; anesthesiology records; pathological findings; progress notes; final diagnosis; discharge notes; clinical summary; autopsy report; and other pertinent information such as Patient Advance Directives and Consent Forms.

D. Documentation Rules

1. The content, form, nomenclature, permitted abbreviations, and timeliness requirements of all portions of and entries in the patient's medical record must be as stated in the Medical Staff Policy and Procedure for Medical Records and other applicable policies governing medical records.
2. Entries must be legible and authenticated by the individual making the entry. Authentication is defined as written or electronic signature, timed and dated.
3. The attending physician is responsible for the timely preparation and completion of the patient Medical Record. Medical Record entries must be authenticated within two weeks following the patient's discharge.
4. All entries must be dated and timed. Entries that are time sensitive in the delivery or documentation of care should be timed using the 24-hour clock. The following entries must be timed using 24-hour clock:
    a. Orders
    b. Post-operative note immediately following surgery
    c. Forms that specify a time documentation requirement
    d. Administration of medications
    e. Restraint and/or seclusion application and removal
    f. Emergency Room log of patient arrival, discharge
    g. Anesthesia note immediately prior to induction
5. Symbols and abbreviations may not be used in the final diagnosis but may be used within the medical record when approved by the Medical Staff.
6. A list of approved and unapproved symbols and abbreviations has been approved by the Medical Staff. Use of unapproved symbols and abbreviations has the potential to negatively impact patient

care. No order for medications will be completed if the order contains a symbol or abbreviation on the ***unapproved*** list until the physician has been contacted for order clarification.

7. An Urgent Care note should be entered into the medical record or dictated for each visit or consult within 24 hours of the encounter.
8. All Urgent Care visit documentation must conform with the Centers for Medicare and Medicaid Services (CMS) 95 or 97 Documentation Guidelines for Evaluation and Management Services (regardless of payer), including:
    a. Chief complaint or reason for visit
    b. History of present illness
    c. Review of systems and pain evaluation
    d. Past family and social history
    e. Physical examination
    f. Assessment and plan
9. A focused medical assessment must be documented prior to or at the time of an invasive procedure or moderate sedation, and should include:
    a. Presenting diagnosis/condition
    b. Description of symptoms
    c. Significant past medical history
    d. Current medications
    e. Any drug allergies
    f. Indications for the procedure
    g. Focused physical exam as indicated
    h. Proposed treatment or procedures
10. Orders:
    a. Orders for ancillary and diagnostic services must include the diagnosis (ICD code) and, as necessary, other appropriate information about the patient's diagnosis, or the sign(s) or symptom(s) providing the justification for the service / treatment.
    An order for medication must comply with the Medical Staff's approved Policies and Procedures which govern the content of, and nomenclature and abbreviations permitted and ***not*** permitted in medication orders, both generally and for specific types of medications.
    b. For treatment orders, an explanation must be provided as appropriate.

11. Documentation of phone consultations must be included in the medical record.
12. All clinical e-mail correspondence with patients must be maintained with the legal, medical record. This should include the patient's initial question and the clinical response.
13. Education and instructions provided to the patient and family should be documented in the record.

IV. CONSENT AND DISCLOSURE

A. Informed Consent

Unless an emergency exists, no care or treatment may be rendered to any patient in the Hospital, Emergency Department, or Urgent Care Clinic without a written consent signed by the patient or his/her properly designated representative. In an emergency situation, when immediate services are required to alleviate or prevent severe pain, disability, or death, and the patient lacks capacity to give consent for the services required, the physician recommending treatment to the patient must follow Hospital policies and procedures regarding obtaining consent from a properly designated representative, such as a surrogate, or providing treatment pursuant to the emergency exception if applicable. Except in an emergency situation as defined above, proper informed consent is a prerequisite to any procedure or treatment that is considered complex based on medical judgment, and includes, but is not limited to the following situations:

1. Operative procedures
2. Invasive procedures that have the potential for serious risks and adverse reactions
3. Blood transfusions or other use of blood products
4. Planned use of moderate sedation
5. Electroconvulsive therapy

The informed consent discussion should include at least information about the specific procedure or treatment, the reasonably foreseeable risks and benefits of the treatment, and the reasonable alternatives for care and treatment.

In all surgical procedures, the physician in whose name the permission for the operation is obtained must participate in person or as a member of the operating team and must be present during the critical portion(s) of the procedure. Such participation may not be delegated without the informed consent of the patient or the patient's properly designated representative.

B. *Disclosure of Unanticipated Outcomes and Medical Errors*

1. Definitions:

   a. Adverse Event: A detrimental effect from a diagnostic test, defect, failure and/or error within the healthcare system, medical treatment or surgical intervention

   b. Unanticipated Outcome: A result that differs significantly from the anticipated result of a treatment or procedure

2. Disclosure

   The attending physician responsible for the patient's care, or his/her designee as appointed by the Chief of Staff, will serve as the primary communicator of an unanticipated outcome or adverse event to the patient and/or family/legal guardian. The person designated as the primary communicator with the patient/family must document in the progress notes of the patient's medical record what was communicated to the patient/family and any response or other discussion.

C. *Sterilization*

Sterilization procedures are to be performed only in accordance with applicable federal and State law. Physicians planning to perform sterilization procedures must carefully reference the requirements and should seek advice from Risk Management to ensure that all elements of the consent process are met whenever there are any concerns about the consent process.

V. PATIENT ASSESSMENT

A. *H&P Requirements* (Must be documented by a member of the SHC Tri-Valley medical staff, or an Advanced Practice Provider with the appropriate privileges.)

1. A history and physical examination (H&P) must be completed no more than 30 days before or 24 hours after inpatient or outpatient admission. If the H&P was completed within 30 days before admission, an updated examination, also known as an H&P Interval, must be completed and documented within 24 hours after admission.
2. The H&P must be completed for every patient prior to surgery, or a procedure requiring anesthesia services, except in emergencies. In all cases, except for emergencies, the H&P and/or H&P Interval must be completed and documented before the surgery or procedure takes place, even if that surgery occurs less than 24 hours after admission or registration.
3. The History and Physical will include, at minimum, the following components and any other information deemed to be relevant by the examining provider:

   a. Chief Complaint

b. History of Present Illness
c. Medications and Medication Allergies
d. Review of Systems
e. Physical Examination
f. Assessment Including Provisional Diagnosis
g. Treatment Plan

4. The H&P Interval will indicate that the H&P was reviewed, the patient was examined, any changes that have occurred, or that "no changes" have occurred in the patient's condition. In the case of a surgical update, it will also confirm that indications for the procedure are still present.
5. In addition to the H&P requirements above, patients undergoing sedation or anesthesia care must also have a Pre-Anesthesia Assessment. The assessment is performed and documented prior to the induction of sedation/anesthesia and considers data from other assessments.
6. The H&P requirement does not apply for Emergency Surgery; however, an H&P must be documented as soon as possible after surgery.
7. Patients in "OB Check" status do not require an H&P. OB Check status is allowed up to 8 hours. Patients will be transitioned to "Antepartum" (OBA) for stays longer than 8 hours at which time an H&P will be required.
8. Records for all obstetrical patients shall be current and shall include a complete prenatal record. A current physical examination shall be included in the Hospital's record.

VI. PLANNING CARE, TREATMENT AND SERVICES

A. Orders

All orders for treatment must be in writing or entered into the electronic medical record, dated and timed. Orders written by an individual who is not a medical staff member or Advanced Practice Provider (NP or PA) authorized to enter orders must be cosigned by the supervising physician prior to implementation.

B. Verbal/Telephone Orders

Verbal/telephone orders may be issued by members of the medical staff or Advanced Practice Providers authorized to write orders to licensed nursing personnel (RN's) and registered pharmacists. Verbal/telephone orders appropriate to their discipline may be given to any licensed physical therapist, occupational therapist, speech-language pathologist, registered laboratory technologist, registered MRI technologist, registered nuclear medicine technologist, registered sonographer, registered x-ray technologist, or dietician.

Verbal/telephone orders may be issued only if the circumstances are such that an immediate order is required, and it would be impractical for the prescriber issuing the order to do so in writing or to directly enter the order into the electronic medical record.

1. Verbal/telephone orders are appropriate in the following situations:
    a. Emergency
    b. If person placing the order is physically unavailable and does not have access to the Electronic Medical Record system
    c. If the physician/clinician is performing a procedure
2. The ordering provider must identify him/herself, and the person receiving the verbal order will read back this identifier as a part of the order transcription process.
3. For Electronic Medical Record, the provider must remain on the phone if asked by the person receiving the verbal order while the order is entered to ensure that the desired order is available in the system and that any alerts are addressed.
4. Medication verbal/telephone orders must be signed within 48 hours by the prescribing practitioner or by attending or covering physician. The physician to whom the verbal order is attributed should cosign it, authenticating authorship and confirming the accuracy, content, and patient identifiers. Members of a Physician Team may cosign verbal orders for any other member of that team if they are sufficiently familiar with the clinical circumstances and appropriateness of the order.

VII. MEDICATIONS

An order for medication must comply with the Medical Staff approved Medication Policies and Procedures which govern the content of abbreviations and nomenclature permitted in medication orders, both generally and for specific types of medications.

A. Complete medication orders must include the name of the drug, dosage, frequency of administration, route of administration, date, time, and signature of the prescriber. There should be a documented diagnosis, condition, or indication for each medication ordered.

B. Orders documented by medical students must be reviewed and counter-signed by a physician prior to implementation.

C. Medications brought by or with the patient to SHC Tri-Valley may not be administered to the patient unless all of the following conditions are met:

1. The drugs have been specifically ordered by the patient's physician or APP and the order entered in the patient's medical record. The order must include the drug name, dosage, frequency, and route.
2. The drugs have been positively identified and examined for lack of deterioration by the pharmacist or physician and have been re-labeled, if necessary, by the pharmacist to provide adequate identification for those responsible for administering the drug.

D. Upon transfer of the patient to the Operating Room, all medication orders are canceled and must be rewritten. It is not acceptable to write a statement such as "Resume all medications orders"; complete orders for each medication must be documented. If there is a change in Service (e.g. Medicine, Surgery) and/or the physician responsible for the patient, all orders for the patient must be reviewed by the new Service and/or physician and reaffirmed or discontinued via order documented in the patient's chart.

E. Medication ordering and administration must comply with all the Medication

Administration Requirements Procedures such as using patient specific information, monitoring the effects of the medications, not using SHC Tri-Valley unapproved abbreviations, etc.

F. The Physician or APP is responsible for ensuring that an indication or diagnosis is present in the medical record for every medication prescribed.

VIII. PROVIDING CARE, TREATMENT AND SERVICES

A. *Daily Care of Patients*

A hospitalized patient must be seen by the attending physician or APP, or appropriate covering physician, at least daily or more frequently as required by the patient's condition or circumstances.

A progress note must be documented on each patient daily in sufficient detail to allow formulation of a reasonable picture of the patient's clinical status at the time of observation.

B. *Follow-Up on Outpatient Test*

An attending physician who orders medical tests on an SHC Tri-Valley outpatient must ensure that the results of such tests are reviewed (by a physician or appropriated Advanced Practice Provider) no later than 2 business days after those results appear in the electronic medical record (or are made available via fax, mail or other means).

C. *Consultations*

1. It is the responsibility of the Medical Staff through the Chiefs of Services and Medical Directors to see that members obtain consultations when appropriate and when requested by the Chiefs of Services, Medical Directors, or Chief of Staff. Services may specify the minimum criteria as to

when a consultation is required. Consultations must show evidence in the Medical Record of the consultant's review of the patient's record, his/her pertinent findings on the examination of the patient, and the consultant's opinion and recommendations. In case of emergencies, a nurse is authorized to seek appropriate medical consultation if the responsible attending is not available.

2. Two types of consultations may be obtained. Each involves different levels of patient care management and overall responsibility on the part of the consultant.
    a. "Consultation only" is ordered when the attending physician wishes the consultant to review the patient's records and pertinent findings to render an opinion and make treatment recommendations. The consultant is not directly involved in patient management, does not place orders in the chart, or have overall responsibility for the patient's care.
    b. "Consultation and management" is ordered when the requesting attending physician wishes the consultant to place orders in the chart and participate directly in patient care management.
3. Patients who exhibit significant psychiatric illness with acute exacerbation of symptoms or new onset of symptoms while hospitalized will be referred for an evaluation by a psychiatrist on the medical staff if the attending physician believes that management of the patient is beyond his/her scope of practice. Patients with alcohol/drug abuse/intoxication/dependence will be referred for psychiatric evaluation if the attending physician believes management of the patient is beyond his/her scope of practice. Consultation will involve diagnostic evaluation, acute management suggestions and assistance, and referral for outpatient treatment as indicated.

D. Sedation and Anesthesia

1. Prior to sedation and anesthesia, a pre-anesthesia evaluation must be completed, including:
    a. A focused H&P with particular attention to
        (1) Any history of adverse or allergic drug reactions with anesthesia or sedation
        (2) NPO status
        (3) Level of consciousness
        (4) Airway assessment
        (5) Brief description of the planned procedure(s)
        (6) Planned anesthesia type, including risks, benefits, and alternatives
    b. Determination of ASA classification
2. At the time of sedation and anesthesia:
    a. Prior to induction of anesthesia or sedation vital signs and oxygen saturation must be

updated.

b. Immediately prior to the use of moderate or deep sedation or the induction of anesthesia, re-evaluation of the focused H&P must be done.

c. Physiological parameters including (but not limited to) vital signs and oxygen saturation must be measured and assessed throughout anesthesia and documented on the anesthesia record or procedure room record.

3. A post anesthesia follow up report by the individual who administered the sedation or anesthesia must be documented within 48 hours after the procedure that necessitated sedation or anesthesia and should specifically document any intra-operative or postoperative anesthesia complications.

E. Operative Care of Patients

1. Either a full operative or procedure report, or a brief operative or procedure note must be documented immediately following surgery or a procedure (inpatient or outpatient) that requires anesthesia, or deep or moderate sedation before the patient is transferred from the operating room or procedure room to the next level of care. If a brief operative or procedure note is written prior to transfer of the patient to the next level of care, a full operative or procedure report must be documented or dictated within 24 hours after the procedure.

   If the practitioner performing the operation or procedure accompanies the patient from the operating room to the next area of care, the note or report can be written in the next area of care. Documentation may be performed by an APP who was present and directly participated during the entire procedure. Documentation must include the following

   a. The **brief** immediate operative or procedure note *must* include *all* the following elements without omission or reference to a record not yet available at time of documenting the note

      (1) The name(s) of the practitioner(s) who performed the procedure and his or her assistant(s)

      (2) The name of the procedure(s) performed

      (3) Complications/findings of the procedure, or indicate “none”, if there were no complications/findings

      (4) Any estimated blood loss, or indicate “none”, if there was no blood loss

      (5) Any specimen(s) removed, or indicate “none”, if there were no specimens removed.

      (6) The postoperative diagnosis

b. The **full** operative or procedure report must include **all** of the elements of the brief operative or procedure note, *plus* the following:

(1) Pre-op diagnosis

(2) Type of anesthesia or sedation

(3) Description of the procedure

(4) Date and time of procedure

2. The documentation of reports required by this section may be delegated to an APP who was present and directly participated during the entire surgery or procedure. The level of involvement of the attending physician (e.g. "was present and directly participated during the entire procedure") must be clearly documented.

IX. COORDINATING CARE AND TREATMENT

A. Discharge/Death

1. Patients may be discharged only on the order of the responsible physician or allied health practitioner or his/her designee. It is the responsibility of the attending physician, dentist, or podiatrist to plan discharge in a timely and coordinated fashion. The responsible practitioner is obligated to communicate to a referring doctor all appropriate medical information and provide the same information to any institution or agency to which a patient is referred following discharge from the hospital. For patients who have been in the hospital for a period of more than 48 hours, the patient's discharge summary should either be documented in the medical record or dictated within 48 hours of discharge. For patients with a stay less than 48 hours the final progress note may serve as the discharge summary and must contain the outcome of hospitalization, the case disposition, and any provisions for follow-up care. All inpatient deaths must have a death summary regardless of length of stay. The discharge or death summary must be completed by the discharging practitioner within fourteen (14) days of discharge.

   In the case of normal newborn infants and uncomplicated obstetrical deliveries a final progress note may be substituted for a discharge summary. An uncomplicated obstetrical delivery does not include a c-section. In all cases, the content of the medical record shall reflect the diagnosis, treatment, and hospital course. The responsible practitioner shall sign all summaries.

2. If a patient leaves SHC Tri-Valley against medical advice, this must be documented in the patient's medical record and the patient should be asked to sign the appropriate release form.

3. Discharge Summary
    a. The Discharge Summary can be directly entered in the electronic health record or dictated for transcription.
    b. The content of the discharge summary should be consistent with the rest of the record and includes:
        (1) Admitting date and reason for hospitalization
        (2) Discharge date
        (3) Final diagnoses
        (4) Succinct summary of significant findings, treatment provided and patient outcome
        (5) Documentation of all procedures performed during current hospitalization and complications (if any)
        (6) Condition of patient upon discharge and to where the patient is discharged
        (7) Discharge medication, follow-up plan, and specific instructions given to the patient and/or family, particularly in relation to activity, diet, medication, and rehabilitation potential
4. Death Summary
    a. The Death Summary is entered in the electronic health record or dictated for transcription.
    b. The content of the death summary should be consistent with the rest of the record and includes:
        (1) Admitting date and reason for hospitalization
        (2) Date of Death
        (3) Final diagnoses
        (4) Succinct summary of significant findings, treatment provided and patient outcome
        (5) Goals of Care – if patient was placed on DNR/palliative/comfort/hospice care status
        (6) Documentation of all procedures performed during current hospitalization and complications (if any)

B. Patient Death

In the event of death, the patient must be pronounced dead by a licensed physician, APP or nurse, per

hospital policy. The physician pronouncing the death is responsible for determining whether the death is reportable to the County Coroner's Office and must make such reports in accordance with the applicable California laws. The body may not be released from SHC Tri-Valley until an appropriate entry by a licensed physician has been made and signed in the patient's medical record. Policies with respect to the release of bodies must conform to California law.

1. The provisional anatomic diagnosis (autopsy report) shall be recorded in the medical record within 72 hours and the complete report should be made a part of the record within three months.

2. Immediately after a cardiac stress test, a detailed report must be written or dictated. Signature is required within 72 hours of transcription (including electronic signature).

3. Within three (3) days after an electroencephalogram, a detailed report must be dictated. Signature is required within 72 hours of transcription (including electronic signature), and 24 hours from completion of exam for in-patients.

X. RULES PERTAINING TO SPECIFIC PATIENT SITUATIONS

A. Autopsy

Unless otherwise required by the Coroner, an autopsy may be performed only with a written consent, signed in accordance with applicable law. In the event of a patient death in the Hospital, the physician/Service is expected to attempt to obtain permission to perform an autopsy from the appropriate legally authorized person.

Autopsies are performed by the SHC Tri-Valley Pathology Department. The Medical Staff, and specifically the attending physician, should be notified of the time and place an autopsy is performed. The complete post-mortem report should be made part of the medical record within three (3) months.

B. Suicidal Patient

For the protection of patients, the Medical and Nursing Staffs, and SHC Tri-Valley, the following standards are to be met in the care of the patient who is determined to be potentially suicidal:

1. Psychiatric consultation must be obtained immediately (or as soon as the patient's condition permits if the suicide attempt has rendered him/her unconscious) after a patient has threatened suicide or made a suicide attempt.

2. Prior to the consultation, the physician in charge of the care should evaluate the type of immediate care the patient requires and write the appropriate orders.
3. If a patient's medical history or symptoms suggest a problem with alcohol and/or other drugs, the attending physician is encouraged to seek information and/or consultation regarding alcohol and drug treatment services to assist with detoxification, referral to community resources or treatment sources, and other support.

C. Restraints and Seclusion

1. A restraint or seclusion may only be used if needed to improve the patient's well-being or to protect the safety of other persons, and less restrictive interventions have been determined to be ineffective.
2. A member of the medical staff or an Advanced Practice Provider with the appropriate privileges may order restraints.
3. The use of restraints and seclusion to manage violent or self-destructive behavior requires the practitioner to evaluate the individual in person within *four hours* of restraint or seclusion application.
4. The use of restraints for safety concerns in the delivery of the patient's medical-surgical care (i.e. for non-violent patients or patients who are not self-destructive) requires a physician, APP, or LIP order prior to application of restraints. If a physician, APP, or LIP is unavailable, and an RN who has successfully demonstrated competence in assessment for restraint has applied restraints for patient protection, a verbal or written order must be placed within 12 hours of the application of the restraint. The patient must be examined by a physician within 24 hours of the initiation of the restraint, and a written order entered into the medical record.
5. Hospital policy specifies the time within which an order must be obtained after each use of restraint or seclusion and the maximum time for the use of either intervention. PRN orders are not allowed. Restraints are time-limited to no more than one calendar day or 24 hours from the original order. The physician, APP, or LIP must do a face-to-face examination of the patient and renew the order at least once each calendar day or 24-hour period from when the order was initiated that the restraint is required.

D. Organ and Tissue Donation

Members of the Medical Staff are expected to follow the SHC Tri-Valley Organ and Tissue Donation for Brain Dead Patients Policy and the Organ Donation after Cardiac Death Policy. These policies state that the California Tissue Donation Network is to be contacted for assessment and potential discussion of donation with the patient's family at or near the time of imminent brain death.

E. *Tissue Specimens*

All tissue specimens that are clinically relevant to the indication for the procedure during which they were removed, or to subsequent therapy, must be examined by a Medical Staff member with privileges to examine such specimens at SHC Tri-Valley to the extent necessary to arrive at a tissue diagnosis. The findings of that examination must be documented by the medical staff member in the patient's medical record.

XI. TRANSFER OF PATIENT

A. If the attending physician transfers the care of a patient to another SHC Tri-Valley Medical Staff member, the transferring attending physician should clearly document the transfer of responsibility in the medical record to the accepting attending physician.

B. Patients being transferred to a skilled nursing facility, intermediate care facility, and the distinct part skilled nursing, must also have the following:

1. Rehabilitation potential
2. Known allergies

XII. CLINICAL SERVICE POLICIES AND PROCEDURES

Each Clinical Service may develop policies and procedures to be administered routinely to all patients admitted to their Service. This does not preclude the Medical Executive Committee from adopting similar policies regarding procedures to be administered to all patients admitted to the Hospital. Where clinical service and medical staff rules appear inconsistent, medical staff rules will supersede service rules.

XIII. EMERGENCY SERVICES

A. The provision of emergency medical services occurs through the Emergency Department of SHC Tri-Valley, which is organized and directed by a member of the Medical Staff who is trained and experienced in Emergency Medicine. The Emergency Department is staffed by members of the Medical Staff.

B. A medical record must be kept for every patient and becomes part of the SHC Tri-Valley legal medical record.

C. A Medical Staff member may determine the need to transfer a patient to another medical facility. This must be done in accordance with EMTALA guidelines and the practitioner making the determination must complete and sign all forms related to the transfer including a transfer statement.

D. Members of the Active Staff must be in close enough proximity to the Hospital to respond to calls from the Hospital or emergency room that require immediate physician attention. A member must respond to calls within fifteen (15) minutes and, in emergency situations that require immediate physical attendance, be physically present in the Hospital within forty-five (45) minutes of being requested to do so.

XIV. CONFIDENTIALITY

A. All members of the Medical Staff, Advanced Practice Providers associated with the Medical Staff, and their respective employees and agents, must maintain the confidentiality, privacy and security of all Protected Health Information in records maintained by SHC or by business associates of SHC, in accordance with any and all privacy and security policies and procedures adopted by SHC to comply with current federal, state and local laws and regulations, including, but not limited to, the HIPAA Privacy Regulations. Protected Health Information may not be requested, accessed, used, shared, removed, released, or disclosed except in accordance with SHC Tri-Valley's health information privacy policies and applicable law. Medical record information about a patient whom a Medical Staff member is treating can be furnished by the medical staff member to any health care provider within the facility who has responsibility for that patient's care. This applies to general patients, psychiatric patients, and substance abuse patients as defined by the California Confidentiality of Medical Information Act and the Health Insurance Portability and Accountability Act of 1996.

B. The use of electronic signature or rubber stamp signature is acceptable only if the practitioner whose signature the electronic signature or rubber stamp represents is the only person who has possession of the electronic user ID and password combination or rubber stamp, and is the only one who uses it.

C. All electronic data pertaining to the medical care of individual patients is a part of the legal medical record and confidential to the same extent as other SHC Tri-Valley medical records. Passwords used by a member of the Medical Staff to access SHC Tri-Valley computers may be used only by such member, who may not disclose the password to any other individual (except to authorized security staff of the computer system). The use of a member's passwords is equivalent to the electronic signature of the member. The member may not permit any practitioner or other person to use his/her passwords to access SHC Tri-Valley computers or computerized medical information. Any misuse may, in addition to any sanctions approved by the Medical Staff and/or the SHC Tri-Valley Board of Directors regarding security measures, be a violation of state and federal law and may result in denial of payment under Medicare and MediCal.

D. The following procedures are excluded from the requirement for a history and physical:

1. Blood transfusions
2. Recurring infusions

3. Recurring therapeutic phlebotomy
4. Outpatient diagnostic imagine procedures that do not require moderate sedation.

XV. DISTINCT PART SKILLED NURSING FACILITY

A. If a patient is admitted to the Distinct Part Skilled Nursing Facility directly from the acute hospital, the acute hospital history and physical will be accepted as the Skilled Nursing Facility history and physical with the addition of an interval note updating the original history and physical. This interval note must be written within twenty-four (24) hours following the admission to the Skilled Nursing Facility.

1. If the acute care hospital history and physical is essentially unchanged, the interval note may simply state the date and that there have been no changes since that exam.
2. If there have been changes since the acute care hospital history and physical examination, the interval note must detail those changes since the last documented exam.
3. A progress note shall reflect the patient's examination, the patient's response to treatment, significant changes in the patient's condition, results of laboratory tests and significant weight changes.
4. A discharge summary shall be written or dictated within forty-eight (48) hours after discharge from the DP/SNF.
5. Standing orders shall not be accepted by the facility.
6. Telephone orders shall be countersigned by the ordering physician within five (5) days.

XVI. FINES FOR NON-COMPLETION OF MEDICAL RECORDS AND OTHER CLINICAL REPORTS

Medical Records other than Operative / Procedure Reports

Members of the Medical Staff are required to complete medical records other than operative/procedure reports and H&Ps within 14 days of the patient's discharge from the Hospital.

Operative/Procedure Reports

These reports should be completed immediately after the procedure but must be completed no later than 24 hours after the end procedure time.

History and Physical Reports

An H&P must be entered into the medical record prior to a surgical or invasive procedure.

An H&P for in-patients, SNF patients must be entered into the medical record within 24 hours of admission. The H&P must contain all the required elements as listed in this policy

Time of Day Deemed Completed

With the exception of operative/procedure reports, all medical records must be completed by 11:59 p.m. on the day due for completion. Any portion of a day is considered as a day.

XVII. PROCEDURES FOR TRACKING DELINQUENCIES AND NOTIFYING MEDICAL STAFF MEMBERS

A. **Process**

1. The Medical Staff delegates to the Health Information Management Department responsibility for implementing a system to assist the medical staff office to fine medical staff members whose records are not completed within the stated time period.
2. The Health Information Management Department shall cause a list to be created each week showing which members are delinquent under this policy, and which records are incomplete. The Medical Records Delinquency List will be transmitted to and reviewed on a weekly basis by the Medical Staff Office and Chief of Staff.
3. The Medical Staff Office will generate and send fine letters to any physician who has accrued a fine in accordance with this policy and at the direction of the Chief of Staff. The fine is accrued at the rate of $100 per day. A list of physicians who have been fined for incomplete medical records will be reported to the Medical Executive Committee on a monthly basis.
4. The Health Information Department will provide members notice of incomplete medical records through their preferred HIM distribution method. Physicians may elect to receive notice via in-basket, fax, or U. S. Mail when incomplete records are identified (first notice). This notice includes the number of days each record is deficient. This notification will be generated and distributed each Wednesday.
5. **Delinquent Records Second Notice**

a. The Health Information Department will provide members notice through their preferred distribution method. Physicians may elect to receive notice by in-basket, fax, or U. S. Mail when records or reports have become delinquent (second notice). This notification will be generated and distributed each Wednesday. Additionally, the HIM Department will contact members who had received a second notice the previous week each Monday when records or reports have become delinquent and they are in danger of being added to the suspension/fine list. This contact shall be made to the office number or using the method that the physician has previously determined. The HIM Department will record the date and time of the notice, and the name of the person to whom the notice is given.

b. Members whose records were not completed by 11:59 p.m. on Wednesday will be added to the fine list which is submitted to the Medical Staff Office and Chief of Staff each Thursday. A telephone call will be made to the physician's office alerting to them of the delinquency. The HIM Department will record the date and time of the notice, and the name of the person to whom the notice is given.

6. **Absences / Delay in Completing Record**

   To avoid unnecessary contacts with medical staff and their office staff, it is suggested that the Health Information Management Department be notified of any absence of 7 days or longer.

Approvals:

Credentialing Committee: 02/20, 6/23

Medical Executive Committee: 7/20, 6/23

Board of Directors: 8/20, 6/23