HOSPITAL PRACTICE HANDBOOK
OF THE

BANNER BAYWOOD MEDICAL CENTER
MEDICAL STAFF

("General Rules and Regulations")

June 6, 2019

f 9/8/09

BBMC MEDICAL STAFF

HOSPITAL-PRACTICE HANDBOOK

(General Rules and Regulations)

TABLE OF CONTENTS

f 9/8/09

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(General Rules and Regulations)

1.0 ADMISSIONS & DISCHARGES: PHYSICIAN RESPONSIBILITIES

1.1 ADMISSIONS

1.1.1 Before Admission: Provisional Diagnosis. The admitting Medical Staff member must provide a provisional diagnosis or valid reason for admission before admission, except in a documented emergency.

1.1.2 Admitting Orders Required. The Admitting or Attending Medical Staff member is responsible for expeditiously written admitting orders to guide patient care. A verbal admission order must be authenticated by the admitting physician promptly (and prior to discharge). Admitting orders should direct care pertaining to diagnoses, allergies, diet, activity, ancillary health care needs, diagnostic evaluations and medications.

1.1.3 Admitting Note Within 24 Hrs. The Attending Physician must see the patient and complete a written admitting note (that justifies admission and determines the plan of treatment) within 24 hours of admission. Exceptions:
a) The Attending Physician must see the patient and write an admitting note WITHIN 12 HOURS of admission to the ICU.
b) Departments may adopt shorter deadlines in departmental rules, as appropriate.

1.1.4 H&P Within 24 Hrs. The Attending Physician is responsible for performing and documenting H&Ps (or updating them, if performed within 30 days prior to admission) within 24 hours after admission and within 24 hours before any inpatient or outpatient surgery procedure or procedure requiring anesthesia services anywhere in the Hospital. While it should not be a routine practice, the Attending Physician may delegate this responsibility to an appropriate physician, but remains responsible for assuring its performance. Exception: Emergencies where a delay would constitute a hazard to the patient will be documented by the Attending Physician.

1.1.5 Required Notification Within 24 Hrs. The Attending Physician of a patient being actively treated for an ongoing condition at the time of admission shall notify the Patient's Treating Physician(s) (Specialist and PCP), within 24 hours of admission to provide an opportunity for the Treating Physician to communicate essential patient information.

1.1.6 "COVER" Physicians must have "cover" by a Medical Staff Member with substantially the same BBMC privileges, unless an exception is granted by the Medical Executive Committee. Cover must include all patients, regardless of healthplan or third party payor and may require more than one physician.

1.1.7 Required Physician Visits. After the initial visit (see 1.1.3), the Attending Physician is responsible for seeing the patient daily. The Consulting Physician should see the patient as often as is clinically indicated. When a patient has a surgical procedure, the surgeon or designee, including the Physician Assistant or Nurse Practitioner, will follow the patient for at least 48 hours and will not stop following the patient until the surgical issues are resolved. Discharging physicians need not visit on day of discharge if order was written within 24 hours of discharge.

1.1.8 Patients Admitted to BBMC.

a) BBMC admits patients 18 and over who require available services.

b) Patients under the age of 18 will be transferred unless the emergency physician deems transport will be life threatening. Elective surgical cases may be performed on patients over the age of 14 where the surgeon believes adult services are appropriate.

1.2 DISCHARGES

1.2.1 Prior Discharge Order

1.2.1.1 A patient may be discharged only on a physician's prior order. The Attending or Consulting Physician [or authorized designee] must write an order for discharge of a patient from the Hospital prior to discharge and include detailed follow-up and care instructions.

1.2.1.2. Definition. "Discharge" means termination of Hospital services to an inpatient or outpatient.

1.2.2 Direct Communication With Treating Physician. The Attending Physician of a patient who is being actively treated for an ongoing condition shall communicate directly with Patient's Treating Physician(s) (Specialist and/or PCP) at discharge to ensure continuity. This may be accomplished by copying the discharge summary dictated within 24 hours.

1.2.3 Discharge Summary. The Attending Physician is responsible for ensuring the completion of a discharge summary. See Rule 3.2.7 for required contents, deadline and exceptions.

2.0 CRITICAL CARE CENTER & TELEMETRY UNITS: PHYSICIAN RESPONSIBILITIES

2.1 RESTRICTED ADMISSIONS; CRITERIA.

2.1.1. The Critical Care Center is reserved for seriously ill patients with medical or surgical problems requiring specialized equipment and/or more comprehensive nursing management.

2.1.2 The Telemetry Units are reserved for the less critical patient who still has the need for more comprehensive nursing care, specialized equipment and monitoring.

2.1.3 The CCC and Telemetry Unit Admission Criteria and Priorities are stated in the CC Service Rules Sec. III.A.2 and III.B.2.

2.2 ATTENDING PHYSICIAN ADMISSION & DISCHARGE RESPONSIBILITIES

2.2.1 The attending physician determines whether his/her patient needs to be admitted to the Critical Care Center and Telemetry Unit utilizing the established Admission Criteria, and makes the request for admission to the Admitting office; and writes orders on admission.

2.2.2 The attending physician must see the CCC patient within 12 hours of admission, consistent with the patient's clinical condition.

2.2.3 If all CC units are filled, the CMO is authorized to admit and discharge patients; such triage decisions are made explicitly, without bias and require no patient consent.

2.2.4 When Telemetry bed requests exceed spaces, the CMO (designee) in conjunction with the attending physician determine according to severity which patients shall be in the units

2.3 ONGOING RESPONSIBILITIES

2.3.1 The attending physician with privileges shall at all times retain authority and responsibility for the medical management of his/her patient in the CCC and Telemetry Units.

2.3.2 A Banner eICU practitioner may give orders for patients when the attending physician is not present.

2.3.3 A CCC STAT or emergent call to a treating physician must be answered within 20 min. of the call; failure to render appropriate emergency care is subject to disciplinary action by the MEC and Department committee.

2.34 The CMO (designee) shall intervene whenever he/she reasonably believes a patient's life is in danger because of improper management; such action must be reviewed at the next regular appropriate Department Committee meeting.

2.3.5 When serious differences of opinion in management arise between the attending physician, consultant, eICU practitioners or nurses, the CMO (designee) shall attempt to arbitrate and may request additional consultants if he/she deems advisable.

3.0 MEDICAL RECORDS: PHYSICIAN RESPONSIBILITIES

3.1 GENERAL PHYSICIAN RESPONSIBILITIES RE: MEDICAL RECORDS

3.1.1 Abbreviations. Members may use an abbreviation or symbol in a medical record only found in Jablonski Dictionary of Medical Acronyms & Abbreviations. Members may not use abbreviations, acronyms or symbols that are included in the Joint Commission "Do Not Use" list. The Jablonski Dictionary may be accessed from the Banner intranet.

3.1.2 Timing & Dating Every Entry. Every entry must be timed, dated, authenticated and legible.

3.1.3 Addendums, Changes and Corrections. Once made, an entry is a permanent part of the record, whether or not the medical record is "complete." Entries may not be altered in any way.

a) Corrections must be made either by addendum and/or by drawing a single line through the error and initialing, dating, and timing both the new entry and the striking.

b) Addendums must be dated and timed when actually written or dictated, and must reference the date and time of the occurrence.

c) If it is necessary to rewrite any physician documentation, the rewritten portion must be dated and timed and the original must remain in the record with the indication that it has been revised.

3.1.4 Proofing Transcribed Dictation. Both the original transcription and the physician's edited version are part of the medical record. Medical Staff members may edit electronically on request.

3.1.5 Protecting Patient Health Information (PHI).

a) Medical Staff members are responsible for safeguarding, directly and indirectly through an agent, patient health information by:

1) using and disclosing PHI only as necessary for treatment, payment or formal, authorized health care operations (peer review, QA and performance improvement) and research.

2) obtaining written patient consent for any other use.

3) protecting access codes and computer passwords which are not to be shared except to provide support for the uses and disclosures listed in #1 above.

4) logging off electronic medical record (EMR) immediately when not in active use.

b) A Medical Staff member who fails to take the reasonably required steps to safeguard confidential patient information violates the Bylaws. The MEC is authorized to enforce reasonable safeguards as it deems necessary depending on the seriousness of the breach, from imposing a mandatory course to revocation or denial of privileges.

3.2 REQUIRED ELEMENTS OF A "COMPLETE" MEDICAL RECORD. The following are the responsibility of the Attending Physician, unless otherwise noted.

3.2.1 Attending Physician. The medical record must identify the physician primarily responsible for the care of the patient. Transfer of primary responsibility is not effective until documented in the record by the transferring physician and by the physician assuming primary responsibility.

3.2.2 History and Physical. (Dentists and podiatrists are responsible for the part of their patients' H&P that relates to dentistry or podiatry.)

a) Deadlines. H&Ps must be performed and documented (or updated, if performed within 30 days before admission) within 24 hours after admission and before any non-emergent inpatient or outpatient invasive procedure or other procedure requiring anesthesia services, including C-Section and tubal ligation. Elective procedures are cancelled in the absence of H&P documentation.

1) Exceptions: Emergencies where a delay would constitute a hazard to the patient are documented by the attending physician.

2) "Updating" means indicating that the information has been reviewed and a physical exam has been performed and updated; signing, timing and dating the copy.

3) "Documented" means handwritten or dictated with a note in the chart to that effect.

b) Required H&P Contents for ALL INPATIENTS:

1) Medical History:

* Chief complaint
* Details of the current illness
* A list of current medications and dosages.
* Report of relevant physical examinations
* Relevant past medical, family and psycho-social history appropriate to the patient's age.
* Any known allergies including past medication reactions and biological allergies.
* Existing co-morbid conditions.

2) Physical Examination:

* Current physical assessment appropriate for the chief complaint and provisional diagnosis and the procedure to be performed.
* Inventory by body system
* Assessment of mental status

3) Provisional Diagnosis: Statement of the conclusions or impressions drawn from (1) and (2) (two preceding paragraphs).

4) Initial Plan: Statement of the course of action planned for the patient while in the hospital.

5) Psychiatric Patient: H&P must include a mental status exam and a comprehensive neurological exam.

c) Required H&P Contents for OUTPATIENTS HAVING PROCEDURES REQUIRING GENERAL, SPINAL, REGIONAL, OR EPIDURAL ANESTHESIA: Same as for inpatients, (b) above.

d) Required H&P Contents for OTHER OUTPATIENTS (as appropriate)

1) Indications/symptoms for the procedure.
2) A list of current medications and dosages.
3) Any known allergies including past medication reactions
4) Existing co-morbid conditions.
5) Assessment of mental status.
6) Exam specific to the procedure performed.

Plus the following for Outpatients receiving IV moderate sedation:

7) Examination of the heart and lungs by auscultation.
8) ASA status
9) Documentation that patient is appropriate candidate for IV moderate sedation.

H&P Not Required: The following procedures alone do not require an H&P: procedures that do not require sedation, including ductograms, cystaspirations, PICCs, bone marrow biopsies, paracentesis, thoracentesis, non-surgical breast biopsies, phlebotomies and imaging-guided procedures not requiring sedation.

3.2.3 Orders: Diagnostic and Therapeutic.

a) All inpatient orders, including verbal, shall be dated, timed, and authenticated within 48 hours.

b) Medical Staff members must communicate, implement and document orders in accordance with Chapter 4 (Orders).

3.2.4 Physician's (Progress) Notes. The physician primarily responsible for the patient's care (or cover) must record a daily progress note at each visit (see 1.1.7). Each note should describe the patient's status, reflect any change in the patient's condition and the results of treatment, and indicate periodic review of the planned course of treatment.

a) Authority. Progress notes shall be written, dated, and signed only by individuals authorized by the Medical Staff: Medical Staff members with clinical privileges, allied health professionals practicing within their approved scope of practice, pharmacists, palliative care nurses, and wound care nurses.

b) Post-Operative Procedure Note. For all surgical patients, a post-operative progress note must be entered in the medical record immediately after surgery. (The note is in addition to the immediately dictated Report (3.2.6a).) The note must include:

1) Post-operative diagnosis
2) Surgeon
3) Assistant surgeon (if applicable)
4) Technical procedures used
5) Findings and specimens removed.
6) Estimated blood loss.

c) Non-surgical Procedure Note. Non-surgical procedures require a procedure note.

d) Unconscious patients. Progress note must document neurological status of unconscious patient.

3.2.5 Documentation of Informed Consent. On admission, the Hospital obtains a general consent for treatment that allows physicians to order routine diagnostic tests for a patient.

Medical Staff members must obtain and document additional informed consent:

a) *for any diagnostic or treatment procedure (wherever performed in the hospital) that is not routine . . .*

1) Non-routine procedures include ANY:
   a) surgical or invasive procedure whether or not requiring anesthesia (e.g., arterial lines, subclavian catheters, lumbar punctures, thoracentesis, EMG, arteriogram);
   b) procedure requiring an anesthetic agent, regional anesthesia or general anesthesia
   c) cardiodiagnostic procedure, including stress test, angioplasty;
   d) biopsy
   e) transfusion of blood or blood products
   f) experimental or investigational treatment, procedure or medication;
   g) endoscopic examination (e.g., bronchoscopy, sigmoidoscopy)
   h) autopsy
2) Exceptions:
   a) venipuncture
   b) intravenous lines,
   c) arterial sticks
   d) intravenous, intradermal, subcutaneous or intramuscular injections

b) . . . *prior to performing the procedure*, except in a documented emergency. (See "Implied Consent" at 10.2) An Emergency exists only if:

1) The person needs immediate medical attention; and
2) An attempt to secure express consent would result in delay of treatment and that delay would increase the risk to the person's life or health; and
3) No available information or knowledge indicates the person refused the treatment in question when he/she had decisional capacity.

The implied consent in an Emergency covers only what is necessary to remedy the condition creating the emergency.

c) . . . by discussing with the patient (or patient's representative) sufficiently for an informed decision to be made:
   1) the nature of the condition for which the procedure is to be performed, the name of the specific procedure or other type of medical treatment proposed, and the alternatives, including not undergoing the procedure; and
   2) the nature and probability of the reasonably foreseeable material risks and benefits from the procedure, and of foregoing the procedure, and from any alternative therapies; and
   3) whether other practitioners may be performing important parts of the procedure. An anesthesiologist (or physician responsible for moderate or deep sedation) must document the discussion leading to informed consent to anesthesia (or moderate or deep sedation).

d) *Once the patient has been informed, another member of the team may obtain necessary signatures (which must include the date and time of signature)*.

e) Copies of Consent Forms received from the physician's office that comply with the requirements above are acceptable and will be made part of the permanent record.

3.2.6 Reports. The Hospital ensures that the following reports are included in the Complete Medical Record:

a) Post-Operative Reports. Immediately after an invasive procedure, the physician who performed the procedure must dictate an operative report (in addition to writing the post-op procedure note). The report must include:
   1) Pre-op and post-operative diagnosis
   2) Procedure performed
   3) Names of and description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon
   4) Surgeon
   5) Assistant surgeon (if applicable)
   6) Any other practitioners performing surgical tasks
   7) Indications for procedure (unless documented elsewhere in the record)
   8) Findings and specimens removed
   9) Description of procedure and techniques used
   10) Type of anesthesia administered
   11) Prosthetic devices. grafts, tissues, transplants, or devices implanted, if any
   12) Intra-operative complications
   13) Estimated blood loss.

b) Final Lab Report.

c) Medical Imaging Report.

d) Special Procedure Reports. EEG, EKG, tissue, x-ray, and other special procedure reports

e) Anesthesia Record.

f) Consultation Reports.

3.2.7 Discharge Documentation.

a) Discharge Order Required. Patients may be discharged only on a physician's prior order.

b) Other Documentation Required for Discharge:
   1) Discharge Summary: The attending physician is responsible for ensuring the completion (within 24 hours) of a discharge summary for all inpatients, unless an exception below fits. The discharging physician must dictate a summary that recapitulates:
      A. the reason for hospitalization,
      B. all relevant diagnoses,

C. significant findings,
D. dates and types of procedures performed,
E. care, treatment and services provided,
F. the patient's condition (outcome of the hospitalization) at discharge,
G. final diagnosis, any secondary diagnoses and/or complications, and
H. specific instructions given to the patient and/or family, including physical activity, medication, diet and follow-up care.
I. When a patient is discharged against medical advice, physician statement regarding the advice communicated to the patient.

2) Exceptions.
A. Discharge Note. A physician may substitute a final discharge progress note for inpatients with "minor" problems or interventions requiring less than 48 hour-admissions, unless otherwise defined by Department. A Discharge Note must include diagnosis, disposition and condition (outcome of the hospitalization) of patient and instructions (e.g., medication, diet, follow-up care) given to the patient and/or family. It must be written within 24 hours of discharge.
B. Death Summary. A death summary is required for all deaths and must be dictated within 24 hours of discharge.
C. Death Pronouncement Note: A death pronouncement note is to be completed at the time the patient is pronounced dead or within 24 hours of death.

3) Home Health (Face to Face Discharge Documentation. When home health services or DME are ordered, the medical record must include a face-to-face assessment by the discharging physician, which must occur within 90 days prior to the start of care.
A. The Face to Face encounter documentation must include:
1. date and time of the Face to Face encounter,
2. the patient's clinical condition,
3. a brief narrative description of the patient's homebound status and the need for skilled nursing services.
B. If the documentation was completed by a nurse practitioner, physician assistant, clinical specialist, or resident, the physician must authenticate the documentation.

3.2.8 Signatures (or "authentication"). Unsigned entries are deemed incomplete.
a) Authentication. The responsible Medical Staff member must authenticate or sign, date, and time all entries. An authenticating practitioner accepts responsibility for the completeness, accuracy and finality of an order, based on the patient's condition.

3.3 ENFORCEMENT.

3.3.1 Deadlines. Medical records are expected to be written, dictated, or completed electronically within the following timeframes:
a) Admitting Note (within 24 hours of admission)
b) Verbal Admission Order (promptly after admission/prior to discharge)
c) H&P (within 24 hours of admission & before invasive procedure or other procedure requiring anesthesia)
d) Operative Note (written immediately post-op)
e) Operative Report (dictated immediately post-op)
f) Special Procedure Reports (interpreted, documented & signed within 24 hours of notice to physician of the test's completion)
g) Discharge Summary (no later than 24 hours after discharge; should be at discharge)

h) Discharge Progress Note (no later than 24 hours after discharge; should be at discharge)
i) Death Summary (no later than 24 hours after discharge; should be at discharge)
j) Transfer Summary (at the time of transfer)
k) Consultation Report (within 24 hours of consultation & before invasive procedure)
l) Verbal Order Authentication (within 72 hours)
m) ER Report (within 24 hours of discharge/disposition from the ED)
n) Psychiatric Evaluation (within 24 hours of admission)
o) Signatures (within 7 days from the date of notice)
p) Response to HIMS request for clarification consistent with the requirements of Rules 3.2 ("Coding Query") (within 24 hours of request)
q) Home Health (Face to Face Discharge Documentation) within 30 days of discharge

3.3.2 Failure to Comply with 3.3.1 Can Result in Suspension of Privileges:

a) Suspension process.

(i) Notice of Missed Deadline. HIMS promptly notifies physician via electronic inbox of missed deadline and reminds the physician that they will be eligible for suspension if the record is not completed within 7 days.

(ii) MEC Review. Seven days after the reminder by HIMS, Medical Staff Services notifies the member that he/she has been suspended and that the member is invited to attend the next regularly scheduled BBMC MEC meeting after onset of suspension to explain his/her delinquent status. If the physician completes the delinquent records prior to the next MEC meeting, his/her attendance at that meeting is not required. If the physician fails to complete the delinquent records and fails to attend the MEC meeting, suspension continues and MEC may take additional disciplinary action.

b) Sanctions**,** Temporary Medical Records Suspension. Members who fail to complete charts within 7 days of the Notice of Missed Deadline **(**Except 3.3.1.n**)** shall lose the privileges to

(i) admit and attend patients
(ii) schedule a patient for any elective invasive or surgical procedure
(iii) Consult and/or
(iv) Fill shifts (as ED Physicians or Hospitalists), until the delinquent records are completed.

The MEC may also deny the physician any prerogative to be on ER call and BBMC may report the physician to the appropriate State Licensing Board.

c) Continuing Responsibilities of Physicians on Medical Records Suspension.

(i) Physicians under Medical Records Suspension (other than those practicing by shifts) shall continue to provide the following care:

A. ER-Call and admissions resulting from such ER-Call, unless MEC has suspended the physician's ER-Call privileges.

B. Routine care for his/her own patients already in the Hospital at the time of suspension. ("Routine care" does not include consultations, invasive procedures or surgery assist.)

C. Prompt emergency care for Hospital patients requiring medical services. The physician's department will review the appropriateness of the "emergency care" designation.

(ii) Suspended physicians must provide cover by one or more physicians with appropriate privileges to assume his/her patient care duties, including ER-call if the MEC has denied the physician the prerogative to cover call.

d) Prohibited Circumvention. If a suspended Staff member admits a patient under another Staff physician's name and exercises any clinical privileges with respect to the hospitalized patient, the MEC will refer the matter to the appropriate clinical department committee for disciplinary action.

e) Permanent Loss of Privileges. Recurring or continuing violation of the HIMS Rules and Regulations may result in further disciplinary action by the MEC.

4.0 ORDERS: PHYSICIAN RESPONSIBILITIES

4.1 DEFINITIONS, PRIORITIES

4.1.1 "Standing Order" means a clinical department-approved protocol for therapeutic and diagnostic orders (See 4.7) An individual physician's order overrides a standing order.

4.1.2 "Pre-Printed Order" & "Pre-Printed Order Set" means a Hospital-approved form for specific types of orders that provide the ordering practitioner with options. Medical staff members should write orders on pre-printed forms when available. Checked options with no modifications need no initials, provided the ordering physician authenticates, dates and times the last page of the order set and indicates the number of pages in the order set and initials or signs every page on which modifications were made.

4.1.3 "Preference Card" means an individual medical staff member's written preferred treatment protocols for a specified diagnosis.

4.2 WRITTEN ORDERS. Whenever possible, orders are to be entered directly into the electronic medical record (EMR).

4.2.1 When the EMR is unavailable, orders are to be written on Banner Health Order form(s), and must be legible, dated, timed and authenticated.

4.2.2 If Physicians or providers do not have the ability to access the EMR to input orders themselves, or if a delay in accepting the order could adversely affect patient care, telephone/verbal orders may be accepted by appropriate facility personnel. Faxed orders are acceptable provided that they are signed, timed and dated (exceptions exist for certain outpatient diagnostic orders).

4.2.3 All orders should be reviewed and continued or discontinued when a patient is transferred from one level of care to another (e.g., from the Emergency Department to an inpatient unit, to or from intensive care units, and/or pre and post-surgery). An order entered into Cerner will be continued until such time as the order is discontinued or modified.

4.2.4 Only orders entered into Cerner will continue after surgery. Orders that are handwritten prior to surgery that are to be resumed after surgery must be ordered electronically after surgery.

4.2.5 Orders as originally written cannot be changed or added to at some future time. When it is necessary to change an order, it must be rewritten with the current date.

4.2.6 Nurses have the responsibility of questioning any order that they feel might harm the patient.

4.2.7 Order which are not legible will be clarified with the responsible physician or provider before they are carried out.

4.3 BBMC PRIVILEGES REQUIRED.

4.3.1 Rule: Orders for medications, diagnostic procedures and treatments require appropriate BBMC clinical privileges or formal BBMC authorization.

4.3.2 Exception: Non-Member Practitioner Orders for Non-Invasive OP Diagnostic and Therapeutic Procedures.

4.3.2.1 Orders for Outpatient tests/procedures may be accepted from physicians licensed either in Arizona or in another state; and from PA and NPs licensed in Arizona.

4.3.2.2 The Hospital rather than the Medical Staff will be responsible for verifying and documenting the practitioner's eligibility for making such orders. Documentation should consist of a copy of current license and/or on-line verification of current license.

4.3.3 A signed order must be received prior to performing outpatient procedures/tests. Orders are valid for the length of the ordered therapy or one year, whichever is shorter.

4.3.4 A statement of the reason for the test and/or diagnosis must be indicated on the order and it must also be signed, timed and dated by the practitioner ordering the test. Orders to "rule out [X]" are not sufficient.

4.3.5 The following facsimiles or original orders are accepted:
- 4.3.5.1 Outpatient scheduling form
- 4.3.5.2 Prescription forms
- 4.3.5.3 Referral forms (can be payor specific)
- 4.3.5.4 Notation in patient's history and physical
- 4.3.5.5 Provider order sheet
- 4.3.5.6 Provider office letterhead (stationery)

4.4 INPATIENT ORDERS OF A NON-PHYSICIAN: Orders by non-physicians for inpatient services must be cosigned or authenticated consistent with Rule 3.2.8

4.5 VERBAL ORDERS.

4.5.1 Verbal orders should be used infrequently, and are discouraged except in the case of emergency.

4.5.2 All verbal orders must be written by the person receiving the order or entered into the EMR; they must identify the ordering practitioner's name; and must be authenticated (countersigned) by the ordering practitioner within 72 hours or prior to discharge, whichever comes first.

4.5.3 Only qualified practitioners authorized by Hospital policy may accept and transcribe verbal orders.

- 4.5.3.1 Except as next provided, verbal orders will be accepted only by a registered nurse (RN) or licensed practical nurse (LPN).
- 4.5.3.2 The following categories of professionals may accept verbal orders provided the orders are directly related to their specialized discipline:
  - a) Registered Pharmacists
  - b) Licensed Respiratory Care Practitioners (RCP)
  - c) Occupational Therapists
  - d) Physical Therapists
  - e) Registered Dietitians
  - f) Speech Therapists
- 4.5.3 In areas other than nursing units, certain telephone orders may be taken by the personnel in each department most qualified to accept them. The director of the department will be responsible for the acceptance of such orders, and for the designation, if necessary, of personnel with the appropriate skills to accept telephone orders. All such orders will be strictly limited to the area of expertise of the department. Bed placement, registration staff and unit secretaries may accept admission orders from physicians only related to the type of bed needed (telemetry vs ICU, etc.) and specifying the reason for the admission.

4.5.4 Telephone orders for treatment of inpatients must be given by a Medical Staff member or a practitioner delegated by the member licensed and credentialed to prescribe such treatment.

- 4.5.4.1 Registered Pharmacists are permitted to give telephone orders under physician-ordered pharmacotherapy consultation.
- 4.5.4.2 Office staff are not permitted to give telephone orders.

4.5.5 Patient safety requires that telephone and verbal orders be "read back" by the person who receives the information.

4.6 MEDICATION ORDERS: PHYSICIAN RESPONSIBILITIES. All therapeutic/pharmacologic substances that are applied, ingested, inhaled or injected must be ordered, regardless of the origin of the substance and must be dispensed for each use by the hospital pharmacy. (Banner "Safe Medication Practices Policy")

4.6.1 Required Contents of Medication Orders:

- 4.6.1.1 Rule: Medication Orders must include:
  - a) Medication Name (including special nomenclature for sustained-release or delayed action dosage forms, e.g. "CD", "XR", etc.)
  - b) Exact strength (metric weight or concentration) of dosage, where applicable (not "1 amp")

c) Dosage [i] amount and [ii] form (if available in a form other than an oral solid), taking into account the clinical status of the patient,

d) Route of administration

e) Dosage (i) Frequency and, if applicable, (ii) duration and/or (iii) number. Certain medication orders that do not specify the duration or number of doses are subject to an automatic stop order (see 4.8.2).

4.6.1.2 PRN Orders: A PRN schedule for a medication will not be assumed unless written as "PRN". All PRN orders must include a frequency and indication (e.g., every 4 hours PRN pain).

4.6.1.3 Range Orders:

a) Range orders permit varying dose or dosing interval over a prescribed range depending on the situation or patient status. Range orders are discouraged, but permitted if indicated.

b) Physician order must specify indication and appropriate dose range and frequency suitable for the specific medication.

4.6.1.4 Outpatient: Outpatient prescription orders should include a brief note or purpose (e.g., nausea), unless considered inappropriate by the prescriber.

4.6.2 Notation, Abbreviations:

4.6.2.1 All prescription orders must be legible.

4.6.2.2. No abbreviations or "slang" terms are to be used for medication names. Abbreviations on the DO-NOT-USE ABBREVIATIONS AND SYMBOLS list MUST NOT BE USED.

4.6.2.3 All prescription orders should be written in the metric system, except for therapies such as insulin, vitamins and heparin that use standard units. The word "Units" should always be spelled out. The abbreviations "ML" should be used in place of "CC".

4.6.2.4 A zero should always precede a decimal expressing less than one (e.g., 0.1 mg NOT .1 mg). A terminal zero must not be used after a decimal. (e.g., 1 mg NEVER 1.0 mg).

4.6.3 Prescriber Identification: Prescriber's name/signature must be legible and the name should be either printed or stamped, in addition to the signature. In addition, the prescriber should also include contact information (telephone or pager number, etc.) for pharmacist or nurse when questions arise about the prescription, unless such contact information is already readily available. (Banner "Safe Medication Practices Policy")

4.6.4 Orders are Required for Medications Brought by Patient

4.6.4.1 Medications (OTC or prescribed) brought by patients into the hospital may not be administered unless unavailable in the Pharmacy and the treating physician writes a specific order satisfying 4.6.1 above.

4.6.4.2 Self-administration of any medication and keeping a medication bedside require A specific order. (Banner "Safe Medication Practices Policy")

4.7 STANDING ORDERS AND PROTOCOLS

4.7.1 Use. To ensure uniformity of care for patients in particular situations, physician orders may be standardized or protocols may be adopted for specific procedures, diagnostic workups or therapies. Once approved, they are implemented unless expressly overridden by the physician.

4.7.2 Standing Order Adoption. Individual Departments may adopt standing orders, which should be included with their Rules and Regulations and reviewed annually for pertinence.

4.7.3 Standing Order Authentication. All standing orders must be authenticated by an authorized practitioner.

4.7.4 Protocol Adoption. Protocols must be approved by the Medical Executive Committee.

4.8 AUTOMATIC STOP ORDERS

4.8.1 For Labs & X-RAYS: All daily lab and chest X-ray orders shall be discontinued automatically after three (3) days, unless:

a) the order specifies an exact period of time,
b) the attending physician reorders the daily lab, or
c) the physician has not been notified before the discontinuance.

4.8.2 For Drugs

a) The Pharmacy and Therapeutics Committee is responsible for determining which medications and medication categories are required to be automatically stopped unless the prescriber specifies otherwise.
b) Pharmacy Services will automatically review medication orders for duration of therapy.
c) Prescribers will be contacted regarding the need to discontinue or reorder medications based on clinical assessment and laboratory findings, unless the medication order indicates the exact number of doses to be administered or an exact period of time for the medication is specified.

4.9 RESTRAINT ORDERS

4.9.1 Restraints require a physician's order. PRN orders are not acceptable.

4.9.2 "Restraints" include both medications and physical means of restricting freedom of movement or normal access to one's body.

4.9.3 A restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

4.9.4 An order is required before initiating each episode of restraint and/or seclusion, and must be renewed within specific time and may not exceed 24 hours.

4.9.5 See Banner Health policies Restraint Use in Violent Situations and Restraint Use in Non Violent Situations.

5.0 CONSULTATIONS AND REFERRALS: PHYSICIAN RESPONSIBILITIES

Good medical practice includes proper and timely use of consultations and effective communications among treating and consulting physicians.

Because BBMC does not have a mandatory-consultation roster, Attending Physicians are responsible for arranging for necessary consultations.

5.1 CHOOSING A CONSULTANT. Except as noted at 5.3.1, the Attending Physician selects the Specialist consultant or referral ("Consultant") in consultation with the patient and:

5.1.1 if the patient has a current relationship with (and wishes to use) the appropriate BBMC Medical Staff specialist, use the patient's existing specialist.

5.1.2 if the patient's health plan does not provide an appropriate Consultant, the choice of appropriate Specialist is at the sole discretion of the ordering physician based on his/her judgment and opinion of the Specialist's clinical performance and ability to provide the needed care.

5.2 PROCEDURES FOR ORDERING CONSULTATIONS:

5.2.1 Physician orders for a consult should be on an order sheet and state:

a) The name of the consultant;

b) The purpose of the consult;

c) The urgency of the consultation:

STAT	(IMMEDIATE)
URGENT	(<6 HOURS)
ROUTINE	(<24 HOURS)

d) If not ordered by the attending physician, that the attending has been notified.

5.2.2 The ordering physician should communicate directly with the consultant.

a) *Stat and Urgent consults*: The requesting Physician is required to contact the consultant.

b) *Routine consults*: The requesting physician is encouraged to have physician-to-physician contact.

5.2.3 The requesting physician must personally obtain a consultant:

a) If he/she does not name the consultant

b) If the named consultant refuses the consult

5.2.4 A consultant requiring more information than is available in the Consult order should contact the requesting physician.

5.3 AUTHORITY TO ORDER CONSULTATION

5.3.1 Attending Physician. The Attending Physician is primarily responsible for calling for a consultation. Unless otherwise directed by the Attending, Consultants may also order consultations, but Consultants must advise the Attending on both the need for and choice of Consultant.

5.3.2 Department Chair, Medical Staff President. The department chair (or Staff President (designee)) may order a consultation:

a) if he/she believes it is required and the Attending Physician has failed to obtain the consultation and

b) the patient agrees.

5.3.3 Requirements for Others:

a) Nursing personnel and Allied Professionals are not authorized to order consultations without authorization of the Attending Physician.

b) After consulting with the Attending Physician about the need for consultation, nursing personnel and Allied Professionals who believe that the Attending Physician is not

seeking appropriate consultation may contact the appropriate department chair (or the Staff President/designee) about the need for such consultation.

5.4 CRITERIA FOR ORDERING CONSULTATION. Unless the attending physician's expertise is in the area of the patient's problem, consultation is recommended when a significant question exists about:

5.4.1 appropriate procedure or therapy,
5.4.2 possible treatment/operative risks,
5.4.3 diagnosis,
5.4.4 psychiatric and behavioral issues, or
5.4.5 when requested by the patient.

5.5 CONSULTATION REPORT SHALL:

5.4.1 report the consultant's findings, opinions and recommendations,
5.4.2 document that the consultant examined the patient, as appropriate, and reviewed the medical record;
5.4.3 be documented (handwritten or dictated) within 24 hours of the consultation and, if the consultation pertains to the decision to operate, before the operation (except in a documented emergency). NOTE: If dictated, the consultant must also immediately note initial findings in the patient's chart.

5.6 REFERRALS. It is important for every specialist to whom a patient is referred to communicate in a timely fashion with the referring physician about the examination or procedure and about recommendations for further treatment. If the referring physician wishes the specialist to take any specific action, he/she should discuss that with the patient and communicate the request on the referral. The specialist must document any deviation from an express request and so notify the referring physician.

5.7 PATHOLOGY CONSULTATION. A member of the Pathology Department is available at all times for consultation on diagnostic problems in clinical pathology as well as about point of care (e.g., bedside) testing and ancillary-testing programs as defined in the hospital's license.

5.8 PROFESSIONAL RELATIONS - Medical Staff members who have complaints about operational matters, or who question the professional judgment or conduct of an individual Medical Staff member or Hospital personnel should communicate their opinion as follows:

5.8.1 Medical Staff members should communicate their concerns about other members confidentially to the Director of the Medical Staff Services, who will protect the confidentiality of both the information and the reporting physician to the extent possible; and will forward the information to the appropriate Section or Department Chair for review
5.8.2 Medical Staff members should attempt to resolve concerns about Hospital personnel and operations when and where the issue arises and in a respectful manner, either directly with the person in question or with that person's immediate supervisor. If the problem cannot be resolved at that time, members should communicate their concern:
(a) via transmittal form, or
(b) using the Hotline, or
(c) directly to the CNO or Administrator on Call, so that an Administrator can resolve the problem promptly.

6.0 TRANSFER, DISCHARGE AND TRANSPORT: PHYSICIAN RESPONSIBILITIES

6.1 TRANSFER FROM HOSPITAL TO ANOTHER FACILITY

6.1.1 Treating Physician Responsibilities. The attending physician:

a) Must write an order for any transfer or discharge.
b) Must discuss with the patient the risks and benefits of the transfer.
c) Must ensure that the patient is assessed for stability and clinical needs prior to transfer.
d) Must appropriately document pertinent medical record information in the medical record prior to transfer.

6.1.2 Definition. "Transfer" means (a) discharge and sending of an inpatient to another hospital for inpatient medical services; or (b) termination of acute hospital services and transfer to a lower level of care.

6.2 TRANSFERS WITHIN THE HOSPITAL

6.2.1 Between Medical Staff Members. Transfers of primary responsibility are not effective until (I) documented on the order sheet or other appropriate place in the record by the transferring physician AND (II) accepted by the physician assuming the primary care of the patient.

6.2.2 From One Unit to Another. Patient transfers from one unit to another or to place a patient in observation or extended recovery require an order by the treating physician and the rewriting of orders by the Medical Staff member responsible for the patient in the receiving unit.
Exceptions:

a) Surgeons' orders written immediately post-surgery in the OR or PACU.
b) Orders for a patient who transfers because of room availability or other administrative reason and not because of the difference between the levels of medical care on the two units.

6.2.3 Transfers for Tests, Services, Therapy, and Procedures. A physician or physician extender order is required to transfer a patient for all tests, services, therapy and procedures. Exceptions may be made through a Medical Staff approved Standing Order or Protocol.

6.3 DISCHARGE

6.3.1. Treating Physician Responsibilities. The treating physician [or authorized designee]:

a) Must write an order for discharge of a patient from the Hospital prior to discharge, and include detailed follow-up and care instructions.
b) Must sign the discharge summary that includes a description of the patient's medical condition and the medical services provided.

6.3.2. Definition. "Discharge" means termination of Hospital services to an inpatient or outpatient.

6.4 TRANSPORT

6.4.1 Treating Physician Responsibilities. The treating physician:

a) Must write an order for the medical service necessitating the transport.
b) Must explain the risks and benefits of the transport and obtain patient consent if the other facility is not in close proximity and does not routinely provide the requested services to BBMC inpatients and if the consent is not documented in the conditions of admission. If consent cannot be obtained, document reasons.
c) Should ensure that the patient is assessed for stability and clinical needs prior and subsequent to transport in the case of transport to another facility.

6.4.2 Definition. "Transport" means sending an inpatient to another healthcare institution for medical services with the intent of returning the patient to the Hospital.

7.0 EMERGENCY ROOM: PHYSICIAN RESPONSIBILITIES

7.1 CALL SCHEDULE.

7.1.1 General. An up-to-date call schedule shall be maintained by the Medical Staff and shall be posted in the Emergency Medicine Departments at all times. This shall be distributed to the on-call physicians one (1) month in advance of its activation and shall be accessible via the Banner Health Intranet website and Medical Staff Services. A call-rotation is from 7 a.m. until 7 a.m.

7.1.2 Who is on the Call Schedule? The call schedule shall list by designated specialty:

a. all physicians (by name, not the group's name) in Staff membership categories required by their departments to take Emergency Room Call and

b. all qualifying physicians who volunteer for ER call through Medical Staff Services.

7.1.3 Substitutions.

a. A physician who is unable to take call for a specific scheduled rotation is responsible for finding a substitute physician member of the medical staff with appropriate privileges for that rotation and for notifying Medical Staff Services (during business hours) or the ED (after hours) of the substitution.

b. Any Staff physician with privileges in the same specialty may assume call for assigned physicians if requested by that physician.

c. The Medical Staff Services Department will make the necessary changes on the call schedule and notify the ED (during business hours).

7.1.4 Response Time. When "on call," a physician shall be available for service by telephone or in person within twenty (20) minutes of the time a call is placed to him/her by the Emergency Medicine physician.

7.1.5 Failure to Respond Appropriately.

a. "On call" physicians who fail to cooperate in rendering appropriate emergency care, regardless of patient's ability to pay, shall be subject to disciplinary action by the Executive Committee.

b. Failure to respond within the specified length of time (twenty minutes), shall cause the Emergency Medicine Department physician to report the on-call physician (through Medical Staff Services) to his/her department committee for review and appropriate action to ensure future compliance.

c. If a patient transfer to another facility is necessitated by failure of the on-call physician to respond or cooperate, the ED must report the on-call physician's name to the receiving hospital pursuant to federal law.

7.1.6 Cover.

a. A physician is permitted to schedule elective surgeries during a scheduled ER-call rotation, provided the physician arranges for appropriate back up coverage.

b. A physician is permitted to be on-call at two hospitals simultaneously, provided the physician arranges for appropriate back up coverage.

7.1.7 Use of Call Schedule. The call schedule is used exclusively by the Emergency Medicine Department physician for follow-up care, consultations and admissions for all unassigned patients.

7.1.8 Follow-up Care. Follow-up care for Hospitalist/Internal Medicine ED Call is included on the "on call" schedule and is voluntary. Rules of Participation:

a. The physician must be a member of the Medical Staff;

b. The physician must agree to treat patients who are discharged from the Emergency Department for at least one visit regardless of ability to pay;

c. The physician must offer patient appointments within 72 hours of discharge; and

d. The physician must sign the written participation agreement.

7.2 NON-AVAILABILITY OF ON-CALL PHYSICIAN: In the event the on-call physician is not available or refuses or fails to respond in a timely manner, the ED physician shall call:

7.2.1 another physician to render care to the patient in the ED, and/or
7.2.2 Banner Transport Services, and /or
7.2.2 the on-call physician's Department Chair for assistance, and/or
7.2.3 the Chief Medical Officer for assistance, and/or
7.2.4 the Regional Patient Placement Office to facilitate the patient's transfer.

7.3 TRANSFER OF PATIENT TO ATTENDING PHYSICIAN. When the Emergency Department physician contacts the attending physician and after acceptance of the patient admission, the attending physician is then responsible for the continued care of that patient. This transfer of care occurs at the time of the phone call/conversation between the physicians and is not related to the actual physical location of the patient. However, if the patient remains physically in the Emergency Department, the Emergency Department physician will intervene in an emergency situation. Nursing staff will be directed to contact the accepting physician for non-emergency orders, and/or changes in patient's condition.

7.4 UNASSIGNED PATIENTS: RESPONSIBILITIES OF SCHEDULED ON-CALL PHYSICIAN

7.4.1 Scheduled on-call physicians are responsible for caring for unassigned patients referred to them by the ED physician, regardless of the patient's pay status. The ED Physician shall determine which clinical specialists' professional medical services are required to treat the unassigned patient.

7.4.2 For purposes of these Rules and Regulations, an "unassigned patient" is a patient with an emergency medical condition:

a) who has no preference for or current relationship with a BBMC specialist or attending physician (e.g., hospitalist or hospitalist group); or
b) whose BBMC treating physician has no preferred BBMC hospitalist or hospitalist group;
c) whose health plan has no preferred BBMC hospitalist or hospitalist group, or
d) who would be an assigned patient but for the physician's unavailability, as determined by the ER Physician (in the ED) or the OB Chair (in L&D), or
e) for whom the determination of whether the patient is assigned would delay the medical screening exam or necessary stabilizing treatment.

7.5 COMMUNITY CALL PLAN. The call schedule may include physicians from one or more other hospitals; all serve their rotation at their own hospital, provided BBMC is participating in the "Community Call Plan" (CCP). Under the CCP, if a patient in the BBMC ER requires the specialty services that are scheduled for a different hospital, BBMC must still provide a medical screening exam and stabilizing treatment within its capabilities before transferring the patient.

7.6 PHYSICIAN RESPONSIBILITY FOR EXISTING PATIENTS PRESENTING TO E.R.:
Circumstances permitting, the ER must attempt to determine whether an ER patient has an existing relationship with a BBMC Medical Staff member ("Treating Physician"). Each department shall define "existing patient" in its departmental Rules. Medical Staff members must respond to call from the ER regarding patients with whom they have an existing physician-patient relationship.

7.6.1 If a Treating Physician has been called by the Emergency Medicine Department regarding an existing patient, and no response has been received within twenty (20) minutes, another attempt will be made to contact the Treating Physician, however, the Emergency Medicine Department physician must institute treatment.

7.6.2 If the Treating Physician has not responded by the end of another twenty (20) minutes, and if further referral of the patient is required, the Emergency Medicine Department physician may contact the on-call physician in the appropriate specialty, rather than waiting for the Treating physician to express a preference.

7.6.3 The on-call physician in the Treating Physician's specialty may be contacted if circumstances so require.

7.6.4 The ER shall refer a Treating Physician to his/her department committee for review for failure to respond within 20 minutes of a second call.

8.0 SURGICAL & OTHER PROCEDURES: PHYSICIAN RESPONSIBILITIES

8.0.1 General. This Chapter describes responsibilities of physicians (whether or not surgeons) performing procedures using moderate or deep sedation or anesthesia anywhere in the Hospital and those physicians responsible for administering the sedation or anesthesia.

8.0.2 Definitions. In this chapter:
"Surgical procedures" or "procedures" include procedures using moderate or deep sedation or anesthesia anywhere in the Hospital.
"Surgeon" means any physician responsible for performing the "surgical or other procedure" and may include, for example, gastroenterologists, radiologists, anesthesiologists and gynecologists.

8.1 SCHEDULING IN THE O.R., L&D AND ENDOSCOPY

8.1.1 Elective Cases.
- a) Only the "Surgeon" or his/her office may schedule elective cases. The scheduling "Surgeon" must specify the procedure and estimate the time required for the procedure.
- b) The "Surgeon" is responsible for identifying and obtaining the anesthesiologist.
- c) The Hospital may cancel Surgical procedures substantially delayed by the "Surgeon's" non-appearance.

8.1.2 Emergency Cases.
- a) Only the "Surgeon" or his/her office may schedule emergency cases.
- b) Emergency cases take precedence over other procedures and are to be performed as soon as a room is available.
  1. Emergency cases are accommodated either by "bumping" a scheduled case or by opening an additional O.R.
  2. Disputes as to priority or emergency will be resolved by the chairman of the appropriate department committee or the CMO if the chairman is not immediately available.
- c) The "Surgeon" should personally request the physician whose case is to be bumped to permit the change.

8.2 PRE-PROCEDURE:

8.2.1 Consents. The physician is responsible to obtain informed consent for the procedure, sedation or anesthesia, and blood or blood products and to verify that the correct procedure has been indicated in accordance with Rule 3.2.5.

8.2.2 Sedation Orders. Only physicians with appropriate sedation privileges may order moderate and deep sedation.

8.2.3 Assessments.
- a) Pre-Operative Diagnosis. Prior to Surgical procedures, the "Surgeon" is responsible for:
  1. Documenting the preoperative diagnosis in the medical record and
  2. Reviewing any relevant results of lab studies, imaging and other diagnostic tests and H&P in the medical record. (See Rule 3.2.2 for H&P deadlines)
- b) Pre-Sedation Assessment. The physician with sedation privileges who orders moderate or deep sedation is responsible for:
  1. Ensuring appropriate patient assessment immediately prior to sedation,
  2. Being present in the room during initiation of moderate or deep sedation administration. (See 8.3.1(b) for post-initiation responsibilities.)
- c) Pre-Anesthesia Assessments are governed by Anesthesiology Department Rules.
- d) Anesthesia Medication Orders. Anesthesia medication orders given by the anesthesiologist performing the case will take precedence over pre-anesthesia medication orders.

8.2.4 Wrong-Patient/Site/Procedure ("Universal Protocol"). Before starting the procedure, "Surgeons" must:

a) Review relevant documents and studies and document the site of the procedure in (a) orders and (b) H&P.

b) Mark the site together with the patient, in cases involving right/left distinction, multiple structures (e.g., fingers, toes) or levels (e.g., spine).

c) Take a "time out" for verbal agreement with anesthesiologist and preoperative nurse on the correct site, patient, procedure and any implants.

8.3 POST-PROCEDURE:

8.3.1 Monitoring.

Anesthesia Patients. Anesthesiologists monitor patients according to departmental Rules.

8.3.2 Surgical Tissue and Foreign Bodies. Operatively removed tissue and foreign bodies must be sent to the Pathology Department with pertinent clinical information. See **Rule 8.5** for exceptions.

8.3.3 Documentation.

a) Comprehensive Post-Operative Progress Report.

Immediately after an invasive diagnostic or therapeutic procedure, a surgeon must:

1) Ensure a post-operative note is in the record that includes
   a) Date and time of surgery
   b) Post-operative diagnosis
   c) Surgeon
   d) Assistant surgeon (if applicable)
   e) Technical procedures used
   f) Findings and specimens removed
   g) Estimated blood loss, and

2) Dictate a detailed post-operative report which includes:
   a) Pre-op and post-operative diagnosis
   b) Specific procedure(s) performed
   c) Surgeon
   d) Assistant surgeon (if applicable)
   e) Other practitioners who performed surgical tasks
   f) Indications for procedure (unless documented elsewhere in the record)
   g) Findings and specimens removed or altered
   h) Description of procedure and techniques used
   i) Type of anesthesia administered In anesthesia record
   j) Intra-operative complications
   k) Estimated blood loss
   l) Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

8.4 PRE-OPERATIVE, INTRAOPERATIVE & POST ANESTHESIA/SEDATION RECORD FOR GENERAL, REGIONAL OR MONITORED ANESTHESIA

8.4.1 Pre-Operative Anesthesia/Sedation Evaluation – A pre-anesthesia/sedation evaluation must be conducted and documented by an individual qualified to administer anesthesia or conscious sedation within 48 hours prior to the procedure. A pre-anesthesia/sedation evaluation of the patient must include review of the medical history, including anesthesia, drug and allergy history; review and examination of the patient; notification of anesthesia risk (per ASA classification); identification of potential anesthesia problems, particularly those that suggest potential complications or contraindications; additional pre-anesthesia as applicable; and development of the plan for anesthesia care, including type of medications for induction, maintenance, and post-

operative care and discussion with the patient of risks and benefits. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before pre-operative medication has been administered. Immediately prior to the induction of anesthesia while the patient is on the procedural table, the patient's vital signs, airway and response to pre-procedure medication must be assessed and the equipment checked.

8.4.2 The intraoperative anesthesia/sedation record will also include the name of the practitioner who administered anesthesia and the name of the supervising anesthesiologist or operating practitioner; techniques used and patient position(s), including the insertion/use of any intravascular or airway devices; name and amounts of IV fluids, including blood or blood products if applicable; time-based documentation of vital signs as well as oxygenation and ventilation parameters; and any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

8.4.3 The post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services and, for outpatients, prior to discharge. The record must include respiratory function, including respiratory rate, airway patency and oxygen saturation; cardiovascular function, including pulse rate and blood pressure; mental status; temperature, pain; nausea and vomiting; and postoperative hydration.

8.5 REQUIRED PATHOLOGY DEPARTMENT EXAMINATION

8.5.1 Examination Required: Rule. All tissues removed by biopsy or at operation anywhere in the Hospital must be sent to the Department of Pathology accompanied by pertinent clinical information. A written report of each examination is automatically included in the patient's chart.

8.5.2 Exceptions. Specimens that by their nature or condition (as determined by the Pathology Department) do not permit meaningful examination are not sent for examination.

8.6 VISITORS AND OTHER INDIVIDUALS

8.6.1 Visitors. Visitors are permitted subject to and in compliance with the Banner Observers policy. For surgical procedures, prior patient consent and approval of the Surgeon and Anesthesiologist are required.

8.6.2 Vendors & Industry reps:

a) Presence of a vendor/industry representative requires prior patient consent and approval of the Surgeon, Anesthesiologist and the Administrator or O.R. Director.

b) Vendors and industry representatives must be credentialed by Banner Health as to their training if their expertise may be relied on during the procedure. Under no conditions may a vendor or industry rep scrub in.

8.7 SURGICAL ASSISTANTS, QUALIFICATIONS. The qualifications of the appropriately credentialed assistant are at the discretion of the "Surgeon," taking into consideration his/her opinion of the best interests of the patient, the wishes of the patient and the opinion of the referring physician.

8.8 STATES OF CONSCIOUSNESS: The continuum of consciousness from the undrugged state to deep anesthesia falls roughly into four states. (Privileges are required for 8.8.2 - 8.8.4, and the surgeon or other practitioner performing a procedure requiring moderate sedation or more must have admitting (or co-admitting) privileges, in accordance with Bylaws Section 7.5)

8.8.1 Minimal Sedation (Anxiolysis) - A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

8.8.2 Moderate Sedation/Analgesia ("Conscious Sedation") – A drug-induced depression of consciousness during which patients respond purposefully to verbal commands (note: reflex withdrawal from a painful stimulus is not considered a purposeful response)-- either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

8.8.3 Deep Sedation/Analgesia ("Unconscious Sedation") – A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

8.8.4 Anesthesia – Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

9.0 INFECTION CONTROL: PHYSICIAN RESPONSIBILITIES

9.1 HANDWASHING. All Medical Staff must wash their hands in a manner approved by the Infection Control Committee before and after they examine patients or perform procedures.

9.2 ISOLATION & PRECAUTIONS: Nursing personnel will inform the physician of the isolation or other infection-control precautions taken and alert the physician of the need to adhere to specified precautions, consistent with the CDC's Isolation Precautions Standards.

9.3 DIAGNOSING INFECTIONS. Medical Staff members who suspect their patient may have a communicable infection are expected to order appropriate studies sufficient to diagnose or rule out conditions requiring isolation.

9.4 RESTRICTED ANTIBIOTICS. To ensure that antibiotics are used to the best advantage for individual patients and with the smallest impact upon the Hospital environment, the use of certain antibiotics may be limited by the MEC.

9.5 REPORTABLE COMMUNICABLE DISEASES. The BBMC Infection Control Specialist reports communicable diseases as required by Arizona law, and will determine whether a disease is required to be reported, upon being provided with the pertinent patient information.

9.6 INFECTION CONTROL POLICIES. Medical Staff members may access Banner infection control policies via the Banner Intranet available at every nursing station.

9.7 STANDARD PRECAUTIONS . It is Hospital policy to consider the blood of every patient as potentially infected with bloodborne pathogens. Medical Staff Members must utilize personal protective equipment as described below.

9.7.1 Gloves. Medical Staff Members must wear gloves when:

a) Drawing blood;

b) Handling bloody materials during and after:
surgery,
trauma repair,
pathological examinations and autopsies;

c) Having contact with blood or body fluids or materials contaminated thereby;

d) Cleaning incontinent patients.

e) Changing surgical, wound, or other type of dressing

9.7.2 Face Shields. Medical Staff Members must wear face shields or masks and eye coverings in all situations in which blood contamination of the mouth, face or eyes might be anticipated.

9.7.3 Gowns. Medical Staff Members must wear impervious gowns or aprons in all situations in which contamination of the clothing by blood or body fluids might be anticipated.

9.8 CONFLICT RESOLUTION. The Infection Control Committee through its chair is authorized to institute prevention or control measures when there is reason to believe that patients or personnel are in danger. Intervention that impacts a specific patient is permitted after diligent efforts to involve the attending physician, in accordance with Bylaws 11.5.2.10.

9.9 HIV-INFECTED PATIENT

9.9.1 Isolation. Patients known to be HIV-positive are not isolated solely on that basis.

9.9.2 Testing. Prior informed consent is required for testing. (BBMC makes a form available, see 10.2.1.b.)

9.9.3 Warning Third Party at Risk; Communication. Without a written informed consent, Medical Staff members may not disclose a patient's HIV status or whether or not a patient has been tested for HIV, absent an applicable exception. The Department of Health Services notifies third parties at risk of infection from a patient; and the Hospital makes any required reports to DHS.

9.10 HIV/HBV/HCV-INFECTED HEALTH CARE WORKER.

9.10.1 Voluntary Testing. Medical Staff members who are infected and perform exposure-prone invasive procedures should take appropriate precautions. Voluntary consultations are available to assist in determining the advisability of any additional patient protections or discontinuing performing the procedure. If a Medical Staff member who is infected with HIV does not use standard precautions that any physician (infected or not) would use, the Medical Staff member can be sanctioned by the MEC.

9.10.2 Definition: "Exposure-prone invasive procedures" are invasive procedures, the performance of which presents a recognized risk of percutaneous injury to the health care worker that is likely to cause the HCW's blood to contact the patient's body cavity, subcutaneous tissues and/or mucous membranes.

10.0 DECISION-MAKING: TREATMENT REFUSAL, CONSENT: PHYSICIAN RESPONSIBILITIES

10.1 PATIENT DECIDES

10.1.1 The patient (rather than a physician or hospital) has the right to accept or reject medical treatment. (The physician has no duty to provide medically unnecessary or inappropriate treatment or services.)

10.1.2 "Patient" in the context of informed consent and decision-making means the person with authority to make health care decisions on behalf of the patient, e.g., surrogate.

10.2 CONSENT.

10.2.1 Consent Is Required for Medical Treatment. (Exception: Emergencies (see 3.2.5(b))

a) General Consent. On admission, the Hospital obtains a patient's general consent for treatment, which allows physicians to order routine diagnostic tests for a patient.

b) Specific Consent. The physician(s) performing a procedure and/or administering sedation, anesthesia or blood products is responsible for ensuring that additional specific written informed consent is obtained for any non-routine diagnostic or treatment procedure. (See Rule 3.2.5)

* Because Arizona has special informed-consent rules for HIV testing, the Hospital makes available written consent forms. (see 9.9.2)

c) Implied Consent. Consent to treatment may be implied in an emergency (see 3.2.5(b)) to the extent necessary to remedy the condition creating the emergency, unless the patient is known to have refused the treatment in question when he/she had decisional capacity

10.2.2 Consent must be "INFORMED" The physician responsible for obtaining consent must take steps to ensure the patient understands all material consequences of both positive and negative results or outcomes as well as alternative treatments and the prognosis with and without treatment.

10.3 DECISION-MAKING CAPACITY. Who is the appropriate person to make the treatment decision?

10.3.1 Adults. Adult patients (18 and over) generally have the right to refuse/accept medical and surgical treatment. Legally authorized representatives can act for incapacitated adults. (See 10.5)

10.3.2. Minors.

a) Minors (under 18) generally lack capacity to consent. Exceptions:

1) Emancipated minors, e.g., minors who are court-ordered; or veterans; or pregnant; or married (or previously married); or living away from home and completely self-supporting (unless under court-ordered custody); or homeless and living apart from parents/guardians. The physician should document the bases for determining that a minor is emancipated.

2) Any mature minor may consent to HIV testing.

3) Any minor may consent (i) to treatment for a STD or a dangerous drug or narcotic, or (ii) to examination, diagnosis and care relating to sexual assault or pregnancy.

b) If the Exceptions in preceding paragraph (a) do not apply, the minor's parent or guardian may request or refuse medical treatment on behalf of the minor. Exceptions: Arizona law prohibits the denial of medical care or treatment to an infant less than one year old, if in the physician's reasonable medical judgment the care or treatment:

1) Is necessary to save the infant's life, AND

2) Will effectively do more than temporarily prolong the act of dying, AND

3) Creates no risks to the infant's life or health that outweigh its potential benefit.

10.4 RESOURCES FOR TREATING PHYSICIANS

10.4.1 Medical Ethics Committee Consultation. A physician is encouraged to consult with the Medical Staff's Medical Ethics Committee whenever he/she is uncertain of his or her obligations under any of the Rules in this chapter or believes:

a) that the refusal of medical care by a patient's legally authorized representative is not in the patient's best interest;

b) that there are conflicts between physicians, between the physician and the patient/family members, or between family members;

c) that the refusal by a pregnant woman threatens the life or safety of a viable fetus; or

d) that the refusal by the sole parent of a minor child risks abandoning the minor child.

10.4.2. Risk Management Consultation. Risk Management is on call 24 hours a day and can assist in resolving refusal-to-consent situations.

10.5 MEDICAL DECISION-MAKING THROUGH SURROGATE OR WRITTEN DIRECTIVES

10.5.1 Policy. At the time of inpatient admission, BBMC (i) informs patients of the right to accept or refuse medical and surgical treatment and to formulate health care directives; (ii) documents whether the patient has executed a health care directive; and (iii) attempts to obtain it for the record.

10.5.2 Definitions.

a) "Health Care Directive" means a written document by a competent adult that is either (or both) a "Health Care Power of Attorney" that appoints an agent (Surrogate) to make heath care decisions or a "Living Will" that directs or guides particular future health care decisions, once the patient becomes unable to make or communicate health care decisions.

b) "Surrogate" means a person who is authorized to make health care decisions for a patient by a (1) Health Care Power of Attorney ("agent"); (2) court order ("guardian"); or statutory priority ("Statutory Surrogate").

10.5.3 Absence of Patient Representative.

a) In the absence of (1) an agent or (2) a guardian appointed by a Court to make health care decisions, BBMC will locate and contact a "Statutory Surrogate" in the following order of priority, as specified in Arizona law:

-Spouse
-Adult Child(ren)
-Parent
-Domestic Partner
-Brother or Sister
-Close Adult Friend

Statutory Surrogates are not permitted to decide to withdraw food or fluid.

b) If BBMC is unable to locate a willing Surrogate within a reasonable time, the attending physician may make health care treatment decisions (other than withdrawal of food and fluid) after obtaining recommendations of the standing Medical Ethics Committee, or if delay is medically inadvisable, after consulting with a second physician who concurs with the attending physician's decision.

10.5.4 Attending Physician Responsibilities for Medical Decisions Based on Health Care Directives.

a) Before implementing a decision of a Surrogate or Health Care Directive, document the basis of the determination that the patient is unable to make or communicate medical decisions. (If unsure, obtain second, documented opinion.)

b) Consult with the patient's Surrogate about the patient's health status and care to the same extent as with the patient.

c) Become familiar with the patient's treatment preferences, as expressed in the Health Care Directive, and comply with the decisions expressed in the directive or by the Surrogate. (If a Surrogate's decision is inconsistent with the patient's Health Care Directive, physician may either refuse to comply with the Surrogate's decision or consult with the Medical Ethics Committee or with Risk Management.

d) If unable to comply with decisions expressed in a Health Care Directive or by a Surrogate because the decisions violate the conscience, (inform the Surrogate and) promptly attempt to transfer the patient's care to a physician who will comply with the decisions. If unable to find a physician willing to comply, the department chairman should be contacted; if the chairman is not immediately available, the CMO should be contacted.

10.6 DO NOT RESUSCITATE; WITHDRAWING/WITHHOLDING LIFE SUPPORT

(Rules 10.1-10.5 relating to refusals to consent and to decision-making via surrogates and written directives also apply to DNR and withholding/withdrawing life support.

10.6.1. Policy:

A) A decision to withhold/withdraw one kind of life sustaining treatment does not necessarily imply that the patient is foregoing any other forms of treatment.

B) Efforts will be made to resuscitate hospital patients unless there is an attending physician's order to the contrary.

10.6.2. Definitions:

a) "Do not resuscitate (DNR)" and "No code" and "No cardiopulmonary resuscitation (CPR)" all mean:

* No basic CPR (no mechanical chest compression, no mouth-to-mouth or bag valve ventilation); and
* No endotracheal intubation; and
* No defibrillation; and
* No resuscitative cardiovascular chemical agents.

b) "Life sustaining treatment" is any medical procedure or intervention, including artificially administered food or fluid, which, in the judgment of the attending physician, if applied, would serve only to prolong the dying process, or to artificially prolong life in a permanent vegetative state or irreversible coma. Life-sustaining treatment does not include the performance of a medical procedure deemed necessary to provide comfort care.

10.6.3. Orders for DNR & Withholding/Withdrawing Life Support:

a) Prior Discussion. The attending physician must discuss the implications of the orders with the patient (surrogate) before issuing the order Specific resuscitative measures should be discussed and documented on the medical record if they differ from the definition of DNR.
Exception to prior discussion for DNR: when the attending physician determines that CPR cannot be expected either to restore cardiac or respiratory function) and time is inadequate to consult with patient (surrogate).

b) Written Orders. Written orders should be entered into the electronic medical record and authenticated by the responsible physician. Order must be unambiguous.

c) Verbal Orders. Verbal order must be witnessed by two RNs who hear the order at the same time; and be authenticated within 24 hours. Telephone orders are discouraged. However, if DNR orders must be placed by telephone, the house staff/resident or RN taking the order will have a witness on the telephone to verify and document the DNR status. Physicians will authenticate the DNR telephone order upon their next visit and document the reasons (as in Rule 10.6.4) even though the patient may have already expired.

d) Residents' Orders. DNR orders written by residents are authenticated by the responsible physician upon his/her next visit.

e) Limited Resuscitation: The specific resuscitative measures to be withheld should be documented in the medical record if they differ from the definition of DNR. "Slow" responses are not acceptable.

f) Where Care Is Not Medically Indicated: Where care is not medically indicated, without benefit or harmful, the physician may refuse to provide care requested by the patient or surrogate. See Provision of Appropriate End of Life Care policy. The physician should reinforce the advantages of allowing a natural death. The patient/surrogate must be advised that the physician intends to write a Do Not Resuscitate/Allow Natural Death (DNR/AND) order. If the patient/surrogate disagrees, he or she will be provided an opportunity to find a new accepting physician and transfer care. In the absence of a court order, a DNR/AND order may be written provided that the physician has consulted with another physician who concurs with his/her decision. The physician is not required to provide new or augmented treatment or restart treatment that had previously been discontinued. Physicians are encouraged to consult with the Medical Staff's Medical Ethics Committee. See Section 10.4.1.

g) Effect of Order: Neither DNR nor withholding-withdrawal orders affect the other medical or nursing care treatment or care orders.

h) Review of Order: The attending physician must review:
   * All DNR and withholding/withdrawal orders in light of the patient's condition whenever the patient's status changes substantially but at least every 72 hours.
   * All DNR orders with the patient (surrogate) before surgery. The medical record and checklist should indicate whether the DNR order is to be suspended, and if so, for what period peri-operatively and post-anesthesia.

i) Rescission: Patients (surrogates) may rescind DNR, withholding and withdrawal orders at any time.

j) Potential Organ Donor: If DNR is ordered and death is imminent, the Hospital will call the Donor Network of Arizona, which will determine suitability and conduct necessary discussions with the patient/surrogate.

10.6.4. Documentation: The attending physician's progress notes should detail:

a) Condition: the patient's complete medical condition and prognosis, basis for the DNR or withholding-withdrawal order.

b) Discussion: summary of discussion between the physician and patient (surrogate) prior to writing order (See 10.6.3(a)).

c) Capacity: basis for physician's determination that patient has medical decision-making capacity when patient requests order. If attending physician questions the patient's capacity, a second medical opinion should be sought and documented.

d) Consultation: if attending physician is surrogate by default, that the attending physician has sought consultation as required under Rule 10.5.3(b).

10.6.5. Resolution of Disputes/Conflicts: Refer to Rules 10.4 and 10.5.4(c).

11.0 IN-HOSPITAL DEATH: PHYSICIAN RESPONSIBILITIES

11.1 CERTIFICATION AND NOTIFICATION

11.1.1 Notification of Next of Kin. The attending physician has responsibility for ensuring that the family is notified of a patient's death.

11.1.2 Death Certificate, Cause of Death. The attending physician is responsible for completing and signing the medical certification of a cause of death within 24 hours of the death. In the absence of the attending, any Medical Staff member who actively treated or cared for the patient anywhere in the Hospital including the ER and CCU or who was in charge of the patient's care for the illness or condition leading to death is authorized to complete and sign the medical certification.
Exceptions:
a. When the decedent's body has been referred to the Medical Examiner.
b. When cause of death remains unknown due to Pathology report delay, the signing physician must write "pending further examination."

11.1.3 Brain Death. Only a physician knowledgeable in contemporary brain death criteria may certify brain death. The physician shall document in the progress notes the clinical criteria used to determine brain death.

11.2 AUTOPSY. The Medical Staff encourages its members to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest that are not referred to the Medical Examiner. The Pathologist who performs the autopsy will complete a summary of the gross findings within three (3) days and add the final signed protocol to the medical record within 60 days.

11.2.1 Pathology Department Requires a Prior Written Order & Consent. If the case meets the criteria for in-house autopsy (see 11.2.2 below) and is not precluded by advance directives, physician or family preference:
a) the attending physician must write an order for the autopsy after
b) obtaining the family's permission, which may be documented by an RN.
i. Contacting Person Authorized to Consent. The Hospital is responsible for reasonable attempts to identify and contact a person authorized to consent to the autopsy.
ii. Persons Authorized to Consent to Autopsy. Legal authority to consent to autopsy lies with the person statutorily responsible for burying the body, who is, in descending order:
- spouse;
- if minor, parents;
- adult children

Thereafter any person willing to assume responsibility for burying the body may do so and may consent to the autopsy, including: guardian; next of kin; friend; fraternal, charitable or religious organization.
iii. Surrogates not authorized. The "surrogate" *medical*-decision-maker (as defined in 10.5.2.b) is not authorized to consent to *post-medical* procedures.

11.2.2 Criteria for Autopsies Performed by Pathology Department. Indications for autopsies include but are not limited to:
a) Unanticipated death
b) Death occurring while patient is being treated under an experimental regimen
c) Death occurring within 48 hours after surgery or an invasive diagnostic procedure
d) Death incident of pregnancy or within 7 days following delivery.
e) Death where the cause is sufficiently obscure to delay completion of the death certificate
f) Death in infants/children with congenital malformations.

The final decision to perform an autopsy rests with the Pathology Department based on autopsy criteria, legality and safety.

11.2.3 Autopsies Not Performed by Pathology Department. The pathologist is responsible for post-mortem examinations only of admitted inpatients unless the case must be referred to the Medical Examiner. Deaths referred to the Medical Examiner include:

a) Death when not under the current care of a physician for a potentially fatal illness, or when an attending physician is unavailable to sign the death certificate
b) Death resulting from violence (including accident, suicide or homicide) or the possibility thereof
c) Death occurring suddenly when in apparent good health
d) Death occurring in prison, or death of a prisoner.
e) Death occurring in a suspicious, unusual or unnatural manner
f) Death from a disease or accident believed to be related to the deceased's occupation or employment
g) Death believed to present a public health hazard
h) Death occurring during anesthesia or surgical procedure

Consent is not required when the County Medical Examiner has accepted a case, but the attending physician should explain to the responsible person that autopsy is required by law.

11.2.4 Notification. The Pathology Department will notify, in advance, the attending physician when the autopsy is being performed.

11.3 ANATOMICAL DONATIONS

11.3.1 Consent to Donation. A Hospital employee trained by the Donor Network of Arizona will consult with the attending physician about the decedent's medical conditions and any known refusal to make a donation.

11.3.2 Prohibitions. Neither the physician who certifies the time or cause of death nor the attending physician at the time of death may participate in the procedures for removing or transplanting a body part or notify an organ or tissue procurement agency of a viable donation.

11.3.3 Documentation. The harvesting physician is responsible for completing an operative note on the form provided by BBMC.

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