

BEAUMONT HEALTH SYSTEM
MEDICAL STAFF PHYSICIAN HANDBOOK
RULES / REGULATIONS / POLICIES

ADDENDUM TO RULES / REGULATIONS AND POLICIES
FOR BEAUMONT HOSPITAL – ROYAL OAK

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Approved by Beaumont Hospital – Royal Oak, Medical Executive Board: March 1, 2016

Approval by Joint Conference Committee Scheduled for: March 24, 2016

Ratification by Board of Directors Scheduled for: April 21, 2016

BEAUMONT HOSPITAL – ROYAL OAK
MEDICAL STAFF PHYSICIAN HANDBOOK
ADDENDUM TO RULES / REGULATIONS AND POLICIES

1.4.6. HISTORY AND PHYSICAL EXAMINATION CONTENTS

Content required for a history and physical examination depends on the setting and circumstance of patient care, anesthesia requirement, and type of procedure. For purposes of clarity, history and physical examinations will be defined either as a 'full' or 'focused' history and physical examination.

A full history and physical examination is required for:

1. All inpatients
2. Outpatients undergoing surgery or major diagnostic procedures requiring general anesthesia, deep sedation, spinal or regional block other than digital.

A focused history & physical examination is required for:

Outpatient services and procedures:

1. Performed with moderate sedation involving the administration of IV or IM pharmacologic agents, such as diagnostic cardiac catheterization and routine upper and lower endoscopies.
2. Performed with local anesthesia and/or oral sedatives when anesthesia services are in attendance

Procedures done with no and / or local anesthesia or oral sedatives, without anesthesia services in attendance, such as skin biopsy, do not require a full or focused history and physical examination.

Full History and Physical Requirements:

The minimum elements required for the full history and physical examination is:

- History of present illness
- Significant or pertinent past medical history
- Significant or pertinent social history
- Significant or pertinent family history
- Medications
- Allergies
- Relevant review of systems
- Physical examination
- Assessment
- Plan of care

In all instances, the examination must include examination of the heart and lungs. Other components of the physical examination areas appropriate to the clinical situation and requirements, if any, stipulated by the chief of service, and are subject to peer review. In the perioperative setting, the anesthesiologist's examination of the heart and lungs will suffice for the examination of these organs. This is germane for those highly specialized physicians who do not routinely examine heart and lungs.

Focused History and Physical Requirements:

A focused history and physical examination for non-inpatient services performed with moderate sedation is to be focused and pertinent to the nature of the procedure.

The minimum data required for the focused history and physical examination is:

- History of present illness
- Significant past medical history that is clinically pertinent to the procedure being performed or the planned course of treatment
- Significant social history that is clinically pertinent to the procedure being performed or the planned course of treatment
- Significant family history that is clinically pertinent to the procedure being performed or the planned course of treatment
- Medications
- Allergies
- Physical examination
- Assessment that is clinically pertinent to the procedure being performed or planned course of treatment
- Plan of care

The physical examination is to consist of a focused examination pertinent to the patient's chief complaint and planned procedure. The examination must minimally include an examination of the heart and lungs. In the perioperative setting, the anesthesiologist's examination of the heart and lungs will suffice for the examination of these organs. This is germane for those highly specialized physicians who do not routinely examine heart and lungs.

The above data may be documented in the pre-sedation / pre-anesthesia assessment on the day of the procedure and / or office exam notes done within 30 days of the procedure. Any pertinent changes in that exam including those which would preclude surgery or the procedure are noted in the "Update" on the day of the procedure after review and consultation with the anesthesia provider, review of the office notes, and focused exam of the patient.

The data gathered through interview and / or observation for the history, including history of present illness, past medical and surgical history, family history, medications, allergies, and review of systems, may be completed by a physician, resident, certified registered nurse anesthetist, physician assistant, nurse practitioner, certified nurse mid-wife, master's-prepared clinical nurse specialist, doctor of nursing practice, medical student, nurse clinician or registered nurse.

The physical examination and interpretation and analysis to determine the plan of care, including initial labs / diagnostic tests, and impression and plan of care, may be completed by a physician, resident, certified registered nurse anesthetist, physician assistant, nurse practitioner, certified nurse mid-wife, or master's-prepared clinical nurse specialist.

All entries into the medical record, whether electronic or handwritten, must be signed, dated and timed. If more than one individual completes the history and physical, the individual signing the plan of care assumes responsibility for the contents of the complete history and physical examination.

As defined in 1.5.4, if the history and physical examination is completed by a resident, the supervising attending physician will authenticate and countersign the history and physical examination. For patients undergoing surgery, the attending's signature must be entered into the record prior to surgery.

While a resident, certified registered nurse anesthetist, physician assistant, nurse practitioner, or certified nurse midwife or master's prepared clinical nurse specialist may sign the history and physical examination, it is the attending physician who is responsible for integrating the information in the history and physical examination, the formulation of the plan of care of the patient and its execution while the patient is hospitalized. At all times, the attending physician is the ultimate responsible party for the care of the patient.

1.4.7. TIMING OF HISTORY AND PHYSICAL

For patients undergoing surgery or a major diagnostic procedure requiring general, spinal or regional anesthesia, the full history and physical examination must be completed before the procedure is performed. A dictated full history and physical examination that has not been transcribed and authenticated does not satisfy this requirement since it is not available for review in a timely manner. In an emergency, when there is no time to record a complete history and physical examination, a progress or admission note describing a brief history and appropriate physical findings and the pre-operative finding shall be entered in the medical record before surgery or the administration of anesthesia.

An appropriate full history and physical examination of all inpatients shall be completed, recorded in the Hospital medical record within twenty-four (24) hours after admission. While a dictated full history and physical examination is also accessible via the dictation system on an immediate basis, as it is not readily available in emergent circumstances, the physician or qualified practitioner as stipulated in Section 1.4.6. must also complete a brief admission or transition of care note as a bridge until the history and physical examination is transcribed. Dictated reports are available in the electronic medical record upon transcription as 'unverified'. All patient records must contain a signed history and physical examination within seven (7) days after admission.

If a full history and physical examination has been performed by a qualified practitioner as stipulated in Section 1.4.6 within 30 days before admission, a legible copy of this report may be used in the patient's medical record, provided that it is updated in writing within twenty-four (24) hours of admission, and the authenticated update reflects pertinent clinical changes since the full history and physical examination was performed. For both inpatients and outpatients undergoing surgery or a major diagnostic procedure requiring general, spinal or regional anesthesia, the full history and physical examination update must be completed before the procedure is performed. The update must be completed by a qualified practitioner as stipulated in Section 1.4.6.

For obstetrical patients presenting for a normal delivery, the pre-natal record may serve as the history and physical if it has been completed within 30 days before admission, provided it is updated in writing at the time of admission. The update must be completed by a qualified practitioner as stipulated in Section 1.4.6.

For non-inpatients undergoing a procedure performed with moderate sedation, if a focused history and physical examination has been performed by a qualified practitioner as stipulated in Section 1.4.6 within 30 days before the procedure, a legible copy of this report may be used in the patient's medical record, provided that it is updated in writing prior to the start of the procedure, and the authenticated update reflects pertinent clinical changes since the focused history and physical examination was performed. The update must be completed by a qualified practitioner as stipulated in Section 1.4.6.

Update of History and Physical Examination

In the context of surgery, the update serves to assure that important interval clinical changes, if any, are discovered and addressed pre-operatively. The update includes the following:

1. Examination of the heart and lungs and other pertinent exam, if any, on the day of the procedure by the operating surgeon or designee
2. Review of previous history and physical examination (done within 30 days), and documentation of pertinent changes if there are any.
3. Pre-anesthesia assessment done by the proceduralist or anesthesiologist on the day of the procedure or an update indicating any changes to it if it was done more than 24 hours before surgery.

When a dentist or podiatrist is to perform a surgical procedure, the responsible dentist or podiatrist must record the dental or podiatric portion of the full or focused history and physical examination in the medical record.

1.4.8. NEWBORN ADMISSIONS

All infants born at Beaumont Hospitals must have a full or focused history and physical examination appropriate to a newborn within twenty-four (24) hours of birth, a daily progress note, an order for discharge, and a final progress note that suffices for the discharge summary.

1.4.9. OVERVIEW OF REQUIREMENTS FOR PROCEDURES PERFORMED BY A PHYSICIAN OR ADVANCED PRACTICE PROFESSIONAL

The nature and risk of a procedure dictates the pre-procedure, intra-procedure and post-procedure documentation requirements. Three types of procedures are defined below: 1) Procedures with or without local anesthesia or oral sedatives, 2) Procedures with sedation where sedating IV or IM sedation is commonly used, and 3) Procedures requiring deep sedation or anesthesia involving general, spinal or major regional anesthesia.

The following table summarizes the requirements for procedures performed by a physician or an advanced practice professional (certified registered nurse anesthetist, certified nurse midwife, nurse practitioner, physician assistant). Note: these requirements do not apply when a physician or an advanced practice professional performs a procedure typically performed by a registered nurse or other staff.

	PROCEDURES NOT REQUIRING ANY ANESTHESIA OR REQUIRING LOCAL ANESTHESIA OR ORAL SEDATIVES	PROCEDURES WITH SEDATION Where Moderate Sedation is the Goal, Usually Involving the Administration of IV or IM Sedatives	PROCEDURES WITH ANESTHESIA Deep sedation or General Anesthesia, Spinal, or Major Regional Block
PRE-PROCEDURE VERIFICATION PROCESS	<ul style="list-style-type: none"> • Written consent • Current medications and allergies • Pertinent clinical information relevant to the procedure being performed • Correct patient, procedure, site identification • 	<ul style="list-style-type: none"> • Written consent • Focused H & P (within 30 days) • Update to focused H&P (day of procedure) • Pertinent clinical information relevant to the procedure being performed • Correct patient, procedure, site identification • Nursing assessment • Pre-procedure evaluation based on clinical pertinence and plan for sedation 	<ul style="list-style-type: none"> • Written consent • Full H & P (within 30 days) • Update to full H&P (day of procedure) • Pertinent clinical information relevant to the procedure being performed • Correct patient, procedure, site identification • Pre-anesthesia evaluation (within 24 hours prior to procedure) • Nursing assessment • Plan for anesthesia
IMMEDIATELY PRIOR TO PROCEDURE	<ul style="list-style-type: none"> • Time Out 	<ul style="list-style-type: none"> • Immediate pre-sedation reassessment • Time Out 	<ul style="list-style-type: none"> • Immediate pre-induction reassessment • Time Out
DURING PROCEDURE		<ul style="list-style-type: none"> • Intra-procedural monitoring 	<ul style="list-style-type: none"> • Intra-procedural monitoring
POST PROCEDURE	<ul style="list-style-type: none"> • Post-procedure progress note 	<ul style="list-style-type: none"> • Post-procedure progress note • Post-procedure monitoring • Discharge assessment 	<ul style="list-style-type: none"> • Post-procedure progress note • Post-procedure assessment • Discharge assessment • Post-anesthesia evaluation (within 48 hours after the procedure)

The data gathering portion of a pre-procedure evaluation may be completed by a physician, resident, certified registered nurse anesthetist, physician assistant, nurse practitioner, certified nurse mid-wife, master's-prepared clinical nurse specialist, medical student, nurse clinician or registered nurse.

The documented need and plan for procedure may be completed by a physician, resident, certified registered nurse anesthetist, physician assistant, nurse practitioner, certified nurse mid-wife, or master's-prepared clinical nurse specialist

The content of the pre-procedure evaluation is to be appropriate to the risk of the procedure to be performed, the anesthesia to be used and the condition of the patient and should be adequate to determine the need for additional diagnostic data. Specific requirements, if any, for the content of the pre-procedure medical evaluation shall be determined by the appropriate Department Chief.

All entries into the medical record must be signed, dated and timed. If more than one individual completes the pre-procedure evaluation, the individual signing the plan of care assumes responsibility for the contents of the complete pre-procedure evaluation.

The data gathering portion of pre-procedure evaluations and documentation for the need and plan for the procedure may be completed by a non-physician as stipulated above. The physician performing the procedure or operation is ultimately responsible for the knowledge of the key information in the pre-procedure evaluation, history and physical, the plan of care and its appropriate execution.

UNIVERSAL PROTOCOL

The Universal Protocol must be completed prior to beginning an operative procedure or a major diagnostic procedure. The Universal Protocol requirements are:

- 1) Conduct a pre-procedure verification process:
 - a. Verify correct patient, correct procedure, and correct site with patient involvement if possible
 - b. Review items that must be available for the procedure such as:
 - i. Relevant documentation such as history and physical examination, pre-procedure evaluation, signed and executed informed consent, nursing assessment, and pre-anesthesia assessment
 - ii. Labeled diagnostic testing and radiology tests that are properly displayed
 - iii. Any required blood products, implants, devices, and / or special equipment for the procedure
 - c. Match the items that are to be available in the procedure area to the patient
- 2) Mark the site
 - a. Site marking is required when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety
 - i. For spinal procedures, in addition to skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level
 - b. Mark the procedure site before the procedure is performed and, if possible, with patient involvement
 - c. The procedure site should be marked by the individual who is accountable for the procedure and will be present when the procedure is performed. A resident who is a member of the surgical team may mark the site if the attending physician is not available.

- d. Site marking is unambiguous and is consistent with Hospital policy. The marking should be sufficiently permanent to be visible after skin preparation and draping.
 - e. If the site cannot be marked or the patient refuses site marking, then the site marking is documented on a diagram
 - f. Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure.
- 3) Perform a time out immediately before the procedure
- a. Time out must be performed immediately before the invasive procedure or making an incision
 - b. Time out is initiated by one team member but involves all team members
 - c. When two or more procedures are performed on the same patient and the individual performing the procedure changes, a second time out is required
 - d. During the time out, the team members agree on the following: Correct patient identity, correct site, and correct procedure
 - e. The completion of the time out must be documented
 - f. In the rare setting of a life threatening situation where the risk of harm outweighs the delay caused by performing a time out, a time out may be waived.

1.4.10. PRE-PROCEDURE SEDATION ASSESSMENT FOR PATIENTS RECEIVING MODERATE OR DEEP SEDATION

Documentation of the pre-procedure assessment and sedation plan is the responsibility of the physician performing the procedure and must be completed prior to initiation of the surgery or procedure except in emergency situations. The assessment and documentation must be completed as outlined in the "Guidelines for Sedation Policy."

1.4.11. OPERATIVE / INVASIVE PROCEDURE NOTES AND REPORTS

An operative progress note is hand-written or computer generated and entered into the medical record by the attending physician or designee before the patient is transferred to the next level of care.

The operative progress note will minimally contain the following elements:

- Patient name, medical record number and birth date
- Procedure date and time
- Name(s) of the primary surgeon(s) and assistant(s)
- Procedures performed
- Description of each procedure finding, including significant unanticipated findings / occurrences
- Post-operative diagnosis
- Estimated blood loss, if applicable
- Specimens removed or altered, if applicable
- Pre-operative diagnosis

Additionally, the progress note may include:

- Anesthesia type or sedation administered
- Procedure description
- Condition of patient prior to leaving the operating room or procedure area

A full operative report must be completed within 24 hours of the surgical procedure. The full operative report shall include elements identified for the operative progress note, including unanticipated findings / occurrences and the condition of the patient when leaving the operating room or procedure area and the following additional elements:

- Procedure description, including:
 - Indications for procedure
 - Technical details of the procedure
 - Devices, grafts, tissues or transplants implanted (may be viewed on the nursing operative record as well)

These requirements apply to all major procedures in all units or settings including the operating room, cardiac catheterization laboratory, radiology department, short stay unit, endoscopy unit, and patient bedside. Dictated reports are available in the electronic medical record upon transcription as 'unverified'. All patient records must contain a signed operative report within seven (7) days after any operative procedure. If a physician will not be available due to a vacation / conference, etc., then a seven (7) day extension in signing the operative report will be granted beginning at the time of his / her return.

As defined in 1.5.4, if the operative note is completed by a resident, the supervising attending physician will authenticate and countersign the operative note.

1.4.12. ANESTHESIA NOTES

A pre-anesthetic evaluation should be completed by an anesthesiologist within 24 hours prior to a procedure requiring anesthesia, which includes documentation of relevant history and the patient's condition and that the anesthesia options and risks have been communicated. If the pre-anesthetic evaluation was done more than 24 hours prior before the procedure, an update is required with a note indicating any change or a note indicating that there are no changes.

1.5. MID-LEVEL PROVIDERS, RESIDENTS, FELLOWS AND MEDICAL STUDENTS

1.5.1. MID-LEVEL PROVIDER APPLICATION AND EVALUATION

The Board of Directors annually defines categories of health care practitioners that shall be eligible to participate in patient care at Beaumont Hospitals as employees of Beaumont medical staff members. The Medical Executive Board shall define limitations of patient care for each category.

Individual mid-level providers prior to rendering services in the Hospital, must complete an appropriate application documenting his / her educational background, training, and current health status, and must be qualified and receive approval by the appropriate Credentials Committee, and Medical Executive Board / written approval, in advance, from the Department Chief and / or the designee of the Chief Medical Officer. An individualized job description including authorized services that may be rendered in the Hospital and within the limitations defined by the Medical Executive Board must have been approved in writing by the Department Chief and / or the designee of the Chief Medical Officer / by the Credentials Committee and Medical Executive Board.

All such mid-level providers shall be subject to all rules, regulations and policies of Beaumont Hospitals and shall be subject to disciplinary action including suspension at the discretion of the Department Chief / Section Head and Chief Medical Officer and shall acknowledge such in writing. Each physician extender must also sign an acknowledgment agreeing to abide by all Beaumont Hospital rules, regulations and policies and to provide documentation of compliance upon request. For purposes of identification, privately employed mid-level providers will document in the medical record the following information: "PE (name) rounding privately for Dr. (name)".

Performance evaluations on mid-level providers must be completed by the supervising physician and submitted to the Department Chief, and / or the designee of the Chief Medical Officer and the Director of Human Resources as appropriate. A personnel file for each physician extender shall be maintained in Medical Administration containing documentation of current licensure, the description of duties and performance evaluations. Appointment to the physician extender staff shall not exceed two (2) years, whereupon the appointment may be renewed or terminated.

Each physician extender must complete an appropriate reapplication documenting his / her educational background, training and current health.

1.5.2. MID-LEVEL PROVIDER SUPERVISION

Mid-level Providers may provide medical care services within their area of competence providing they do so under the supervision of a member of the Medical Staff who shall at all times maintain responsibility for patient care. All mid-level providers shall:

- a. Be licensed by and in good standing with the State.
- b. Have their credentials and qualifications approved by the Board of Directors upon the recommendation of the appropriate Credentials and Qualifications Committee and Medical Executive Board.
- c. Be assigned to an appropriate Department or Section.
- d. Carry out their clinical activities subject to the policies and procedures of the entity referred to in (c), and subject to the administrative policies then in effect of Medical Administration.
- e. Provide patient care services under the direction and supervision of a Medical Staff member, within the scope and limitations of their job description / approved procedures.

- f. Be subject to focused and ongoing professional practice evaluation as described in the Medical Staff Peer Review Policy.
- g. Receive performance evaluations from their hospital supervisor or supervising physician, reviewed by the Department Chief.
- h. Not be considered members of the Medical Staff for any purpose.

1.5.3. RESIDENT AND FELLOW JOB DESCRIPTION

Residents / fellows are selected, appointed, evaluated and provided graduated responsibility under supervision in accordance with the William Beaumont Hospital Institutional Review Document as approved by the Accreditation Council on Graduate Medical Education (ACGME).

Residents / fellows must agree to and sign the terms of the Contract for Residency / Fellowship Training prior to beginning their employment. This contract spells out, in summary form, the duties and responsibilities of the Resident or Fellow.

Department Chief / Program Director shall assign residents / fellows to specific duties and arrange proper supervision of residents / fellows. Both the Graduate Medical Education Department and the individual Residency & Fellowship programs shall maintain written policies and guidelines of the roles, responsibilities, and patient care activities of residents / fellows, including required supervision. These written policies and guidelines shall define the mechanisms by which the Program Director and supervising physicians determine appropriate levels of progressive responsibilities in patient care for each resident / fellow.

Residents / fellows shall be supervised by members of the medical staff in accordance with the Rules / Regulations / Policies defined herein.

1.5.4. RESIDENT AND FELLOW SUPERVISION

- a. All patient care provided by residents / fellows must be supervised by members of the Medical Staff with appropriate clinical privileges.
- b. Residents / fellows shall promptly see all newly admitted patients assigned to them and complete the required medical evaluation. Residents / fellows will notify the attending physician that the patient has been admitted and discuss the initial management of the case with him / her.
- c. Residents / fellows should report to the attending physician all complications and should promptly report to the attending physician any significant change in a patient's condition.
- d. The order documenting a decision for withholding CPR may be in writing, or entered electronically, and may be a telephone order from an attending physician to another physician / mid-level provider or to a registered nurse (the latter must be witnessed by another registered nurse on the telephone and documented as such). All No CPR orders will be on form #4562 "Orders for CPR Status." The order may be reviewed by the patient / surrogate for accuracy with the physician / mid-level provider.

In this case, the order must be countersigned by the attending physician and a progress note describing the basis for the order must be written by the ordering physician / mid-level provider. The progress note should address any discussion with the patient and / or the patient's surrogate, which indicates knowledge of the patient's wishes including consideration of any written Advance Directives known to the physician / mid-level provider.

- e. When a patient dies, the resident / fellow shall immediately notify the attending physician and shall discuss with him / her the question of obtaining an autopsy,

anatomic gift and notification of the family. Additionally, the resident / fellow should contact the bereavement representative to assist with issues surrounding the patient's death.

- f. The supervising attending physician will authenticate and countersign, at a minimum, the history and physical examination, discharge summary, operative note, and consultations. The time frame for authentication by the attending physician is 7 days. Exception: the history and physical examination must be authenticated prior to surgery for surgical patients.

1.5.5. MEDICAL STUDENT SUPERVISION

- a. Roles and responsibilities of medical students shall be defined by their medical school and the responsible Department Chief and Program Director.
- b. All patient care provided by medical students must be supervised by residents, fellows and / or members of the Medical Staff with appropriate clinical privileges.