

Department of Veterans Affairs

Nebraska-Western Iowa Health Care System

MEDICAL STAFF

RULES and REGULATIONS

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RULES of the MEDICAL STAFF
VETERANS HEALTH ADMINISTRATION (VHA)
VA Nebraska-Western Iowa Health Care System
Omaha, Nebraska
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MEDICAL STAFF RULES

1. GENERAL

- A. 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.
- B. 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.
- C. The Medical Staff as a whole shall hold meetings at least annually.
- D. The Executive Committee of the Medical Staff (XCOM) serves as the executive committee of the Medical Staff and between the Current Bylaws requires a recorded annual meeting, acts in their behalf. The Committee is responsible for continually reviewing the quality of the clinical care carried out in the facility.
- E. Each of the clinical Services 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.
- F. Information used in quality improvement as referenced in Article IX, cannot be used when making adverse privileging decisions.

2. PATIENT RIGHTS *

- A. Patient's Rights and Responsibilities: This Organization supports the rights of each patient and publishes policy and procedures to address rights including each of the following:
 - i) Reasonable response to requests and need for service within capacity, mission, laws and regulations.
 - ii) Considerate and respectful care that fosters a sense of dignity, autonomy, and civil rights.
 - iii) Collaboration with the physician in matters regarding personal health care.
 - iv) Pain management including assessment, treatment and education.
 - v) Information with regard to names and professional status of physicians and all other health care providers responsible for care, procedures, or treatments.
 - vi) Formulation of advance directives and appointment of surrogate to make health care decisions.
 - vii) 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.

- viii) Access to information about patient rights, handling of patient complaints.
- ix) Participation of patient or patient's representative in consideration of ethical decisions regarding care.
- x) Access to information regarding any human experimentation or research/education projects affecting patient care.
- xi) Personal privacy and confidentiality of information.
- xii) 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.
- xiii) Authority of Chief of Staff or Service Chief 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).
- xiv) Foregoing or withdrawing life-sustaining treatment including resuscitation.
- xv) Nondiscrimination against individuals who use or abuse alcohol or other drugs and persons infected with the human immunodeficiency virus.

B. Living Will, Advance Directives, and Informed Consent

- i) Competent patients have the right to consent to and, equally, to decline any treatment including the provision of life-sustaining treatment. Accordingly, life-sustaining treatment will not be provided to competent patients who decline it. Similarly, life-sustaining treatment will be provided, consistent with prevailing medical practice, when the competent patient consents or in emergent situations where informed consent may be implied. When the competent patient withdraws consent to any treatment to which the patient has previously consented, including the provision of life-sustaining treatment, such treatment will be withdrawn. He/she will be informed of the medical consequences of such decisions.
- ii) Medical decisions regarding the patient's diagnosis and prognosis, and treatment options to be presented to the patient, shall be made by the attending physician in consultation with, as appropriate, other members of the treatment team.
- iii) With respect to the documentation of decision making concerning life-sustaining treatment, the following information, at a minimum, will be documented in the progress notes by the attending physician: The patient's diagnosis and prognosis; an assessment of the patient's decision making capacity; treatment options presented to the patient for consideration; the patient's decisions concerning life-sustaining treatment.
- iv) Competent patients will be encouraged, but not compelled, to involve family members in the decision making process. Patient requests that family members not be involved in or informed of decisions concerning life-

sustaining treatment will be honored, and will be documented in the medical record.

- v) Advance Directives: The patient's right to direct the course of medical care is not extinguished by the loss of decision making capacity. In order that this right may be respected in cases involving such patients, VHA recognizes the right of an adult person to make an advance directive, in writing, concerning all treatment, including life-sustaining treatment. Any competent patient may execute a declaration requesting that some or all life-sustaining treatments be withheld or withdrawn. The desires of any VA patient, as expressed at the time the advance directive is to be implemented, shall supersede those previously expressed in an advance directive. In addition, an advance directive may be revoked by a declarant at any time.
- vi) Substituted Judgments: The rights of patients to direct the course of medical treatment are not extinguished by the lack of decision making capacity or by the fact that an advance directive has not been previously executed. VHA is directed by statute to ensure, to the maximum extent practicable, that medical care is provided only with the full and informed consent of the patient or, in appropriate cases, the patient's surrogate decision maker. Accordingly, "Substituted Consent" shall be secured from an incompetent patient's surrogate decision maker prior to the initiation of treatment, except in emergent situations. The person making decisions for a terminally ill patient who lacks decision making capacity should act as that patient's "surrogate" for purposes of consenting to, or declining, life-sustaining treatment. Life-sustaining treatment will not be withheld or withdrawn under this paragraph unless the attending physician is satisfied that the decision of the surrogate decision maker is based on reliable indicators of the direction the patient would personally give were the patient able to do so. Such indicators might include, but are not limited to, the following:
 - (a) Oral or written statements or directives rendered by the patient during periods when the patient had decision making capacity.
 - (b) Reactions voiced by the patient, when the patient had decision making capacity, concerning medical treatment administered to others.
 - (c) Deductions drawn from the patient's religious, moral, ethical, or philosophical beliefs, from the patient's value system, or from the patient's consistent pattern of decision making with respect to prior medical care. In cases where such indicators are lacking, conflicting, or are insufficient (due, for example, to remoteness or non-specificity) to form a reliable basis for decision making based on the patient's own subjective wishes, life-sustaining treatment will be withheld or withdrawn only when the surrogate decision maker and the attending physician agree that the withholding or withdrawal of life-sustaining treatment would be in the patient's best interests. In cases where the attending physician believes in good faith that the decision of the surrogate decision maker is equivocal, does not reflect the patient's

own desires or best interests, or is based, even in part, on factors (such as self-interest) other than the advancement of the patient's own desires or best interests, the attending physician may decline to implement the decision to withhold or withdraw life-sustaining treatment. Such cases will be referred to an Ethics Advisory Committee or similar body, or Chief of Staff.

3. RESPONSIBILITY FOR CARE*

A. Conduct of Care

- i) Management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff.
 - (a) The attending Staff 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.

Medical Assessment of the patient shall include:

- a. Medical history, including:
 - 1. Chief complaint
 - 2. Details of present illness
 - 3. Relevant past, social and family history
 - 4. Inventory by body system, including pain assessment
 - 5. Summary of the patient's psychological needs
 - 6. Report of relevant physical examinations
 - 7. Statement on the conclusions or impressions drawn from the admission history and physical examination

8. Statement on the course of action planned for this episode of care and its periodic review
 9. Clinical observations, including the results of therapy
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- (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, or prepare a complete admission within forty eight (48) 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. 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 Resuscitate (DNR) 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 DNR 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.

- (1) 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.
- (i). The Medical Staff shall adopt a method of providing medical coverage in the Emergency Room at the Omaha Division. This shall be in accord with the Health Care System's basic plan for the delivery of such services. In the event of a medical emergency situation at a Division or CBOC where acute care is not provided, the local emergency number (911 or otherwise designated) shall be called. The physician shall direct care of the patient until emergency personnel arrive at the Division. Upon arrival of emergency personnel, the patient shall be immediately transferred to the closest facility that can provide emergency care.

B. Consultations:

- i) 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.
- ii) 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.
- iii) 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.
- iv) Responsibility for Requesting Consultations: The attending practitioner is primarily responsible for requesting consultation when indicated. Any qualified practitioner with clinical privileges in this Health Care System can be called for consultation within his/her area of expertise. Department Chiefs shall assign consultation request to appropriate staff members.

- v) Psychiatric Consultations: Psychiatric consultation must be requested for all patients who attempt suicide or take a chemical overdose. If the patient refuses to see the consultant, this fact must be documented by the consultant in the medical record.
- C. Discharge Planning: Discharge planning is initiated as early as a determination of need is made.
 - i) Discharge planning provides for continuity of care to meet identified needs.
 - ii) Discharge planning is documented in the medical record.
 - iii) Criteria for discharge are determined by the Multidisciplinary Treatment Team.
 - iv) Discharge plans, including patient/caregiver education, medications, treatment, follow-up, and patient agreement are documented in the medical record.
- D. Discharge
 - i) Patients shall be discharged from the Facility only upon the written order of the physician and the discharge summary will **be completed prior to** discharge. At time of dictating the final summary, 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.
 - ii) 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.
- E. Autopsy –
 - i) Autopsy services are provided by Pathology Section. 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.
 - ii) 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 BUSOF Policy 009 and PLM Policy 00006. 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.
 - iii) Autopsy Rates. Autopsies are encouraged as per VHA policy.

- iv) 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 BUSOF Policy 009 and PLM Policy 00006. 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.
 - v) 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.
- F. Standard precautions will be vigorously enforced for preventing transmission of infectious diseases.

4. PHYSICIANS' ORDERS *

A. General Requirements

- i) Orders are entered into the electronic medical record (EMR).
- ii) Verbal orders are strongly discouraged except in emergency situations.
- iii) 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 authenticated within the time frame specified by law and regulation.

B. Medication Orders

- i) All drugs used in the Facility must be on the National Formulary or be Investigational Drugs that have been approved by the Research and Development 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.
- ii) All drugs used in the Facility will be stored and dispensed by the Pharmacy.
- iii) Duration of Orders:
 - (a) Schedule II control drugs: On Inpatient, (Acute care and CLC) drugs will be written for periods not to exceed seven (7) days unless comment made to allow up to fourteen (14) days and must be reentered by electronic entry into EMR for each succeeding period.

- (b) Schedule II controlled drugs: On outpatient, will be written for periods not to exceed thirty (30) days.
 - (c) Schedule III – V controlled drugs: May be written for a period not to exceed ninety (90) days for inpatient and outpatient prescriptions.
 - (d) Antibiotics orders must include the duration of the therapy.
 - (e) Orders for all other drugs will be written for a period not to exceed ninety (90) days from the date the first medication was ordered before they expire and must be rewritten, renewed, or copied.
- iv) Ambulatory Care Medication Orders:
 - (a) All prescriptions must be entered electronically.
 - (b) All prescription controlled substances will follow VHA Handbook 1108-1.
 - (c) Ninety (90) days is the maximum duration for applicable outpatient prescriptions.
 - (d) The number of refills authorized on a single prescription may not to exceed one year.
- v) Domiciliary Care Medication Orders:
 - (a) All prescriptions must be entered electronically.
 - (b) Controlled substances are limited to a 7 day supply.
 - (c) Thirty (30) days is the maximum duration for Domiciliary Care prescriptions
- vi) 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.
- C. Standardized Order Sets (protocols): Standardized order sets are reviewed by Section or Service Chief and modified if needed. 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.
- D. 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.
- E. Informed Consent:

- i) Informed consent will be consistent with legal requirements and ethical standards, as described in Facility policy Informed Consent.
 - ii) 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.
- F. Submission of Surgical Specimens: All tissues and objects removed at operation shall be sent to the Facility pathologist who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis.
- G. Special Treatment Procedures:
- i) DNR (Do Not 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.
 - ii) 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.

5. ROLE OF ATTENDING STAFF

- A. Supervision of Residents and Non-Physicians
- i) Residents are supervised by members of the Medical Staff in carrying out their patient care responsibilities.
 - ii) 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.
 - iii) Mid-Level and certain Associate Health Practitioners are supervised by the Medical Staff and are monitored under a Scope of Practice statement.
- B. Documentation of Supervision of Resident Physicians
- i) 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 ACOS/ED 003, Medical Staff Bylaws, these Rules, and VHA Handbook 1400.1 Resident Supervision.
 - ii) 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.

- C. Designated administrative staff will be authorized to make administrative entries as approved by the Chief of Staff. These administrative entries can be for the purposes of: (1) creating electronic forms for the inclusion into the computerized patient record system, (2) administratively closing open requests or orders, (3) entering administrative progress notes, (4) entering notes to disposition consultation requests and (5) completing other requirements as requested by the Chief of Staff or his/her designee.

6. MEDICAL RECORDS *

A. Basic Administrative Requirements:

- i) Entries must be electronically entered where possible, which automatically dates, times, authenticates with method to identify author, may include written signatures.
- ii) It is the responsibility of the medical Practitioner to authenticate and, as appropriate, co-sign or authenticate notes by Mid-Level Practitioners.
- iii) Final diagnosis and complications are recorded without use of abbreviations and symbols. A list of abbreviations not to use 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.
- iv) Completion and filing of reports of diagnostic and therapeutic procedures must be accomplished within 24 hours.
- v) Release of information is required per policy and standard operating procedures for the Facility.
- vi) 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.
- vii) 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.

B. All Medical Records must contain:

- i) Patient identification (name, address, DOB, next of kin).

- ii) Medical history including history and details of present illness/injury.
 - iii) Observations, including results of therapy.
 - iv) Diagnostic and therapeutic orders.
 - v) Reports of procedures, tests and their results.
 - vi) Progress notes.
 - vii) Consultation reports.
 - viii) Diagnostic impressions.
 - ix) Conclusions at termination of evaluation/treatment.
 - x) Informed consent before procedures or treatments undertaken and if not obtainable, the reason, as stated in Facility Policy Memorandum "Informed Consent."
- C. Inpatient Medical Records: In addition the items listed in section B above, all inpatient records must contain, at a minimum:
- i) A history that includes chief complaint, history of present illnesses, childhood illnesses,, adult illnesses, operations, injuries, medications, allergies, social history (including occupation, military history, and habits such as alcohol, tobacco, and drugs), family history, chief complaint, and review of systems;
 - ii) A complete physical examination includes (but not limited to) general appearance, review of body systems, nutritional status, ambulation, self-care, mentation, 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. The note must be authenticated by provider at the earliest possible time, but always within 24 hours of being written in CPRS.
 - (a) If the H&P was completed prior to the admission or procedure, it must be updated the day of admission. If it is more than 30 days old, a new one must be completed.
 - (b) Inpatient H&P must be completed within 24 hours, 48 hours for long term care; and 7 days for the Domiciliary
 - iii) A discharge plan (from any inpatient admission or Domiciliary), including condition on discharge.
 - iv) Have a discharge summary (from inpatient or Domiciliary) dictated no later than the day of discharge.
 - v) Completed within 30 days of discharge.
- D. Outpatient Medical Records: In addition the items listed in section B above, all outpatient records must contain, at a minimum:
- i) A progress note for each visit.

- ii) Relevant history of illness or injury and physical findings including vital signs.
- iii) Patient disposition and instruction for follow-up care.
- iv) Immunization status, as appropriate.
- v) Allergies.
- vi) Referrals and communications to other providers.
- vii) List of significant past and current diagnoses, conditions, procedures, drug allergies,
- viii) Medication reconciliation, problem, and any applicable procedure and operations on the Problem List

E. Surgeries and Other Procedures:

- i) All aspects of a surgical 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 support any associated coding data and to provide continuity of care.
- ii) Preoperative Documentation:
 - (a) In all cases of elective and/or scheduled major surgery and/or diagnostic and therapeutic procedures, and if circumstances permit, in cases of emergency surgery, the supervising or staff Practitioner must evaluate the patient and write a pre-operative (pre-procedural) note describing: the findings of the evaluation, diagnosis(es), treatment plan and/or choice of specific procedure to be performed; discussion with the patient and family of risks, benefits, potential complications; and alternatives to planned surgery and signed consent
 - (b) Invasive procedures and surgeries involving local and/or moderate sedation require a focused history and physical or Subjective/Objective/Assessment/Plan (SOAP) note 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.
 - (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) 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 holds jurisdiction.

- iii) Immediate Post-Operative Documentation: A post-operative progress note must be written, or directly entered into the patient's health record, by the surgeon immediately following surgery and before the patient is transferred to the next level of care.
 - (a) The immediate post-operative note must include:
 - (1) Pre-operative diagnosis,
 - (2) Post-operative diagnosis,
 - (3) Technical procedures used,
 - (4) Surgeons,
 - (5) Findings,
 - (6) Specimens removed, Blood loss and
 - (7) Complications.
 - (b) The immediate post-operative note may include other data items, such as:
 - (1) Anesthesia,
 - (2) Drains,
 - (3) Tourniquet Time, or
 - (4) Plan.
- iv) Post-Operative Documentation: An operative report must be dictated and completed by the operating surgeon immediately following surgery. Immediately means upon completion of the operation or procedure, before the patient is transferred to the next level of care. 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.
- v) 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.

7. INFECTION CONTROL *

- A. Isolation is described in Infection Prevention Policy.
- B. Standard Precautions are described in Infection Prevention Policy
- C. Reportable Cases are described in Infection Prevention Policy

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.

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.

- A. 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.
- B. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment by the Physical Standard Board.
- C. 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.

- D. 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.
- E. 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.
- F. 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.

10. PEER REVIEW *

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

Adopted by the Medical Staff,
Nebraska-Western Iowa Health Care
System, Omaha, Nebraska, on this 2nd
Day of December, 2014.

RECOMMENDED

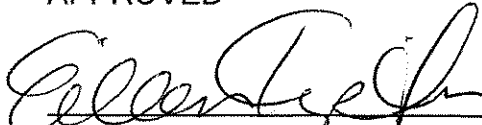


GRACE L. STRINGFELLOW, MD
Chief of Staff

12/2/14

Date

APPROVED



EILEEN KINGSTON
Acting Director

12.22.14

Date