HENDRICK MEDICAL CENTER

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SECTION 1

1.1 Purpose

The following Medical Staff policy will direct the maintenance and content of all medical records. All records are the property of the Hospital and may only be released in keeping with the applicable Hospital Policy or Procedure.

1.3 Policy

General Content – Basic Requirements

Each Member of the Medical Staff is expected to comply with the requirements concerning the satisfactory completion of medical records. The medical record shall at a minimum contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among healthcare providers.

Only statements relevant to the clinical management of the patient should be included in the medical record. Inappropriate language and/or derogatory comments about patients, hospital employees or Medical Staff Members or other practitioners should not be entered into the medical record.

Medical record documentation should be recorded in the patient's medical record as soon as possible, but not to exceed thirty (30) days from discharge. Suspension processes begin at seven (7) days after allocation or discharge (e.g., H&P not on chart within specified time frame regardless of discharge date). In the event that a medical record cannot be completed by the Physician, the record can only be closed as permanently incomplete, on order of the Medical Staff PI Committee.

1.2 Definitions

Practitioner – for purposes of this policy related to deficiencies and delinquencies, Practitioner means Medical Staff members, psychologists, orthotists, and prosthetists but does not include Advanced Practice Providers.

Physician means MD, DO, Oral Surgeon.

Scribe means a person who serves as a professional copyist or writer who writes, edits, and/or transcribes for a Physician. Scribes are not Allied Health Professionals and are processed through the Human Resources Department of the Hospital.

2.2 Electronic Health Record

All Medical Staff members and Allied Health Professionals providing direct inpatient care are expected to utilize the Electronic Health Record (EHR). This includes all documentation including but not limited to order entry and progress notes. Referring Staff members who provide no care or treatment to patients or who are not consulted with regard to patient care or treatment are excluded from this requirement. Prior to entering orders and electronic documentation in the EHR, all Medical Staff members and Advanced Practice Professionals are expected to successfully complete and educational program in the use of the EHR and show evidence of readiness to utilize the EHR.

The use of a scribe, at the Medical Staff Member's expense, does not exempt the Medical Staff Member from having to complete this education and demonstrate readiness nor does it relieve the Member from any obligations under the Medical Staff Bylaws, these Rules and Regulations, or medical staff policies and procedures. Documentation of each Practitioner's EHR usage will be maintained for Medical Staff members and Allied Health Professionals in the form of ongoing professional practice evaluation (OPPE).

It is understood that under extreme circumstances, such as computer failure, network failure, system downtime or certain disaster situations, utilization of the EHR may be impractical or impossible. In such situations, written documents and/or orders, when used, must meet all general guidelines set forth in this document as well as all regulatory and compliance requirements.

2.3 Authentication and Countersignatures

2.3.1 Authentication

All orders for treatment shall be signed by the Medical Staff member or if applicable APP responsible for such orders. The Attending Physician shall be held responsible for a complete medical record for each patient. All entries in the medical record shall be legible, dated, timed and authenticated (written or electronically generated). Electronic signature or computer generated signatures are acceptable as authentication. Signature stamps are not acceptable.

Medical record entries by psychologists, orthotists and/or prosthetists do not require authentication by a Medical Staff member.

All telephone or verbal orders shall be dated, timed and signed by the person receiving the order and/or providing the services. The order shall include the name of the ordering Medical Staff member and the date and time the order was given. Telephone orders will be authenticated by the Medical Staff member or APP if applicable, who placed the order on the next visit but no later than forty-eight (48) hours.

2.3.2 Countersignature

A. All admission orders entered by Allied Health Professionals on behalf of a sponsoring Medical Staff member must be countersigned by the sponsoring Medical Staff member as soon as practical but no later than twenty-one (21) days of patient discharge.

B. All other entries in medical records must be countersigned if prepared by the Medical Staff member's AHP, including but not limited to the following:

1. Medical History;
2. Physical examination report;
3. Diagnostic and therapeutic orders;
4. Preprinted orders;
5. Clinical observations, such as progress notes and consultation reports;
6. Appropriate diagnostic and therapeutic test reports, interpretations and results;
7. Pre-operative, operative and post-operative diagnoses and evaluations; and
8. Discharge summaries.

C. Medical record entries by psychologists, orthotists and/or prosthetists do not require countersignature by a Medical Staff member.

2.4 History and Physical

2.4.1 History and Physical

A. The report of the history and physical examination shall reflect the following components:

1. Chief complaint;
2. Details of present illness;
3. Allergies;
4. Medications;
5. Relevant past, social and family histories (appropriate to the patient's age);
6. Significant medical/surgical history (existing co-morbid conditions);
7. Inventory of body systems;
8. Physical examination, including pertinent laboratory tests and imaging studies;
9. Impression including appropriate provisional diagnosis;
10. Substantiation for admission versus outpatient observation;
11. Relation between current and previous recent admissions, as appropriate;
12. Conclusion, treatment plan and treatment limitations, if applicable.

B. When a history and physical examination is not in the medical record before the patient is to undergo surgery or any invasive procedure, the operation or procedure shall be delayed unless it is otherwise stated in writing in the medical record, or clinically obvious, that such delay would be detrimental to the patient's health. In such cases, the provisional diagnosis and a general statement indicating the imperative risk may be substituted. However, a complete history and record of a physical examination must be completed immediately after completion of the surgery or procedure.

C. If a history and physical has been documented within the last thirty (30) days, it may be used in conjunction with an admission note which updates the history and physical. Both documents shall be recorded and signed in the patient's medical record no later than twenty-four (24) hours after admission or prior to procedure, whichever comes first. If the history and physical has not been entered within seven (7) days of the deficiency allocation, the physician may be administratively suspended for failure to complete medical records.

D. A consultation note containing the components of a history and physical will suffice as a formal admission history and physical.

E. All patients undergoing an invasive procedure performed with intravenous (IV) moderate sedation shall have an H&P on the chart within twenty-four (24) hours prior to the scheduled procedure.

F. For all invasive procedures the Medical Staff Member who will be performing the invasive procedure will personally perform a pre-procedure evaluation and obtain informed consent for such invasive procedure.

G. For all invasive procedures, a post-procedure note will be placed in the patient's medical record by the Medical Staff Member performing the invasive procedure. For purposes of these rules and regulations, the Centers for Medicare and Medicaid Services (CMS) definition of surgical or invasive procedures shall apply. CMS currently defines surgical and other invasive procedures as "operative procedures in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice."

1. Invasive procedures encompass a range of services including:
    a. Minimally invasive dermatological procedures (e.g., biopsy, excision, or deep cryotherapy for malignant lesions);
    b. All procedures in the surgery section of the CPT;
    c. Procedures such as percutaneous transluminal angioplasty and cardiac catheterization;
    d. Minimally invasive procedures involving biopsies or placement of probes or catheters requiring entry into a body cavity through a needle or trocar.

2. Invasive procedures exclude the use of instruments such as otoscopes or specula or anything during routine examinations or very minor procedures such as drawing blood.
3. An invasive procedure must be something the Medical Staff member or APP has privileges to perform.

H. A discharge summary may be used for a history and physical, operative/procedure note and discharge note, for treatment of a minor nature and/or diagnostic, which is anticipated to require less than forty-eight (48) hours of Hospitalization. If the patient's stay extends beyond forty-eight (48) hours, a separate discharge summary is required. Documentation must include:

1. History and physical;
2. Course of treatment;
3. Patient's condition at discharge;
4. Discharge instructions and follow-up care required; and
5. Final diagnosis.

I. Recurring outpatients or patient with continuing ambulatory care require a Summary List established by the third visit and updated each subsequent visit. The Summary List shall be viewed with each separate admission and shall be updated when changes occur and must be readily available/accessible to all who provide care, treatment and services. The Summary List will include at least the following:

1. Significant diagnoses;
2. Significant operative/invasive procedures;
3. History of adverse or allergic drug reactions;
4. Medication taken by the patient.

Summary Lists are required in ~~at least~~ the following areas, at a minimum:

1. Radiation Therapy;
2. Wound Care;
3. Infusion Clinic;
4. Endoscopy;
5. Pain Management;
6. Pulmonary Rehab;
7. Cardiac Rehab;
8. Heart Failure Clinic.

J. Podiatry and Dental Patients

All podiatric and dental patients (except patients of oral surgeons) shall be admitted by a physician member of the Active Medical Staff and shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician member of the Active Medical Staff shall be responsible for the care of any medical

problem that may be presented at the time of admission or that may arise during hospitalization.

Podiatrists and dentists are responsible for their portion of the H&P specific to their privileges.

The responsibilities of the admitting Active Medical Staff physician and the treating Podiatrist/Dentist shall be the same as for any other patient admitted to the Hospital and shall include a medical history pertinent to the patient's condition, a physical examination delineating any abnormalities, and assessment of the patient's ability to undergo surgery and anesthesia. The record should include a detailed description of the operative episode with a pre-operative diagnosis and an operative report detailing the procedure and intra-operative findings.

K. Emergency Department

The record for each Emergency Department visit will include at least the following, or if not obtainable, the reason indicated:

1. Adequate identification data;
2. Time and means of arrival and who transported;
3. Pertinent history of the injury or illness and physical findings, including vital signs;
4. Allergy history;
5. Listing of current medications;
6. Details of first and/or emergency care given the patient prior to arrival;
7. Evidence of general and appropriate informed consent, or if not obtainable, the reason indicated (see Informed Consent section);
8. Diagnostic and therapeutic orders;
9. Description of significant clinical, laboratory and radiological findings;
10. Treatment given;
11. Clinical observations, including results of treatment;
12. Diagnosis or diagnostic impression;
13. Conclusions at the termination of evaluation/treatment, including final disposition, patient's condition on discharge or transfer, and instructions given to the patient and/or significant other for necessary follow-up care;
14. Whether the patient left against medical advice.

2.4.2 Consultations

A. When an attending seeks a consultation, the consultant shall enter a note in the record which shall include:
   1. Reason for consultation;
   2. Findings in the case;
   3. Recommendations.

B. The attending Physician is responsible for requesting consultations when indicated. All consultation requests must include a call-back number for the ordering physician. Additional consultations may be appropriate, but should include discussion and input from the Attending Physician.

C. A patient's request for an additional Medical Staff Member(s) to participate in his/her care will be directed by the attending Physician prior to such requested Medical Staff member accessing the patient's PHI, including the medical record, unless such additional Medical Staff Member has the right to access such records independently of the patient request for consultation. In the event the attending Physician determines that the patient's condition does not necessitate a consultation, the attending Physician will notify the patient of this decision not to approve the request for a patient-directed consultation as soon as possible after the decision is made.

D. A consultant must be qualified and privileged in the clinical subject for which the consultation is sought. The need for consultations cannot always be prescribed by a diagnosis or procedure planned; however, the following may be considered as indications for consultations:

1. The diagnosis is obscure after ordinary diagnostic procedures have been completed;
2. When there are therapeutic risks that are known to be extreme or there is doubt as to the choice of therapeutic measures to be utilized;
3. The patient's response to therapy is unexpectedly poor or the patient is not a good risk for operation or treatment;
4. If the attending physician has reason to believe that others possess greater expertise which might benefit the patient or in unusually complicated situations where specific skills of other practitioners may be needed;
5. The patient exhibits severe psychiatric symptoms;
6. When requested by the patient or family.
7. Consultation and treatment shall be requested for and offered to all patients who have attempted or are suspected of having attempted suicide or who are believed to be a risk to self or others. Any services offered must be documented in the patient's medical record.

2.4.3 Informed Consent

It is the responsibility of the treating Medical Staff member to obtain informed consent of the patient in accordance with Hospital policy. It is the treating Medical Staff member's non-delegable duty to advise the patient, or appropriate patient representative, of the procedure, risks and benefits involved, alternative treatments and other pertinent information. Informed consent must be obtained by the treating Medical Staff member and informed consent shall be documented in the medical record or on a written consent form. The treating Medical Staff member must obtain informed consent prior to any consent form being presented to the patient or patient representative for signature.

Except in cases of emergency, an informed consent form, validly executed according to Hospital policy, shall be required before administering anesthesia in all patients.

For further reference, refer to Hospital's Informed Consent Policy.

2.4.4 Orders

A. Every patient shall have an initial order to a specific patient admission type.

B. All written orders must be legible and properly documented. Orders which are not legible or properly documented will not be carried out until corrected or clarified by the appropriate licensed staff Member.

C. Summary (blanket) orders to resume previous medications are prohibited. Post-operative and all transfer orders must include all aspects of patient care. "Resume previous orders or previous medication(s)" will not suffice.

D. All Standing Delegated Orders and orders done through protocol require Physician signature except the pneumonia and influenza vaccinations.

E. Orders for radiology examinations should include a concise reason for the study.

F. A specific order for patient discharge/transfer shall be given by the attending Medical Staff member or designated representative unless the patient leaves the Hospital against medical advice or expires.

G. Where a Medical Staff member is using a preprinted/electronic order set, the last page must be signed, dated and timed. The Medical Staff member should initial, date, time each place on the preprinted order set where changes, such as additions, deletions, or strike-outs of components that do not apply, have been made. It is not necessary to initial every preprinted box that is checked to indicate selection of an order option, so long as there are no changes made to the option(s) selected.

H. When transferring a patient to a lower level of care, the nurse may provide the transferring Physician a current set of orders that may be continued after the transfer. The transferring Physician is responsible for reviewing and approving all orders prior to transfer.

For those patients moving to a higher level of care, the Physician will review the previous orders and give new orders as soon after the transfer as possible. The patient's transfer to a higher level of care will not be delayed pending review and approval of the orders by the Physician.

For patients being admitted to an affiliate facility (i.e., long term acute care, skilled nursing unit, house calls), the admitting Physician must provide Admission Orders

prior to admission to the facility. To facilitate admission orders, the nurse may provide the admitting Physician a current set of orders that may be continued after admission to the affiliate facility.

2.4.5 Operations (Operative Report/Immediate Post-Op Progress Note)

A. Immediately after surgery or an invasive procedure, a brief progress note shall be entered in the medical record before the patient is transferred to the next level of care. This progress note includes at least the following:

1. The name(s) of the primary surgeon(s) and his or her assistant(s);
2. Procedure performed;
3. Findings of the procedure;
4. Estimated blood loss;
5. Specimens removed;
6. Postoperative Diagnosis.

B. After surgery or other invasive procedure, a final Operative Report shall be entered into the medical record within twenty-four (24) hours and includes at least the following:

1. The name of the Medical Staff member who performed the procedure and anyone who assisted with the procedure;
2. The name of the procedure performed;
3. Findings of the procedure;
4. Any estimated blood loss;
5. Any specimen removed;
6. Postoperative diagnosis;
7. Detailed description of the procedure; and
8. Complications.

C. If the final Operative Report has not been entered within seven (7) days of the deficiency allocation, the physician may be administratively suspended for failure to complete medical records.

D. If the surgeon/proceduralist accompanies the patient to the next level of care, the postoperative progress note may be documented from that location.

E. If the elements outlined above are entered into the electronic health record immediately after the surgery/procedure, a separate immediate post-operative progress note, made immediately available, is not required.

2.4.6 Anesthesia

A. Pre-anesthesia Evaluation

1. A pre-anesthesia evaluation shall be performed by an individual qualified to administer anesthesia for each patient who receives general, spinal, epidural, regional, or monitored anesthesia (deep sedation). It shall be completed and documented within forty-eight (48) hours immediately prior to delivery of anesthesia and must include at least the following elements:

    a. Pre-Operative Interview (if possible given the patient's condition) and examination of the patient;
    b. Review of medical history, including anesthesia and drug and allergy history;
    c. Notation of anesthesia risk;
    d. Identification of potential anesthesia problems;
    e. Additional pre-anesthesia data information (such as consultation or further tests);
    f. Development of plan for the patient's anesthesia care.

2. A re-evaluation of the patient shall be performed immediately before administering anesthesia.

B. Intra-operative Anesthesia Record

1. An intra-operative anesthesia record shall be completed for each patient who receives general, spinal, epidural, regional or monitored anesthesia (deep sedation) by the practitioner administering anesthesia and must include at least the following elements:

    a. Name and Hospital identification of the patient;
    b. Names of Practitioners who administered anesthesia, and as applicable, the name and specialty of the supervising physician and the name of the operating Practitioner;
    c. Name, dosage, route and time of administration of drugs and anesthesia agents;
    d. Techniques used and patient position, including the insertion/use of any intravascular or airway devices;
    e. Name and amounts of IV fluids, including blood and blood products;
    f. Time-based documentation of vital signs as well as oxygenation and ventilation parameters;
    g. Complications, adverse reactions, or problems occurring during anesthesia including:
    h. Time and description of symptoms;
    i. Vital signs;
    j. Treatment rendered;
    k. Patient's response to anesthesia and treatment.

C. Post-anesthesia Evaluation

1. The medical record shall reflect an assessment by an anesthesia professional of the patient's physiological status immediately after the procedure to include at least the following:

    a. Patient's vital signs and level of consciousness;
    b. Medications, IV fluids, blood products or/and blood components;
    c. Unanticipated events or complications and the management of those events.

2. A separate post-anesthesia evaluation shall be completed and documented within forty-eight (48) hours by an individual qualified to administer anesthesia for each patient who receives general, spinal, epidural, regional, or monitored anesthesia (deep sedation). The evaluation should not begin until the patient is sufficiently recovered from the acute administration of anesthesia so as to participate in the evaluation but within forty-eight (48) hours. The evaluation must include the following elements:

    a. Respiratory function, to include respiratory rate, airway patency, oxygen saturation;
    b. Cardiovascular function, including pulse rate and blood pressure;
    c. Mental status;
    d. Temperature;
    e. Pain;
    f. Nausea and vomiting;
    g. Post-operative hydration.

D. Moderate Sedation

1. A pre-sedation assessment shall be performed and documented by a Medical Staff Member in the Department of Anesthesia or those privileged in moderate sedation for each patient who receives moderate sedation. A re-evaluation of the patient shall be performed and documented immediately before administering moderate sedation.

2. Patients receiving moderate sedation will be monitored continuously for oxygenation, ventilation and circulation.

3. A post-sedation assessment shall be performed and documented for each patient who receives moderate sedation and shall include the patient's physiological status, mental status, and pain level.

2.4.7 Progress Notes

A. Progress notes should be documented on a daily basis by at least one Medical Staff member, with the exception of admission and discharge days.

B. Progress notes for the Skilled Nursing Facility (SNF) shall be documented per State law and as determined by SNF.

C. Each progress note shall include the date, time and signature of the author.

2.4.8 Discharge Summary/Transfer Summary/Death Summary

A. The discharge summary should recapitulate and include:
1. Significant findings;
2. Procedures performed and treatment rendered;
3. Consultations performed;
4. Any complications during the hospitalization;
5. Condition of the patient on discharge;
6. Provisions for follow-up care, unless documented in the electronic health record generated discharge instructions;
7. Any specific instructions given to the patient and/or family, if any, unless documented in the discharge instructions;
8. Final diagnosis.

B. Death summaries are required on admitted patients outside the Emergency Department who expire regardless of the length of stay and shall include the following at a minimum;

1. A preliminary cause of death;
2. Final diagnosis;
3. Principal diagnosis. If the principal diagnosis depends on unreported diagnostic investigation (such as a pathology report), a provisional diagnosis is acceptable;
4. A listing of all significant co-morbid diagnoses; and
5. A listing of all complications

C. For outpatient visits where the patient was not admitted, or transferred, or if the patient stayed forty-eight (48) hours or less, a final progress note may be substituted for the discharge summary provided the note contains the following:
1. Outcome of visit/final diagnosis;
2. Disposition of the case;
3. Provisions for follow-up care

D. If the discharge, transfer, or death summary has not been entered within seven (7) days of the deficiency allocation, the physician may be administratively suspended for failure to complete medical records.

2.4.9 Medication Reconciliation

Medication reconciliation documentation shall be completed and authenticated including any new medication(s) prescribed. For additional information, refer to the Medication Reconciliation Policy.

2.4.10 Obstetrical Patients

There shall be a history and physical examination on every obstetrical patient. A signed copy of a prenatal record from the attending Practitioner's office may be substituted for a history and physical examination provided an admission note updating the prenatal record as of the date of admission is included in the patient's record.

The H&P/update note must state what, if any, changes have occurred since the previous history and physical examination was recorded. Except in the case of an emergency admission, this note must be in the medical record within twenty-four (24) hours of the time of admission and, except in the case of an emergency, prior to any surgical or invasive procedure.

For additional information, refer to the History and Physical section.

2.4.11 Autopsies

Every Medical Staff Member should attempt to secure autopsies in all cases of unusual deaths. Autopsies will not be performed at Hospital. The Nursing Supervisor is available to assist physicians and families with their request for an autopsy to be performed at another facility.

2.4.12 Unapproved Abbreviations

The Medical Staff shall only use abbreviations approved by the Health Information Services Department or the PI Committee.

2.4.13 Cancer Staging

Documentation for staging shall be placed on the patient's medical record. The treating Physician, defined for the purposes of this documentation requirement as the individual providing the first definitive course of treatment for the disease process, shall be responsible for the documentation relative to the clinical and pathological tumor, node, metastasis portions of the documentation.

2.4.14 Restraints

A. Use of restraints are specific to patient behavior:

1. Non-violent behavior – patient is preventing or disrupting planned treatment or care by pulling tubes and trying to disconnect from a ventilator;

2. Violent behavior – patient is violent, hitting staff or peers, and is a danger to self or others.

B. Restraints require an order from Physician stating non-violent or violent/self-destructive behavior, clinical justification for restraint, type of restraint and time limit of restraint (PRN orders are not permitted). All orders, including telephone and verbal orders must be authenticated with signature, date and time.

C. For order timeframes, face to face evaluations, documentation by physicians, and all else related to restraints, refer to Hospital policy on restraints.

2.5 Medical Record Deficiencies and Delinquencies

If medical records have not been **COMPLETED** within seven (7) days of the delinquency notification, Medical Staff member or independent advanced practice AHP may be administratively suspended for failure to complete medical records.

2.5.1 Deficiency

For deficiencies, "Practitioner" is defined as Medical Staff members, psychologists, orthotists and/or prosthetists but does not include physician assistants or advance practice nurses.

A. Practitioners have the option of contesting assignments made to them by the Health Information Services department. If contested, a review will be conducted by the Director of Health Information Services to determine if the assignment was made correctly.

1. If determined to have been assigned incorrectly, the deficiency will be reassigned.

2. If determined to have been assigned correctly, the deficiency will be reassigned to the Practitioner who contested.

B. If the Practitioner contests the assignment a second time, an automatic review will be conducted by the Director of Health Information Services with the physician liaison to the Performance Improvement Committee for the medical records function.

1. If the physician liaison believes the assignment was made incorrectly, the Director of Health Information Services will reassign the deficiency.

2. If the physician liaison agrees with the assignment, he/she will contact the Practitioner in question.

C. After discussion with the physician liaison, if the Practitioner continues to disagree with the assignment, the matter will be forwarded to the Performance Improvement Committee for review.

1. If the Performance Improvement Committee determines the assignment was made incorrectly, the Director of Health Information Services will reassign the deficiency.

2. If the Performance Improvement Committee determines the assignment was made correctly, the Practitioner in question will be notified.

3. If the deficiency is not resolved after notification by the Performance Improvement Committee within seven (7) days, it will be addressed as a medical record delinquency.

2.5.2 Delinquency

For delinquencies, "Practitioner" is defined as Medical Staff members, psychologists, orthotists and/or prosthetists. AHPs sponsored by a Practitioner will be suspended if the Practitioner is suspended.

A. All medical records shall include a final diagnosis at the time of discharge. All dictation/documentation in the medical record must be completed within seven (7) days of allocation. Final diagnoses which cannot be determined at the time of discharge due to incomplete or pending diagnostic tests must be completed within seven (7) days of discharge or completion of such tests. All authentications must be completed within fourteen (14) days of allocation.

B. A Practitioner whose medical records lack dictation/documentation after seven (7) days from allocation will receive notification from the Chief of Staff, or his/her designee. This notification will also inform the Practitioner that the incomplete records must be completed within the next seven (7) days to prevent automatic suspension of all staff privileges. The Health Information Services department will send notification that includes the number of the incomplete medical records, items incomplete and the patient name.

C. A Practitioner whose medical records lack signatures/authentications after fourteen (14) days from allocation will receive notification from the Chief of Staff, or his/her designee. This notification will inform the Practitioner that the incomplete records must be completed within the next seven (7) days to prevent automatic suspension of all staff privileges.

D. Upon automatic suspension, the Practitioner will be notified by a certified, or hand-delivered, letter from the Chief of Staff. The Practitioner as well as AHPs sponsored by the Practitioner will be suspended. The name of the affected Practitioner and any AHPs he/she sponsors shall be placed on the "Suspended List". The Chief of Staff shall have the authority and responsibility to provide alternative medical coverage for patients of the suspended Practitioner.

E. Practitioners not completing all dictation/documentation in the medical record within seven (7) days of automatic suspension will be removed from the Medical Staff and must complete an initial application if he/she wishes to return to the Hendrick Medical Staff or Allied Health Professionals Staff.

F. Information pertinent to a Practitioner's delinquency patterns in completion of records shall be forwarded to the Credentials Committee for review as part of such Committee's examination of qualifications of said Practitioner for reappointment to the Medical Staff or Allied Health Professionals Staff.

1. A Practitioner who resigns and fails to complete all his/her medical records will be reported to anyone who makes an inquiry as having "resigned – not in good standing."

2. If a Practitioner leaves the Hospital either voluntarily or involuntarily and does not complete their medical records within sixty (60) days, the medical records may be filed as permanently incomplete and the Practitioner may be reported to the Texas Medical Board by the medical executive committee.

2.5.3 Extended Leave or Vacation

It is the Practitioner's responsibility to notify the Health Information Services Department if a leave or vacation is planned that exceeds two (2) weeks. In the event the leave extends unexpectedly past three (3) weeks, the Health Information Management Department may initiate the process to file the charts as permanently incomplete.

2.6 Administrative Suspension or Revocation

The purpose of this section is to establish an enforcement mechanism for suspension processes for Medical Staff and Allied Health Professionals for medical record delinquency.

2.6.1 Failure to Complete Medical Records

Practitioners shall not be permitted to schedule elective admissions, surgery and/or procedures and elective anesthesia, with the exception of in-house patients if suspended for failure to complete medical records. They may not vote on Medical Staff issues or exercise office-holding prerogatives while suspended. In addition, the Practitioner's Membership and clinical privileges may be suspended for failure to complete medical records for three (3) weeks in a row from availability until such records are completed. Suspended Practitioners providing operative procedures on an in-house patient(s) or currently treating an in-house patient(s) may continue to treat that in-house patient(s). Future admission and surgical scheduling will be denied until the Practitioner is removed from suspension and has completed his/her medical records.

2.5.3 Notification to Practitioner of Suspension or Reinstatement

A. Notification to Suspend – the process for notification to suspend Medical Staff members, APPs, and AHPs is defined in Health Information Management Policy and Procedures and elsewhere in this policy.

B. Notification to Reinstate – upon completion of all incomplete medical records, clinical privileges may be reinstated upon verification of completion of records or exemption from the Chief of Staff.