

# **VA** SAN DIEGO HEALTHCARE SYSTEM



*A Division of VA Desert Pacific  
Healthcare Network*

## **MEDICAL STAFF RULES & REGULATIONS**

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## **Rule 1: General**

1. The Rules relate to role and/or responsibility of members of the Medical Staff and individuals with clinical privileges in the care of any and all patients.
2. Rules of Departments or Services will not conflict with each other, rules and policies of the Medical Staff, or with requirements of the Governing Body.
3. The Medical Staff as a whole shall hold meetings at least semi-annually.
4. The MEC serves as the executive committee of the Medical Staff and between the annual meetings, acts in their behalf. The Committee is responsible for continually reviewing the quality of the clinical care carried out in the facility.
5. Each clinical Service shall conduct meetings at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of patient care and treatment. Minutes must reflect discussion by medical staff and responsible party of patient care issues, with resultant significant conclusions, recommendations, action taken, and evaluation of follow-up actions.

## **Rule 2: Patient Rights and Responsibilities**

1. This Organization supports the rights of each patient and publishes policy and procedures to address rights including each of the following:
  - a. Reasonable response to requests and need for service within capacity, mission, laws and regulations.
  - b. Considerate and respectful care that fosters a sense of dignity, autonomy, and civil rights.
  - c. Collaboration with the physician in matters regarding personal health care.
  - d. Pain management including assessment, treatment, and education.
  - e. Information with regard to names and professional status of physicians and all other health care providers responsible for care, procedures, or treatments.
  - f. Formulation of advance directives and appointment of surrogate to make health care decisions (38 CFR17.32).
  - g. Access to information necessary to make care decisions that reflect patient's wishes, including potential outcomes, risks and benefits and consequences of refusal of treatment.
  - h. Access to information about patient rights, handling of patient complaints.
  - i. Participation of patient or patient's representative in consideration of ethical decisions regarding care.
  - j. Access to information regarding any human experimentation or research/education projects affecting patient care.
  - k. Personal privacy and confidentiality of information.
  - l. Action by a legally authorized person to exercise a patient's rights if a patient is judged incompetent in accordance with law or is found by a physician to be medically incapable of understanding treatment or unable to communicate his/her wishes.
  - m. Authority of Service Chief or Chief of Staff to approve/authorize necessary surgery, invasive procedure, or other therapy for a patient who is incompetent to provide informed consent, when no next of kin is available.
  - n. Foregoing or withdrawing life-sustaining treatment including resuscitation.
  - o. Nondiscrimination against individuals who use or abuse alcohol or other drugs and persons infected with the human immunodeficiency virus.

## **Rule 3: Responsibility for Care**

### **3.1 Conduct of Care**

1. Management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff.
  - a. The Attending Physician is responsible for the preparation and completion of a complete medical record for each patient. This record shall include a medical examination, an updated problem list, identification data, chief complaints, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, medical and/or surgical treatment, operative report, pathological findings, progress notes, doctor's discharge instructions sheet, including condition on discharge (discharge note) and final diagnosis, and final summary.
  - b. A medical history and physical examination is completed within 30 days before admission or registration. The practitioner must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law, VHA regulations and hospital policy. The content of complete and focused history and physical examination is delineated in Section 3: Responsibility for Care, of the Medical Staff Rules and Regulations.
  - c. The staff physician responsible for the patient must sign the admission note if it is prepared by a resident, intern, or mid-level Practitioner, or make a note on the admission workup or progress notes to the effect that he/she "agrees with the admission workup and findings" or make whatever comments he/she thinks the case warrants within twenty four (24) hours of admission to the hospital, or prepare a complete admission within seventy two (72) hours of admission to the CLC. In the event a resident, intern, or Mid-Level Practitioner prepares an admission workup, all will be retained, but the official workup will contain the responsible Medical Staff physician's approval signature. All resident documentation will follow procedures outlined in the VHA Handbook 1400.1, Resident Supervision.
  - d. Food and nutrition products are administered only on the prescription or order of a Medical Staff member, an authorized house staff member, or other individual who has been granted authority to write such prescriptions or orders, within their scope of practice.

- e. Progress note entries should be identified as to the type of entry being made, (e.g., Resident Note, Attending Note, Off Service Note, etc.). The Attending Note must be signed by the Attending physician.
  - f. Progress notes will be written by the Practitioner at least once daily on all acutely ill patients or according to the Service policy in the Plan for the Provision of Care. Progress notes are written for all patients seen for ambulatory care by the medical staff.
  - g. Evidence of required supervision of all care by the attending physician shall be documented in the medical record, the frequency of notes dependent upon the severity of the illness of the patient. It is a cardinal principle that responsibility for the care of each patient lies with the staff physician to whom the patient is assigned and who supervises all care rendered by residents.
  - h. Upon determination that a Do Not Attempt to Resuscitate (DNAR) order is appropriate, the order must be written or, at minimum, countersigned by the attending physician in the patient's medical record. There must be documentation of the order and how the decision was reached (e.g., discussed with patient or family). At any time a DNAR order is written, the patient's rights will be observed. Once the order has been entered, it is the responsibility of the attending physician to ensure that the order and its meaning are discussed with appropriate members of the Facility staff, particularly the nursing staff, so that all involved professionals understand the order and its implications.
  - i. Patients will not be transferred out when the Facility has the means to provide adequate care. Patients who are medically stable for transport may be authorized for transfer only after authorization is given by the appropriate provider as defined in facility policy.
2. Under similar clinical circumstances, the same quality of patient care is provided, by all individuals with delineated clinical privileges, within and across Departments and Services and between all staff members who have clinical privileges.
  3. There is to be a comparable level of quality of surgical and anesthesia care throughout the Facility.

### **3.2 Consultations:**

1. Consultation: Except in an emergency, consultation with a qualified physician is desirable when in the judgment of the patient's physician:
  - a. The patient is not a good risk for operation or treatment,
  - b. The diagnosis is obscure, and/or

- c. There is doubt as to the best therapeutic measures to be utilized.
2. Consultant: A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Staff and the Professional Standards Boards on the basis of an individual's training, experience, and competence.
3. Essentials of a Consultation: A satisfactory consultation includes examination of the patient and review of the medical record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.
4. Responsibility for Requesting Consultations: The patient's physician, through the Chiefs of Services, shall make certain that members of the staff do provide consultation in a timely and appropriate manner as needed.
5. Psychiatric Consultations: Psychiatric consultation must be requested for all patients who are acutely suicidal. If the patient refuses to see the consultant, this fact must be documented by the consultant in the medical record.

### **3.3 Discharge Planning:**

Discharge planning is initiated as early as a determination of need is made.

1. Discharge planning provides for continuity of care to meet identified needs.
2. Discharge planning is documented in the medical record.
3. Criteria for discharge are determined by the Multidisciplinary Treatment Team.
4. Discharge plans, including patient/caregiver education, medications, treatment, follow-up, and patient agreement are documented in the medical record.

### **3.4 Discharge**

1. Patients shall be discharged from the Facility only upon the written order of the physician and the discharge summary or summary note (for 23 hour observation status) will be entered into the medical record no later than the day of discharge. At the time of discharge, the responsible member of the Medical Staff shall review the medical record to ensure that documents therein pertain to the patient and contain accurate data. The record shall be completed within thirty (30) days of the discharge of the patient. The physician or dentist shall complete his/her portion of the record within thirty (30) days, including authentication.
2. Patients from Ambulatory Surgery/Procedure Unit can be discharged based upon order of Licensed Independent Practitioner familiar with the patient or when the Practitioner is not available, based on relevant medical staff approved criteria. The Practitioner's name is recorded in the patient's medical record.

### **3.5 Autopsy**

1. Autopsy services are provided by the Pathology and Laboratory Medicine Service. The availability of these services will be made known to the family of each decedent and the Medical Staff will attempt to secure authorization for autopsy examination in all deaths. The autopsy is a significant instrument for continuous monitoring activity as part of the Performance Improvement Program within the Facility.
2. There will be legal authorization by the next of kin for autopsy in all instances prior to the initiation of an autopsy, except as provided in 38 CFR 17-155. Whenever possible, the physician responsible for the care of the patient at the time of death will be designated to request permission from the next of kin to perform an autopsy.
3. Autopsy examination may be performed for medico-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.155 and JAHVH HPM 11-31 Autopsy Services (which includes Criteria for assignment to medico-legal status).
4. Autopsy Rates. Autopsies are encouraged as per VHA policy.
5. Autopsy Criteria. VHA policy encourages autopsies be requested from next-of-kin for all deaths, with the request and response documented in the clinical record. Autopsy performance is tracked for quality management purposes as described in JAHVH HPM 11-31, Autopsy Policy. Those cases meeting criteria as Medical Examiner's cases per policy will be referred to the appropriate County Medical Examiner's Office in accordance with state statutes.
6. Cases in which death was due to suspected negligence, incompetence, or criminal activity require referral to the Medical Examiner, as do all cases in which death may be due to occupational causes.

**Standard precautions will be vigorously enforced for preventing transmission of infectious diseases.**

## **Rule 4: Physician's Orders**

### **4.1 General Requirements**

1. Orders are entered into the electronic medical record (EMR).
2. Verbal orders are strongly discouraged except in emergency situations.
3. Telephone orders will be accepted when the provider is not in the facility and cannot return in a timely manner and does not have ready access remotely to CPRS. They will be accepted by Registered Nurses, Pharmacists, Physician Assistants, Advanced Practice Registered Nurses, Certified Registered Nurse Anesthetists, etc. as designated by facility policy and when it clearly is in the best interest of patient care and efficiency. Appropriate staff receiving the order telephonically will first write down the verbal order and read back the order to the physician to ensure correctness. Verbal/telephone orders will be entered by the nurse or pharmacist and signed electronically by the physician within 24-hours or the next working day whichever is earlier.

### **4.2 Medication Orders**

1. All drugs used in the Facility must be on the National Formulary or be available as a non-formulary option. Additions to the National Formulary can be requested thru the VISN Pharmacy and Therapeutics (P&T) Committee. Exceptions to the foregoing requirements may be made in use of "provisional drugs" or "non-formulary drugs" which can be issued under specific conditions. National criteria for non-formulary medications are developed by the National VA Medical Advisory Panel and/or at the VISN level. Exceptions are based on an individual patient case by case basis.
2. All drugs used in the Facility will be stored and dispensed by the Pharmacy.
3. Duration of Orders:
  - a. Inpatient: Refer to MCM 11-8 Medications Orders for Inpatients
  - b. Outpatient orders: Refer to MCM 119-9
  - c. Self Medication (SCI ONLY): Refer to MCM 119-14
  - d. Domiciliary Care/ Residential Treatment Program: Refer to MCM 119-3
4. Transfer of Patients: When a patient is transferred from one level of care to another level of care, or there is a change in physician of record, orders must be written for the new level of care. Where a patient is transferred from one nursing unit to another but remains under the care of the same physician, the existing orders remain valid.

### **4.3 Standardized Order Sets (protocols):**

Standardized order sets are reviewed periodically by Section or Service Chief and modified as needed and should be reviewed at the Medication Safety Committee and the Pharmacy and Therapeutics Committees and finally approved by the Medical Executive Committee. All standardized order sets in the EMR/medical record shall be authenticated by a Medical Staff member and are to be signed for each usage by medical staff. All concerned personnel shall be notified of revisions to standardized order sets by the Section or Service Chief.

### **4.3 Investigational Drugs:**

Investigational drugs will be used only when approved by the appropriate Research and Development Committee and the P&T Committee and administered under approved protocol with patient informed consent, under the direct supervision and legitimate order of the authorized Principal Investigator or designated investigator.

### **4.4 Informed Consent:**

1. Informed consent will be consistent with legal requirements and ethical standards, as described in Facility policy of Informed Consent. The Facility uses the IMED consent software to document the majority of informed consents.
2. Evidence of receipt of Informed consent, documented in the medical record, is necessary in the medical record before procedures or treatment for which it is required.

### **4.5 Submission of Surgical Specimens:**

All tissues and objects except teeth removed at operation shall be sent to the Facility pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.

### **4.6 Special Treatment Procedures:**

1. DNAR (Do Not Attempt to Resuscitate) and Withholding/Withdrawal of Life Sustaining Treatment
  - a. A description of the role of the physician, family members and when applicable, other staff in decision.
  - b. Mechanisms for reaching decisions about withholding of resuscitative services, including mechanisms to resolve conflicts in decision making.
  - c. Documentation in the medical record.
  - d. Requirements are described in Facility Policy Memoranda, Medical Staff Bylaws, and these Rules.
2. Sedation/Analgesia involves the administration of medications that have a risk for undesirable side effects, either immediately or delayed, and may be utilized

only within the guidelines of an established protocol in the center policy related to Sedation/Analgesia and according to approved privileges. Only by those Practitioners with approved and current privileges to do so.

## **Rule 5: Role of Attending Staff**

### **5.1 Supervision of Residents and Non-Physicians**

1. Residents are supervised by members of the Medical Staff in carrying out their patient care responsibilities.
2. Medical staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone, except that this may result in loss of faculty appointment.
3. Mid-level and certain Associate Health Practitioners are supervised by the Medical Staff and are monitored under a Scope of Practice statement.

### **5.2 Documentation of Supervision of Resident Physicians**

1. Sufficient evidence is documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician as described in Facility Policy Memoranda, Medical Staff Bylaws, these Rules, and VHA Handbook 1400.1 Resident Supervision.
2. Entries in the medical record made by residents or those non-physicians (e.g., PAs, ARNPs, etc.) that require countersigning by supervisory or attending medical staff members are covered by appropriate Facility policy and include:
  - a. Medical history and physical examination.
  - b. Discharge Summary.
  - c. Operative Reports.
  - d. Medical orders that require co-signature.
    - (1) DNAR.
    - (2) Withdrawing or withholding life sustaining procedures.
    - (3) Certification of brain death.
    - (4) Research protocols.
    - (5) Investigational drug usage, ONLY permitted by named principal investigators or co-investigators previously designated in the study.

*NOTE:* Because medical orders in EMR do not allow a second signature (co-signature), the attending must either write the order for (1) through (5) above; or in an urgent/emergency situation, the house staff or non-physician must obtain verbal concurrence from the attending, document in the progress notes the discussion and concurrence, and can write and sign the order. The attending medical staff member must then co-sign the progress note noting the discussion and concurrence .within 24 hours.

3. Residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, residents are allowed to certify and re-certify treatment plans as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising Practitioner over and above standard setting-specific documentation requirements (VHA Handbook 1400 page 6).

## **Rule 6: Medical Record**

### **6.1 Basic Administrative Requirements:**

1. Entries must be electronically entered where possible, which automatically dates, times, authenticates with method to identify author.
2. Certain records may be dictated on the approval of the Medical Records Committee (MRC). Certain paper forms (e.g., flow sheets) are not able to be directly entered into CPRS. The MRC is responsible for approving the use of such forms and for assuring processes exist to scan or otherwise incorporate them into CPRS in a timely manner.
3. CUTTING AND PASTING BETWEEN NOTES IS STRONGLY DISCOURAGED. IN ANY INSTANCE WHERE TEXT IS COPIED FROM A PRIOR NOTE AND NOT MODIFIED OR UPDATED, THE ORIGIN OF THE TEXT MUST BE SPECIFICALLY CITED.
4. It is acceptable and appropriate to refer to current documentation in CPRS that was reviewed rather than repeating or pasting the information into the note. Details related to referring to current documentation can be found in [MCM 11-22, Electronic Entry of Medical Record Information](#).
5. Final diagnosis and complications are recorded without use of abbreviations and symbols. Dangerous and Unapproved Abbreviations can be found in related Facility policy, and is available in CPRS and VISTA. Those abbreviations are not acceptable for use either handwritten or in the EMR.
6. Completion and filing of reports of diagnostic and therapeutic procedures must be accomplished within 24 hours.
7. Changes to the basic administrative requirements are the responsibility of the MRC both for the format and content of the medical record. The MEC will approve substantive changes, including decisions regarding format, such as the way in which the electronic record is maintained. Additional details related to administrative requirements can be found in [MCM 11-12, Medical Records Committee](#) and [MCM 11-22, Electronic Entry of Medical Record Information](#).
8. Release of information is required per policy and standard operating procedures for the Facility.
9. All medical records are confidential and the property of the Facility and shall not be removed from the premises without permission (ROI from the Patient/consultation with the privacy officer as appropriate). Medical records may be removed from the Facility's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records on file shall be available for the use of Medical Staff.

10. Access to medical records of all patients shall be afforded to Medical Staff members for bona fide study and research, consistent with preserving patient confidentiality and privacy. Specific confidentiality requirements are found in Title 38 U.S.C. 7332.

## **6.2 All Medical Records must contain:**

1. Patient identification (name, address, DOB, next of kin).
2. Medical history including history and details of present illness/injury.
3. Allergies (drugs, foods, and other)
4. Clinical observations, including results of treatment.
5. Treatment
6. Diagnoses and/or diagnostic impressions
7. Diagnostic and therapeutic orders.
8. Reports of procedures, tests and their results.
9. Progress notes.
10. Referrals to other practitioners (in and out of VASDHS)
11. Consultation reports.
12. Conclusions at termination of evaluation/treatment.
13. Informed consent before procedures or treatments undertaken and if not obtainable, the reason, as stated in [MCM 11-43, Informed Consent](#).
14. The patient's preferred language for healthcare communication.

## **6.3 Inpatient Medical Records:**

In addition the items listed in section 6.2 above, all inpatient records must contain, at a minimum:

1. An Admission History and Physical (H&P) and any update to the H&P will be entered using the template(s) approved by the MRC acting on behalf of the MEC. The admission assessment will be completed within 24 hours of admission for all acute care admissions and not more than 72 hours after admission for long term care/community living center admissions. The H&P will include chief complaint, history of present illness, past medical history, past surgical history, medications (including medication reconciliation), allergies, social history (including occupation, military history, and habits such as alcohol, tobacco, and drugs), family history, and review of systems.
2. A complete physical examination includes (but not limited to) general appearance, review of body systems, nutritional status, ambulation, self care, mental status, social, review of the results of pertinent studies which includes but not limited to, laboratory, radiology tests, and other applicable findings

based on the patient assessed personal history. Key examination medical impressions will be documented in the note.

3. The Admission H&P will include impressions, conclusions, and a plan of care.
4. The H&P will be dated and signed by a physician or provider granted a scope of practice to perform an admission assessment. Physical examinations by medical students, interns or other non-licensed physicians, residents, nurse practitioners, or physician assistants, will be confirmed and co-signed by an attending physician.
  - a. The attending co signature of the admission H&P will be completed by the end of the next calendar day for all acute care admissions and not more than 72 hours after admission for long term care/community living center. The attending will either separately document concurrence with the admission H&P and plan of care as an addendum or in a separate note (by the end of the next calendar day or 72 hours for long term care/community living center).
5. An assessment of decisional capacity (including whether the patient has the capacity to leave the inpatient service) or identification of a surrogate decision maker if needed.
6. Resuscitation status.
7. Completed within 30 days of discharge.

#### **6.4 Discharge Summary:**

A discharge summary (from any inpatient admission or residential rehabilitation program) or summary progress notes (from 23 hour observation status) must be entered no later than the day of discharge or within 24 hours of death or irregular discharge. It must include sufficient information to justify the admission, the diagnose(es), concisely recapitulate the hospitalization, including the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, as appropriate. Instructions regarding physical activity after discharge, medications, diet, and follow-up care will also be included. The summary must include:

1. Medical Diagnoses: List the principal diagnosis, i.e., that condition established after study to be chiefly responsible for the admission of the patient to the hospital for care; then, in order of clinical importance, list all other diagnoses for which treatment was given. Diagnoses must include post-operative complications or infections and drug or serum reactions. All diagnoses need to include a site and etiology, when applicable, and must be stated in full, without symbols and/or abbreviations, and in accordance with the latest edition of International Classification of Disease (ICD).
2. Psychiatric Diagnoses. Diagnoses must be stated in accordance with the latest edition of Diagnostic and Statistical Manual of Mental Disorders (DSM). The

diagnosis must be recorded in AXIS format and, if applicable, must include the Global Assessment of Functioning (GAF) score.

3. Operations and surgical procedures must be stated in full, without symbols and/or abbreviations, and in accordance with the latest edition of CPT and/or ICD Procedural Index. The site involved and the procedures performed must be stated. The listing must include all operations, diagnostic and therapeutic procedures, and the date performed. All procedures need to be documented in the text of the summary.
4. The name of the member of the medical staff responsible for patient's care and the primary physician, if applicable.
5. Details about the admission or residential rehabilitation program such as:  
The reason for admission (principal diagnosis, i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital) and other diagnoses and/or conditions treated while in the hospital. All operations and procedures performed and the treatment rendered during current admission, with dates. Pertinent past medical history, review of systems (including allergies or drug sensitivities), laboratory and radiological data, physical examination findings, particularly abnormalities. Brief description of the hospital stay to include treatment received and treatment outcomes. Condition upon discharge. NOTE: Condition must be more specific than "improved" and needs to permit measurable comparison with condition on admission. Place of disposition, (e.g., home, nursing home, etc). Discharge instructions to patient, or responsible other, to include: Information regarding condition or proper home care. Medical follow-up. Medications on discharge. Diet instructions. Activity and/or limitations. Specific date to return to work. NOTE: State if a period of convalescence is required, if retired, or if any of this is to be determined at a later date.
6. The discharge summary needs to be prepared for all releases from VHA care, including deaths. Transfers to other levels of care, such as: VHA domiciliary care, VHA nursing home, or other VHA medical centers, must be documented by a discharge summary. (vii) Responsibility for the preparation of the discharge summary and for its content rests exclusively with the member of the medical staff having primary care responsibility for the patient. The treating specialty from which the patient is discharged is responsible for completing the summary. (viii) The summary should be documented prior to discharge, or within 24 hours of death or irregular discharge. When the discharge summary is completed more than 24 hours prior to discharge, local policy determines the timeframe when an addendum is required.

7. If not the author, the supervising practitioner must review the summary, make appropriate edits, and indicate approval by co-signature.
8. If the patient has a psychosis or an organic mental impairment, there must also be a statement regarding the patient's competency to handle VA funds.
9. If the discharge summary concerns a death case, there must be a statement that an autopsy was or was not performed, or is planned.

## **6.5 Autopsy**

Preliminary or provisional anatomical diagnoses must be documented within 72 hours of autopsy.

Final protocols must be completed, signed, and properly filed within 30 days of autopsy.

The Death Certificate must be amended when the results of an autopsy require a change in cause of death.

## **6.6 Observation Patient Records:**

A 23-hour observation patient is one who presents with a medical condition showing a significant degree of instability or disability, and who needs to be monitored, evaluated, and assessed for either admission to inpatient status or assignment to care in another setting. The length-of-stay in an observation bed is not to exceed 23 hours 59 minutes. In addition the items listed in section B above, all observation records must contain, at a minimum: admission orders, initial assessment, progress note, discharge orders/transfer orders, summary diagnoses, and a summary progress note. Details on 23-hour observation documentation requirements are in [MCM 11-77 23-Hour Observation for Inpatient Beds](#).

## **6.7 Outpatient Medical Records:**

In addition the items listed in section 6.2 above, all outpatient records must contain, at a minimum:

1. A progress note for each visit.
2. Relevant history of illness or injury and physical findings including vital signs.
3. Patient disposition and instruction for follow-up care.
4. Immunization status, as appropriate.
5. Referrals and communications to other providers.
6. List of significant past and current diagnoses, conditions, procedures, drug allergies,
7. Medication reconciliation, problem, and any applicable procedure and operations on the Problem List
8. A copy of the patient's Advanced Directive or living will (if applicable).

## **6.8 Surgeries and Other Invasive Procedures:**

1. All aspects of a surgical/procedure patient's care, including ambulatory surgery, pre-operative, operative and post-operative care, must be documented. Surgical interventions, diagnostic procedures, or other invasive procedures must be documented to the degree of specificity needed to provide continuity of care and support any associated coding data.
2. Preoperative/procedural Documentation:
  - a. In all cases of elective and/or scheduled major surgery/procedure, and if circumstances permit, in cases of emergency surgery/procedure, the supervising or staff Practitioner must evaluate the patient and write a Physician Admission H&P.
  - b. Invasive procedures and surgeries involving local and/or moderate sedation, the supervising or staff Practitioner may use an alternative note title. The note must include a focused history and physical addressing pertinent positive/negative information, indications for the procedure, known risks related to the procedure, and a physical exam pertinent to the procedure. A formal consultation to the service for performing the procedure that includes all required content will serve as an H&P if done w/in 30 days, but must be updated the day of the procedure. This does not apply to simple procedures such as LPs, paracenteses or thoracenteses, skin biopsies, etc.).
  - c. Except in an emergency, no patient may go to the operating room without a complete history and physical examination recorded in his/her chart plus recorded results of lab work and x-rays.
  - d. When an initial H&P are not recorded before an operative procedure, the procedure will be canceled unless the attending physician states in a note that such a delay would be detrimental to the patient. Such a note must appear in the patient's medical record in the Progress Notes section and an H&P completed promptly thereafter, but no later than 24 hours following the procedure.
  - e. A surgical operation shall be performed only with documented informed consent of the patient or his/her legal representative except in emergencies at which time the Chief of Staff or Chief of Surgery holds jurisdiction.
3. Immediate Post-Operative/Procedural Documentation: A post-operative/procedural progress note should be written, or directly entered into the patient's health record, by the surgeon/proceduralist immediately following surgery and before the patient is transferred to the next level of care. Or, the surgeon/proceduralist must be immediately available to care for the patient until the note is completed. The next level of care is defined as out of the recovery area for surgeries or procedures.

- a. The immediate post-operative/procedural ("brief op") note must include:
  - (1) Pre-operative diagnosis,
  - (2) Post-operative diagnosis,
  - (3) Technical procedures used,
  - (4) Surgeons,
  - (5) Findings,
  - (6) Specimens removed, and
  - (7) Complications.
  - (8) Estimated blood loss
4. Operative/Procedural Documentation: An operative report must be dictated and completed by the operating surgeon following surgery. A procedural report must be entered into CPRS by the proceduralist following the procedure. The body of the report needs to contain the: indication for the procedure; operative findings; technical procedure used; specimens removed; post-operative diagnosis; names of the supervising Practitioner, primary surgeon, and assistants; and the presence and/or involvement of the supervising Practitioner. The full post-operative or procedure report must be signed by the surgeon or practitioner within 7 days.
5. Post Anesthesia Care Unit (PACU) Documentation:
  - a. PACU documentation must include the patient evaluation on admission to, and discharge from, the post-anesthesia care unit, a time-based record of vital signs and level of consciousness (either paper or electronic), all drugs administered and their doses, type and amounts of intravenous fluids administered, including blood and blood products, any unusual events including post-anesthesia or post-procedural complications, and post-anesthesia visits.
  - b. The health record must document the name of the LIP responsible for the patient's release from the recovery room, or clearly document the discharge criteria used to determine release.
  - c. For inpatients, there needs to be at least one documented post-anesthesia visit after leaving the post-anesthesia care unit. The note needs to describe the presence or absence of anesthesia-related complications.
  - d. For outpatients, Ambulatory Surgery personnel (i.e., a nurse) must call the patient after surgery, to assess any complications, including anesthetic complications, as appropriate.

## **6.8 Delinquent Medical Records**

1. Records should be created contemporaneously with care whenever possible. A record deficiency occurs when the required contents of the medical record have not been dictated or authenticated in a timely fashion.
2. Records that remain incomplete after the following timelines will be reported to the practitioner and the respective Service Chief for action to be taken as needed to assure completion:
  - a. Ambulatory Records are considered delinquent if not authenticated within 7 days after the patient visit.
  - b. Verbal or Telephone Orders not authenticated by the provider within 3 days of release by the receiving RN.
  - c. Inpatient Admission Assessment (Admission H&P) or update to H&P not authenticated by the author by the end of the calendar day following admission.
  - d. Inpatient Admission Assessment (Admission H&P) or update to H&P not cosigned by the supervising attending by the end of the calendar day following admission.
  - e. Attending concurrence with inpatient assessment and plan of care by addendum to H&P or separate note by the end of the calendar day following admission.
  - f. Inpatient consultations not authenticated by the author within 48 hours of the consultation.
  - g. Brief operative notes if not entered and authenticated prior to transfer to the inpatient service (unless the patient is accompanied by the surgeon to the next level of care).
  - h. Final Operative Report not dictated or entered directly into the medical record within 24 hours following an invasive procedure, and not authenticated within 7 days following an invasive procedure.
  - i. A Discharge Summary is expected to be dictated or directly entered into the medical record prior to discharge whenever possible, Discharge Summaries will be considered delinquent if not dictated or directly entered into the record within 72 hours of discharge, and not authenticated within 7 days following discharge.
  - j. Clinical documents marked as requiring co signature not cosigned by the supervising practitioner within 7 days of authentication.

3. In all instances, records not completed within 30 days of the encounter (or discharge for an inpatient) will be reported to the Medical Executive Council for consideration for Professional Practice Evaluation standards.

## **Rule 7: Infection Control**

1. Isolation Precautions and Procedures are described in Infection Control Policy
2. Standard Precautions are described in Infection Control Policy
3. Reportable Cases are described in Infection Control Policy

## **Rule 8: Continuing Education**

All Medical Staff members shall participate in their own individual programs of continuing medical education (CME) in order to keep themselves informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care, to refresh them in various aspects of their basic education, and to meet requirements for re-licensure. Medical Staff members are responsible to see that their own participation in continuing education programs and conferences both in and outside the Facility are documented and verifiable at the time of reappraisal and re-privileging.

## **Rule 9: Health Status and Impaired Professional Program**

The VHA recognizes its responsibility to assist impaired professionals and collaborate with available programs designed to intervene, monitor, refer to treatment, and advocate for physicians and dentists.

1. Where there is evidence that a physician or dentist's practice is impaired as a consequence of chemical dependence or mental or physical illness, the Chief of Staff's office will be notified. Practitioners are allowed to self-refer to a program for assistance for psychiatric, emotional, or physical problems. Assistance in the self-referral may be obtained from their Service Chief or Chief of Staff.
2. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment by the Physicians Well Being Committee.
3. In cases of known or suspected impairment due to physical and/or mental illness, the Chief of Staff may request the Director to authorize a Special Physical Examination as authorized VA Handbook 5019, Part II, and applicable hospital policy. The Special Physical Examination will be tailored to the clinical circumstances and may involve a physical examination, imaging studies, neuropsychological testing, or other indicated measures. The fitness for duty examination will be conducted by or under the direction of the Occupational Health Program or outside medical examiner, which will assess the findings and make a recommendation on the Practitioner's fitness for duty based on such findings. If the determination is unfavorable to the Practitioner, or in cases of uncertainty, the findings will be presented to an ad hoc Physical Standards Board.
4. VA and Facility policies, responsibilities and procedures of the Employee Assistance Program and the VA Drug-Free Workplace Program are applicable for physicians, dentists, and other healthcare professionals.
5. Confidentiality of the Practitioner seeking referral or referred for assistance will be kept, except as limited by law, ethical obligation, or when the safety of a patient is threatened. In all instances, every effort will be made to protect the confidentiality of the individual referred for assistance.
6. The hospital will sponsor periodic educational program regarding illness and impairment issues. Licensed independent Practitioners will be issued written information regarding illness issues at the time of initial appointment and re-appointment to the medical staff.

## **Rule 10: Peer Review**

1. All Medical Staff members shall participate in the facility protected peer review program established by the appropriate VHA policy.
2. All Medical Staff members will complete ongoing required training associated with the associated VHA policy.

## **Rule 11: Disclosure of Adverse Events**

1. All Medical Staff members shall abide by the Facility disclosure policy in accordance with the appropriate VHA policy.
2. All Medical Staff members will document disclosures using the appropriate note titles as described in the Facility disclosure policy.

## **Rule 12: Emergency Roles during a Disaster**

1. Licensed Independent Practitioners who are members of the Medical Staff are critical members of the facility disaster response. During a disaster facing the VASDHS, all compensated members of the Medical Staff are expected to report to their service chief or supervisor. If a Practitioner is unable to report to work, s/he should contact their service chief or supervisor to provide their status. If the service chief or supervisor cannot be reached, the Practitioner should contact the National Employee Hotline at 1-866-233-0152 or online at [https://www.va.gov/emergency/apps/eei/contact\\_info.cfm](https://www.va.gov/emergency/apps/eei/contact_info.cfm) to provide his/her status.
2. For additional resources and information regarding VASDHS emergency management, disaster response and procedures, and roles during a disaster and/or emergency please review MCM 00-85 and the Comprehensive Emergency Management Plan (CEMP) at:

<http://vaww.sandiego.portal.va.gov/sites/director/Emergency%20Management/default.aspx>

### **Rule 13: Committees of the Medical Staff**

Charters for Medical Staff Committees can be found on the Chief of Staff/Medical Director Sharepoint site at:

<http://vaww.sandiego.portal.va.gov/sites/COS/Committee%20Management/Forms/AllItems.aspx>

**References:**

[MCM 11-08 Medication Orders for Inpatients](#)

[MCM 11-22, Electronic Entry of Medical Record Information](#)

[MCM 11-31 "Sedation"](#)

[MCM 11-43, Informed Consent](#)

[MCM 11-77 23-Hour Observation for Inpatient Beds](#)

[MCM 119-3 Domiciliary](#)

[MCM 119-9 Medication Orders for Outpatients](#)

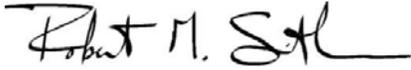
[MCM 119-14 Self Medication](#)

[MCM 136-32 Control and Monitoring of Medical Records](#)

[MCM 136-06, Privacy and Disclosure of Individually-Identifiable Health Information from Medical Records](#)

[VHA Handbook 1907.01 Health Information Management and Health Records](#)

RECOMMENDED BY THE MEDICAL EXECUTIVE COMMITTEE AND APPROVED AT  
A CONVENED MEETING OF THE MEDICAL STAFF OCTOBER 30, 2012

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ROBERT M SMITH, MD  
CHIEF OF STAFF/ MEDICAL DIRECTOR

APPROVED

X 

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JEFFREY T GERING, FACHE  
DIRECOR, VASDHS  
Signed by: Gering, Jeffrey T.