# MEDICAL STAFF RULES AND REGULATIONS

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## ARTICLE 1: GENERAL

1.1 **Coverage**: Physicians are responsible for assuring adequate coverage for their patients. Any physician designating cases to the care of a patient to another physician shall insure that the physician has privileges at the Medical Center and consents to accept the patient. In case of failure to name such designee, the Chairman of the appropriate clinical department, the Chief of Staff, Chief Executive Officer or Chief Medical Officer or his/her designee, shall have the authority to call any member of the Medical Staff to attend these patients.

1.1.1 Treating Family. Unless specifically preauthorized, reviewed and deemed appropriate by the Chief of Staff or Chief Medical Officer, practitioners may not treat immediate family members EXCEPT in an emergency or where another QUALIFIED practitioner is not available timely. Family member is defined as parents, children, siblings and spouse.

1.2 **Pediatric Patients**

1.2.1 A pediatric patient is:

a. A patient under age 18.
b. A patient regardless of age with a chronic illness that commenced during childhood and who, in the belief of a pediatric physician or subspecialist, can be appropriately managed in a pedicatric unit; and
c. A patient regardless of age who requires services and treatment that pediatric nurses are better trained and qualified to provide.

1.2.2 A pediatric patient does not include:

a. A patient under age 18 seeking obstetrical or gynecologic treatment or services; and
b. A patient over the age of 14 who, in the belief of the treating adult physician, can be treated appropriately on an adult unit.

1.3 **Emergency Department Call:**

1.3.1 Coverage Responsibilities. Physicians serving on the call roster of the Emergency Room are responsible to cover their call or assure coverage by a Medical Center Medical Staff member with appropriate privileges, and to notify the Medical Staff Services' office of any changes prior to any changes being made. A staff member serving on the call roster for the Emergency Department is responsible to see that changes in originally assigned call days are covered by an appropriately credentialed member of the Medical Center Medical Staff with like privileges.

1.3.2 Follow Up Care. If the ED physician determines that the patient may be discharged without seeing the on-call physician but must be seen in follow up, the on-call physician will be required to offer a follow up care appointment to the patient.

1.3.3 All staff members agree to accept assignment of care of medically indigent patients regardless of compensation.

1.3.4 Mid-level practitioners who are appropriately credentialed may respond for On Call physicians where agreed upon by both the ED physician and the On Call physician. The ED physician can require that the On Call physician respond directly if the ED physician does not believe care can be appropriately provided by the mid-level practitioner.

1.4 **Emergency Department Response Requirements:**
Absent extenuating circumstances, the on call physician, the patient's attending physician, and all treating practitioners must respond within thirty (30) minutes to calls from the Emergency Department.

1.5 **Research:** All research being conducted, sponsored by, or otherwise affiliated with MEDICAL CENTER facilities and Medical Staff must be in compliance with current Banner policies.

1.6 **Disclosure**: The attending physician will disclose a serious incident to the patient, if competent or to the patient's designated decision-maker or family if the patient is not competent. A serious incident is an unintended or unanticipated event not consistent with routine care that resulted in the need for further treatment and/or intervention or caused

temporary or permanent patient harm, loss of function or death. The physician will develop a plan for disclosure in collaboration with other caregivers and Medical Center personnel. The physician will document or assure documentation in the medical record of the facts disclosed to the patient, the response and identity of those in attendance.

1.7 **Consent**: Physicians must provide the patient/surrogate with information about the risks, benefits and alternatives of the procedure so that informed consent can be obtained from the patient/surrogate. (See Banner Health policies on consent for further information.) A physician order is needed to obtain consent for surgery. A physician may delegate his/her responsibility to obtain Informed Consent to his/her Physician Assistant or Nurse Practitioner.

1.8 **Consent/Orders for Blood Products**
Physicians must provide the patient/surrogate with information about the risks, benefits and alternative of blood/blood products so that informed consent can be obtained.**Availability**: Attending physicians with patients in the Medical Center must be accessible by pager, cell phone, office, answering service or have call coverage by a physician on the Medical Staff with appropriate privileges.

1.10 **Availability:** Consulting physicians, including surgeons, with patients in the Medical Center must be accessible by pager, cell phone, office phone, answering service or have call coverage by a physician on the Medical Staff with appropriate privileges. Where a physician (including a surgeon who has performed surgery on the patient during the admission) performs surgery or provides a consult to a patient for a condition that appears to require no further specialized treatment during the admission and the physician signs off the case, the physician need not be accessible or have coverage for that patient after the physician signs off the case.

1.11 **Management of Suspected or Substantiated Abuse/Neglect/Exploitation:** Members of the Medical Staff shall report or cause to be reported all cases of suspected or substantiated abuse or domestic violence in accordance with current Arizona State Law and Medical Center policy.

1.12 **Access to Credentials File:** The practitioner's credentials file will be available to him/her for review with the exception of portions of the file which are peer review protected. Upon request, practitioners will be provided with copies of documents in their credentials file that were provided by them or previously given to them.

## ARTICLE 2: ADMISSION POLICIES

2.1 Members of the Medical Center's Medical Staff may admit patients suffering from all types of diseases, injuries and conditions provided proper facilities and personnel are available to handle such patients. Physicians shall be held responsible for giving such information as may be necessary to assure the protection of other patients and Medical Center personnel from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self-harm. Patients may be treated only by physicians who have submitted proper credentials and have been duly appointed to membership on the Medical Staff or have been granted temporary privileges.

2.2 Each patient in the Medical Center is assigned one attending physician. The attending physician or designee shall be responsible for the care of the patient from admission through discharge.

2.3 Patients will not be discriminated against on the basis of race, creed, sex, national origin, religion or sources of payment for care.

2.4 Patients who request emergency services shall receive a medical screening examination. Personnel qualified to conduct a medical screening exam include a doctor, Emergency Department Physician Assistant, Emergency Department Nurse Practitioner, or a psychiatric nurse practitioner who has been approved to provide medical screening examinations. If stabilizing treatment, admission or follow up care is required, this will be arranged by the patient's attending practitioner. Patients who present to the Emergency Department and who have no attending physician with appropriate privileges at the Medical Center shall be treated and admission arranged for by the doctor on duty in the Emergency Department at the time and assigned to members of the Medical Staff on call or their designee in the service to which the illness of the patient indicates assignment.

2.5 Patients admitted for dental services must be admitted by a Medical Staff physician. Patients admitted for podiatric surgical procedures must be admitted with a physician member of the Medical Staff. The attending physician or designee

is responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization and shall determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient.

2.6 Except in an emergency, no patient shall be admitted to the Medical Center until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible. (For the purpose of these Rules and Regulations, the term "emergency" may be applied to any patient whose condition is such that any delay occasioned by compliance with any of these Rules and Regulations might prejudice the physical welfare of the patient.).

2.7 Absent extenuating circumstances, physicians or physician's NP or PA are expected to respond to calls from the nursing unit requesting a call back within thirty (30) minutes from the time the nurse has placed the call. Physicians must respond promptly to STAT calls.

2.8 Absent extenuating circumstances, when a patient has been admitted from the Emergency Department and arrives at the nursing unit, nursing staff will contact the patient's attending physician, treating physician, physician's NP or PA, or the physician's covering physician, who is expected to respond within thirty (30) minutes from the time the nurse has placed a call to the physician's service or office if a call back is requested.

2.9 Each patient is to be visited by the attending physician or his/her physician designee within 24 hours of admission or sooner if the patient's condition warrants physician intervention.

2.10 Patients admitted to the Critical Care Unit must be seen by the patient's admitting/consulting or attending physician within 12 hours of admission or sooner if the patient's condition warrants physician intervention.

2.11 Attending physicians or their physician designees are required to see patients each calendar day following admission. Patients in the acute rehabilitation unit must be visited by a physiatrist at least five (5) times per week. Allied Health Practitioner visits shall not suffice for physician rounding.

2.12 In the management of any admission, it is the attending physician's responsibility to utilize medical resources efficiently. This may involve activities listed below which are commonly needed in accomplishing the utilization management goals of the Medical Center and its Medical Staff.

- 2.12.1 Admit patients on the day of their elective surgery or procedure or provide documented reasons of medical necessity for earlier admission.
- 2.12.2 Facilitate, when possible, the appropriate pre-admission testing and medical clearance for elective surgical admissions.
- 2.12.3 Cooperate with case manager and/or physician advisors when issues or questions arise regarding necessity for admission or continued stay.
- 2.12.4 Participate in appeal of outside denials if the denial is felt to be unjustified.

2.13 The practitioner is not required to visit his/her medically stable patient on the day of discharge as long as the practitioner visits the patient on the day prior to discharge.

2.14 The appropriate Section Chief or Department Chairman is to be notified by Administration if a patient is not appropriately visited by the attending physician or physician designee.

2.15 Patient care is routinely transferred between various providers during any given Medical Center stay and may include referral of complete responsibility, transfer of on-call responsibility and transfer of a patient to a separate unit. Patient "hand-off" is the opportunity to convey critical information to the assuming provider. Hand-off Reports are to be interactive and should include critical information about the patient in regard to diagnosis, treatment plan, anticipated follow-up, pending test results, discharge plans, medication/treatment list. Any staff member transferring cases to the care of another practitioner shall determine that the practitioner is a member of the Medical Staff of Medical Center or has temporary privileges for the care of these patients only.

2.16 Intensive Care Units/Telemetry – any physician on the Medical Staff with ICU admitting privileges may admit a patient to the Intensive Care Unit and any physician on the Medical Staff with admitting privileges may admit a patient to the Telemetry Unit

if the patient requires treatment, observation, or nursing care. Banner selected admission and discharge criteria will be followed and adhered to by all practitioners utilizing these units.

## ARTICLE 3: CONSULTATIONS

3.1 **Authority to Order Consultation**
Consultation is encouraged for all seriously ill patients or for those whose medical problem is not within the scope of the attending physician.

3.2 The attending physician is primarily responsible for calling a physician consultation. Unless otherwise directed by the attending, consultants may also order physician consultations, but should check with the attending on the need for and choice of consultant.

3.3 If appropriate consultation is not sought by the attending physician, the Chairman of the appropriate department should contact the attending physician with the recommendation for consultation in the care of his/her patient. If the attending physician refuses to seek appropriate consultation, the Chairman of the appropriate department may request such consultation. Each department may establish its own consultation requirements subject to approval by the Medical Executive Committee. A Nurse Practitioner or Physician Assistant may see the patient at the discretion of the consulting physician. The consultant will see the patient as often as clinically indicated.

3.4 **Not Authorized to Order Consultation**
Nursing personnel are not authorized to order a physician consultation. After appropriate discussion with the attending physician, nursing personnel with responsibility for a patient who believe the attending physician is not seeking appropriate physician consultation must follow the chain of command policy to address the concern.

Allied Health Professionals are not authorized to order a physician consultation. After appropriate discussion with the attending physician, Allied Health Professionals with responsibility for a patient who believe that the attending physician is not seeking appropriate physician consultation must contact their sponsoring physician who will contact the department chairman as appropriate.

3.5 All Consults performed by a Nurse Practitioner and Physician Assistants must be signed by the sponsoring physician or his designee within twenty-four (24) hours of notification of consultation being initiated. Preoperative consults require approval by the sponsoring physician in person before the patient is taken to the OR. The NP or PA is to dictate the discussion and recommendations of the physician in the consultation note. The sponsoring physician must sign the consult acknowledging the communication with the practitioner did occur and the recommendations reflected in the consult note are accurate.

3.6 Direct physician to physician communication when requesting a consultation from a colleague is optimal for enhancing efficiency, quality and safety of patient care. Except where patient care situations dictate otherwise, direct physician to physician communication is required for all consultations ordered as STAT by the practitioner who has written an order for the consult. If waiting to speak to the physician will result in an unacceptable delay/problem for the patient the consult may be accepted by the physician's designee in consultation with his/her sponsoring physician. This applies to all patient care areas. For routine consultations, the referring physician should directly communicate with the desired consultant whenever possible. The specific reason for the consultation should be included with the entered or verbal order for the consultation. The attending physician is responsible for requesting the consultation with a physician order. All consultations shall be requested by specifying the individual physician. Routine consultation requests will be called at the time the consultation is ordered to the number designated by the physician as his office or preferred contact number. In the event a consultant orders another consultant on the case, he or she is encouraged to notify the attending physician. Each member of the Medical Staff is expected to work with his or her answering service to develop an appropriate triage protocol for consultation requests that may come in during the hours the physician's office is closed. Physician orders for a consult should be entered in the EMR and state:

a. The name of the consultant/consultant's group
b. The purpose of the consult
c. The urgency of the consultation

3.7 A satisfactory consultation includes examination of the patient as well as the health record. When operative procedures are involved, the surgical consultation shall be recorded prior to the operation except in an emergency. The consultant shall make and authenticate a record of his/her findings and recommendations in every such case. The attending physician should state clearly if the consultant requested is only to make recommendations, is to write orders, or is to assume care of the patient.

3.8 For inpatient admissions, the initial consultation must be rendered and documented within 24 hours for situations that are not considered imminently serious or potentially life-threatening. Every effort should be made to coordinate orders between multiple consultants and the attending physician. The attending physician will coordinate orders unless he/she specifies differently.

3.8-1 For observation patients, it is the goal of the Medical Staff for consultants to see patients in observation status within 12 hours of notification when possible. If the consultant is not available within the desired timeframe, another consultant may be considered.

3.9 For subsequent consultation visits, a nurse practitioner or physician assistant may see the patient at the discretion of the consulting physician. The consultant will see the patient as often as is clinically indicated. No consulting physician is required when a psychiatric nurse practitioner consultation is requested.

3.10 Upon signing off of a case the consultant must either inform the attending physician; and if applicable add his/her own depart portion of the EMR regarding any medications to be prescribed upon discharge and any follow-up instructions recommended for the patient. The above information must be included in the consultant's sign off note.

3.11 When a patient is being examined in the Emergency Room or is admitted to the Medical Center for attempted suicide, or when a patient attempts suicide while in the Medical Center, it is recommended that a psychiatric or psychological consultation be obtained. Patients who have attempted suicide or are thought to be suicidal must be cleared for discharge from the Emergency Room (not for inpatients) via phone consultation or in person by a psychiatrist, psychologist or trained behavioral health professional who is a member of the Medical Staff or Allied Health Staff of the Medical Center

3.12 Patients who are emotionally ill or who suffer the results of alcoholism or drug abuse will have a written plan defining the care, treatment or appropriate referral. Patients seen in the Emergency Room for other psychiatric problems must be cleared for discharge from the Emergency Room via phone consultation or in person by a physician who is a member of the Medical Staff of Medical Center.

Patients seen in the Emergency Room for psychiatric problems must be cleared for discharge from the Emergency Room via phone consultation or in person by the patient's PCP ~~or~~ psychiatrist or psychiatric nurse practitioner who must be a member of the Medical Staff or Allied Health Staff of Banner Boswell Medical Center. If the patient's responsible physician does not have privileges at Medical Center or the patient does not have a responsible physician, a trained behavioral health professional or the psychiatrist on call will be contracted to clear the patient for discharge.

3.13 **Mandatory ICU Consults by Pulmonary/Critical Care Physician or an Intensivist**
All patients admitted to the ICU must have a consultation from a Critical Care/Pulmonologist physician or an Intensivist excluding Cardiovascular and Thoracic surgery patients. When the consulting physician signs off of the case it is expected that a formal hand-off be completed and documented in the record.

3.14 **Physician Obligation to Notify of Changes in Condition**
It is the obligation of the physician (attending or consultant) to notify pertinent consultants or to instruct the nurse to do so when such physician becomes aware of a change in the patient's condition that warrants notifying the applicable consultant.

3.15 **Authority to order consultation**
The attending physician is primarily responsible for calling for a physician consultation. Unless otherwise directed by the attending, consultants may also order physician consultations, but should check with the attending on the need for and choice of consultant.

3.16 **Not Authorized to Order Consultation**

Nursing personnel are not authorized to order a physician consultation. After appropriate discussion with the attending physician, nursing personnel with responsibility for a patient who believe the attending physician is not seeking appropriate physician consultation must follow the chain of command policy to address the concern.

Allied Health Professionals are not authorized to order a physician consultation. After appropriate discussion with the attending physician, Allied Health Professionals with responsibility for a patient who believe that the attending physician is not seeking appropriate physician consultation must contact their sponsoring physician who will contact the department chairman as appropriate.

3.17 **Criteria for Ordering Consultations**
Unless the attending physician's expertise is in the area of the patient's problem, consultation with a qualified Medical Staff member is recommended when requested by the patient or when a significant question exists about:
3.17.1 Appropriate procedure or therapy
3.17.2 Possible treatment/operative risks
3.17.3 Diagnosis
3.17.4 Psychiatric and behavioral issues

## ARTICLE 4. MEDICAL RECORD POLICIES

A. General Rules

4.1 **General**
4.1.1 A Medical Record is established and maintained for each patient who has been treated or evaluated at the Medical Center. The Medical Record, including electronic data, medical imaging, pathological specimens and slides, are the property of the Medical Center.
4.1.2 For purposes of this Medical Records section, practitioner includes physicians, dentists, podiatrists, advanced practice nurses, physician assistants, and other practitioners with privileges to give orders, provide consultations and/or perform surgical procedures.

4.2 **Purpose of the Medical Record** - The purposes of the medical record are:
4.2.1 To serve as a detailed database for planning patient care by all involved practitioners, nurses and ancillary personnel.
4.2.2 To document the patient's medical evaluation, treatment and change in condition during the Medical Center stay or during an ambulatory care or emergency visit.
4.2.3 To allow a determination as to what the patient's condition was at a specific time.
4.2.4 To permit review of the diagnostic and therapeutic procedures performed and the patient's response to treatment.
4.2.5 To assist in protecting the legal interest of the patient, Medical Center and practitioner responsible for the patient and to provide data for use in the areas of quality and resource management, billing, education, and research.

4.3 Electronic Medical Record (EMR) - Banner Health is a "paper light" organization. As such, physicians need to adhere to record keeping practices that support the electronic environment. As much data as possible will be created electronically and paper-based documentation will be scanned. Records will be accessed by physicians and other users online and the records will not be printed for internal use.

4.4 Use of EMR – All medical record documents created after the patient is admitted will be created utilizing BH approved forms or BH electronic systems to allow for patient information to be exchanged and shared electronically among healthcare providers. This includes Operative/Invasive Procedure Reports, Consultations, Discharge Summaries, and Progress Notes. The following documents are exceptions:

4.4.1 Documents from contracted/credentialed external sources that pertain to the delivery of patient care, such as radiology and telemedicine reports and select physician orders, with approval by the BH System Forms Committee. These reports must meet the time requirements and contain the data elements specified in the Medical Staff Rules and Regulations.
4.4.2 Banner Health approved forms and templates that are pre-populated and maintained by the provider with physician specific information such as consents and discharge instructions. These forms will be required to meet Banner Health forms template guidelines for bar-coding/scanning purposes and should not be

photocopied by the provider. This exception does not apply to pre-populated forms maintained by Standard Register.

4.4.3 Other documents that are created utilizing BH unapproved forms or non-BH electronic systems after the patient is admitted may be accepted only through approval of the BH System Forms Committee.

4.5 Access to the EMR - Access to patient information on the EMR will be made available to Medical Staff and Allied Staff members and their staff through Clinical Connectivity. All access to electronic records is tracked and unauthorized access to a patient's record is not permitted.

4.6 EMR Training - Practitioners who are appointed to the Medical Staff or Allied Health Staff pending electronic medical record training (CPOE) and who have not completed this training within six (6) months of appointment will be considered to have voluntarily resigned from the staff. Practitioners will be advised of the training requirement at or prior to appointment and reminded of the requirement five (5) months from the date of appointment. Exceptions will be made on a case by case basis to be determined by the facility CEO.

4.7 Whenever possible, orders will be entered directly into the electronic medical record (EMR). When the EMR is unavailable orders should be documented on Banner Health Order form(s).

4.8 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.

4.9 All orders should be reviewed and continued or discontinued when a patient is transferred from on 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.

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

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

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

4.13 **Retention** - Current and historical medical records are maintained via clinical information systems. The electronic medical record is maintained in accordance with state and federal laws regulatory guidelines and Banner's Records Retention Policy.

4.14 **Confidentiality of Patients' Medical Records** - The medical records are confidential and protected by federal and state law. Medical record access to confidential materials by authorized individuals is only permissible when access is sought for patient care, payment, peer review, risk management, approved research, or other appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored. In addition, Banner Health safeguards patients' records against unauthorized disclosure and/or use, loss, defacement, and tampering. Unauthorized access or disclosure of confidential patient information or tampering, loss or defacement of medical records constitutes grounds for disciplinary action.

4.15 **Release of Patient Information** - Banner Health releases patient information only on proper written authorization of the patient or as otherwise authorized by law and Banner policies. Medical Records may be removed from the Medical Center only in accordance with state and federal law, a court order, or subpoena, the permission of the Medical Center's Chief Executive Officer, or designee, or in accordance with Banner Health's policies. Unauthorized removal of an original medical record or any portion thereof from the Medical Center or disclosure of Patient Information constitutes grounds for disciplinary action.

4.16 **Passwords** - All practitioners must maintain the confidentiality of passwords and may not disclose such passwords to anyone.

4.17 **Information from Outside Sources** - Health record information obtained on request from an outside source is placed in the medical record and is available to the professional staff treating the patient. This information will contain the source facility name /address. Results of examination (Laboratory and X-Ray) performed prior to admission of the patient to the Medical Center and that are required for or directly related to the admission are made a part of the patient's Medical Center record.

4.18 **Abbreviations** - Practitioners shall be responsible to use only approved symbols or abbreviations in the medical record. See Banner Health's policy "Medical Records Abbreviations and Symbols" List. Only standard abbreviations can be used. See Banner Health's "Do Not Use Abbreviations and Symbols List." Medication dosages should be expressed in the metric system and a leading zero must always precede a decimal expression of less than one (i.e., 0.1 mg not .1 mg). A terminal or trailing zero is never to be used after a decimal (e.g., 1 mg never 1.0 mg).

4.19 **Responsibility** - The attending physician is responsible for each patient's medical record. The medical record must dentify who is primarily responsible for the care of the patient. Transfer of primary responsibility of the patient are not effective until documented in the clinical information system by the transferring physician and accepted on the clinical information system by the accepting physician. All clinical entries in the patient's record must be accurately dated, timed and individually authenticated by the responsible physician. Authentication means to establish authorship by written or electronic signature and shall consist of the practitioner's name and professional title indicating the professional credential. Electronic signature authentication of medical records is the standard practice.

4.20 **Counter-authentication (Endorsement)**

4.20.1 Physician Assistants - history and physical reports, operative/invasive procedure notes, consultations and discharge summaries must be counter-authenticated timely by the physician. Each clinical event must be documented as soon as possible after its occurrence. Progress Notes do not require counter-authentication.

4.20.2 Nurse Practitioners - history and physical reports, operative/invasive procedure notes, consultations and discharge summaries must be counter-authenticated timely by the physician. Each clinical event must be documented as soon as possible after its occurrence. Progress Notes do not require counter-authentication.

4.20.3 Medical Students

1st & 2nd Year - Access to view the patient chart only. May not document in the medical record.

3rd & 4th Year – May document progress notes only and must be endorsed (countersigned, counter-authenticated) timely by the physician.

*4.20.4* Residents and Fellows - History and physical reports, operative/invasive procedure notes, consultations and discharge summaries must be counter-authenticated timely by the physician. Each clinical event must be documented as soon as possible after its occurrence. Progress Notes do not require counter-authentication.

4.20.5 Each clinical event must be documented as soon as possible after its occurrence. The Health Information Management Services Department does not monitor countersignatures by Residents or Fellows. Appropriate action will be taken by the specific training programs.

4.21 **Legibility** – All practitioner entries in the record must be legible, pertinent, complete and current.

4.22 **Medical Record Documentation and Content** – The medical record must identify the patient, support the diagnosis, justify the treatment, and document the course and results of treatment and facilitate continuity of care. The medical record is sufficiently detailed and organized to enable:

4.22.1 The responsible practitioner to provide continuing care, determine later what the patient's condition was at a specified time, and review diagnostic/therapeutic procedures performed and the patient's response to treatment.

4.22.2 A consultant to render an opinion after an examination of the patient and review of the health record.

4.22.3 Another practitioner to assume care of the patient at any time.

4.22.4 Retrieval of pertinent information required for utilization review and/or quality assurance activities.

4.22.5 Accurate coding diagnosis in response to coding queries.

4.23 **History and Physical Examination** ("H&P") - A history and physical examination must be performed within 24 hours after admission or registration for inpatients or observation or prior to surgery or invasive procedure or any procedure in which IV moderate sedation or anesthesia is administered. The H&P shall be completed by a physician or Allied Health Professional

who is approved by the medical staff to perform admission history and physical examinations, and placed in the medical record. The completed H&P must be on the medical record or the case will be cancelled unless the responsible physician documents in writing that such delay would constitute a hazard to the patient.

A legible office history and physical performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to non-emergent inpatient or outpatient invasive procedure including any surgery or a procedure requiring anesthesia or conscious sedation.

4.23.1 For patients admitted to a Rehabilitation Unit, the admitting rehabilitation physician must conduct an H&P that includes all required elements. A Nurse Practitioner or Physician Assistant may complete the H&P but the rehabilitation physician must visit the patient and must assure that all required parts of the post-admission evaluation are completed within 24 hours of admission.

4.23.2 The Emergency Room Report or Consultation report may be used as the H&P as long as all of the elements in section 4.19 are included and the document is filed as an H&P on the EMR.

4.24 **Responsibility for H&P** – The attending Medical Staff member is responsible for the H&P, unless it was already performed by the admitting Medical Staff member. Physician Assistants and Nurse Practitioners may complete the H&P if permitted in their position summary. H&Ps performed prior to admission by a practitioner not on the Medical Staff are acceptable provided that they are updated and/or approved timely by the attending physician. An oral surgeon with appropriate privileges who admits a patient without medical conditions may perform the H&P, and assess the medical risks of the procedure to the patient. Dentists and podiatrists are responsible for the part of their patients' H&P that relates to dentistry or podiatry, in addition to the medical H&P. A podiatrist may perform the complete History and Physical or H&P update for out- patient podiatric surgical cases.

4.25 **Contents of H&P** – For all inpatients, observation patients, and for those outpatients having procedures requiring general, spinal or epidural anesthesia, or IV moderate sedation, the H&P must include the following documentation as appropriate:

4.25.1 Medical history
4.25.2 Chief complaint
4.25.3 History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status
4.25.4 Relevant past medical, family and/or social history appropriate to the patient's age
4.25.5 Review of body systems
4.25.6 A list of current medications
4.25.7 Any known allergies including past medication reactions and biological allergies
4.25.8 Existing co-morbid conditions
4.25.9 Physical examination: current physical assessment
4.25.10 Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
4.25.11 Initial plan: Statement of the course of action planned for the patient while in the Medical Center.

4.26 **Emergency Department Reports** – A report is required for all Emergency Department visits. The following documentation is required:

(a) Time and means of arrival
(b) Pertinent history of the illness or injury, including place of occurrence and physical findings including the patient's vital signs and emergency care given to the patient prior to arrival, and those conditions present on admission
(c) Clinical observations, including results of treatment
(d) Diagnostic impressions
(e) Condition of the patient on discharge or transfer
(f) Whether the patient left against medical advice
(g) The conclusions at the termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment and services

4.27 **Progress Notes** – Progress notes should be electronically created at least every day (when the patient is seen on a daily basis in accordance with these Rules and Regulations) and more frequently if the practitioner deems it appropriate. For rehabilitation admissions a physician progress note must be documented by the responsible physician a minimum of 5 days per week. Progress notes should describe not only the patient's condition, but also include response to therapy.

(a) Admitting Note- The responsible provider must see the patient and document an admitting note (that justifies admission and determines the plan of treatment) within 24 hours of admission.

4.28 **Consultation Reports** – A satisfactory consultation includes examination of the patient as well as the medical record and should be electronically recorded or dictated within 24 hours. When operative/invasive procedures are involved, the surgical consultation shall be recorded prior to the operation (except in an emergency).

4.29 **Intraoperative & Post Anesthesia/Sedation Record for General, Regional or Monitored Anesthesia**

4.30 **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 may be completed in the procedural areas before pre-operative medication has been administered. The evaluation should be completed and recorded prior to the patient's transfer to the surgical services operating area 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, must be assessed and the equipment checked.

4.31 **Intraoperative & Post Anesthesia Record** – An intraoperative anesthesia record will be maintained for each patient and include drugs/agents used, pertinent events during indications maintenance of emergence from anesthesia/sedation, all other drugs, intravenous fluids and blood components given.

4.32 **Intraoperative & Post-Anesthesia Record** – An intraoperative anesthesia 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 amount of anesthetic medications administered; 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.

4.33 **Post-Anesthesia Evaluation** – 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 post-operative hydration.

4.34 **Operative and Procedure Reports** – An operative or other high-risk procedure report is documented upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.

4.34.1 The exception to this requirement occurs when an operative or other high-risk procedure progress note is documented immediately after the procedure, in which case the full report can be documented within a time frame defined by the hospital.

4.34.2 If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be documented in the new unit or area of care.

4.34.3 **The operative or other high-risk procedure report includes the following information:**

- The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
- The name of the procedure performed
- A description of the procedure
- Findings of the procedure
- Any estimated blood loss
- Any specimen(s) removed
- The post-operative diagnosis

4.34.4 When a full operative or other high-risk procedure report cannot be documented immediately into the patient's medical record after the operation or procedure, a progress note is documented in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and assistant(s), procedures performed and a description of each procedure finding, estimated blood loss, specimen(s) removed, and post-operative diagnosis.

4.34.5 Prior to any operative/invasive procedure(s), the medical record must contain an informed consent.

4.35 **Special Procedures:** EEG's, EKG's, treadmill stress tests, echocardiograms, medical imaging and other special procedure reports will be interpreted and documented within 24 hours of notice. Notice will be a communication to the physician or agent to inform the provider of the test completion.

4.36 **Discharge Documentation –** At the time of discharge but no later than 24 hours after, the responsible physician shall complete a discharge summary on all inpatient and observation hospitalizations 48 hours or greater in length.

4.36.1 The discharge summary shall include:

4.36.2 Reason for hospitalization

4.36.3 Concise summary of diagnoses including any complications or co-morbidity factors

4.36.4 Hospital course, including significant findings

4.36.5 Procedures performed and treatment rendered

4.36.6 Patient's condition at discharge (describing limitation)

4.36.7 Patient/family instructions for continued care and/or follow up.

4.37 The Final discharge progress note should be documented immediately upon discharge for inpatient stays less than 48 hours, observations and extended recovery. The note shall include

4.37.1 Final Diagnosis (es)

4.37.2 Condition of patient

4.37.3 Discharge Instructions

4.37.4 Follow up care required

4.38 **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, which must occur within 90 days prior to the start of home health or within 30 days after the start of care. The face-to-face encounter documentation must include:

4.38.1 Date and time of the face-to-face encounter.

4.38.2 The patient's clinical condition.

4.38.3 A brief narrative description of the patient's homebound status and the need for skilled services. If the documentation was completed by a nurse practitioner, physician assistant, or clinical nurse specialist, the physician must authenticate the documentation.

4.39 **Documentation of Death** - A death summary is required for all deaths regardless of length of stay and must be documented at the time of death and no later than 7 days thereafter by the responsible practitioner.

4.40 **Documentation for Inpatient Transfers to another facility –** The transferring physician must dictate or electronically create a transfer summary regardless of length of stay to include documentation that patient was advised of risks/benefits of transfer at the time of transfer but no later than 24 hours thereafter..

4.41 **Amending Medical Record Entries**

4.41.1 Electronic Documents (Structured, Text and Images) - Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error or omission through the EMR. The EMR will track all changes made to entries.

Once an entry has been authenticated and an error is found, the EMR will force the author to record his/her comments in the form of an electronic addendum in which the individual will document the erroneous information, authenticate the entry and the system will be date and time stamp the entry.

If information is found to be recorded on the wrong patient, regardless of the status of the entry, the EMR will not allow deletion of any entries. The entry recorded in error must be documented as such by the author, and re-enter the information on the correct patient.

4.41.2 Paper-Based Documents - Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error by drawing a single line through the erroneous entry, but not obliterating it, and initialing and dating the error.

Errors or omissions discovered at a later time shall be corrected by the individual with a new entry. The person making the change shall sign and note the date of the change and reason for the change. The new entry shall also state who was notified of the change and the date of such notification. The individual must notify the HIMS Department to permit a review of the erroneous documentation for recording in-error criteria within the EMR. Any physician who discovers a possible error made by another individual should immediately upon discovery notify the supervisor of that clinical or ancillary area.

Upon confirmation of the error, the patient's attending physician and any other practitioners, nurses or other individuals who may have relied upon the original entry shall be notified as appropriate.

4.42 **Copy and Paste Functionality**

Medical staff members and Allied Health Professionals may not indiscriminately copy and paste documentation from other parts of the applicable patient's records. If copying a template, the practitioner shall make modifications appropriate for the patient. If copying a prior entry, the practitioner shall make appropriate modifications based upon the patient's current status and condition. The practitioner must reference the date of a prior note as appropriate. When copying patient data into the medical record from another provider, the practitioner must attribute the information to the person who performed the task unless it is readily apparent, based upon the nature of the information copied, that the data was entered by another provider. If referencing a form within the record, the form must be referenced with sufficient detail to identify the course. Example, "for review of systems, see form dated 8/1/13."

4.43 **Timely Completion of Medical Records**

Complete Medical Record - The Medical Record is not considered complete until all its essential elements are documented and authenticated, and all final diagnoses and any complications are recorded, consistent with these Rules.

4.44 **Timely Completion of Medical Record Documents**

All medical record documents shall be completed within time frames defined below:

| Documentation Requirement | Timeframe | Exclusions |
|---|---|---|
| Emergency Room Report | Documented within 24 hours of discharge/disposition from the ED | |
| Admitting Progress Note | Documented within 24 hours of admission | |

| | | |
|---|---|---|
| History & Physical | Documented within 24 hours of admission and before invasive procedure | |
| Consultation Reports | Documented within 24 hours of consultation | |
| Post op Progress Note | Documented immediately post-op | |
| Provider Coding Clarification | Completed within 7 days of notice. Practitioner may be suspended if query is not completed in 7 days. | |
| Operative Report | Documented Immediately post op and no later than 24 hours after the procedure | |
| Special Procedures Report | Documented within 24 hours of notice | |
| Discharge Summary Report | Documented at the time of discharge/disposition but no later than 24 hours after discharge | Not required on all admissions less than 48 hours. |
| Discharge Progress Note | Documented at the time of discharge but no later than 24 hours after discharge for all admissions more than 48 hours. | |
| Death Summary | Documented at the time of death/disposition but no later than 24 hours after death | |
| Death Pronouncement Note | Completed at the time the patient is pronounced within 24 hours | |
| Transfer Summary | Documented at the time of transfer no later than 24 hours | |
| Signatures | Authentication of transcribed or scanned reports and progress notes, within 7 days from the date of discharge | |
| Verbal Orders | Dated, time and authenticated within 72 hours. | |
| Psychiatric Evaluation | Documented within 24 hours of admission | |
| Home Health (Face to Face discharge Documentation) | Completed within 30 days of discharge. | |
| Verbal Admission Orders | Must be authenticated (countersigned) by the ordering practitioner promptly and prior to discharge. | |

4.45 **Medical Record Deficiencies –** Physicians are advised of incomplete documentation via the physician inbox. The Health Information Management Services Department shall advise physicians, by fax, mail or electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has met or exceeded the timeframes in section 4.44. The notice will include a due date and a list of all incomplete and delinquent medical records.

If a vacation prevents the practitioner from completing his /her medical records, the practitioner must notify the Health Information Services Department before or upon return from vacation; otherwise, the suspension/sanction will remain in effect until the documentation is completed.

If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the practitioner or the practitioner's office must notify the Health Information Management Services Department.

When an individual practitioner has notified the Health Information Department of him/her being out of town or ill prior to being placed on suspension, the suspension process will be waived. The practitioner will be given one week after his/her return to complete any delinquent records.

4.46 **Medical Record Suspensions** - A medical record is considered eligible for suspension/sanction based on the timeframes in Section 4.44.

If the delinquent records are not completed timely, providers will receive a notice and his/her admitting and surgical/procedure scheduling privileges will be temporarily suspended until all medical records are completed.

(a) Upon temporary suspension, the delinquent member shall have no admitting, treating, surgical and/or consultative privileges, other than patients needing emergent care, until delinquent records have been completed. Cases scheduled for the day the automatic suspension report is generated may be performed but records must be completed by the end of the day. Thereafter, physicians must complete their records to proceed with scheduled cases. A member whose privileges have been suspended under this Section shall be allowed to continue the medical and surgical care only of patients who were in the Medical Center under his/her care prior to imposition of the temporary suspension of privileges. Suspension of privileges does not apply to emergency cases nor does it preclude a physician from taking assigned or voluntary call rotations. Specifically, a suspended physician shall NOT: admit new patients, schedule new admissions, treat patients under an associates/covering physician's name, perform consultations on new patients, schedule inpatient or outpatient surgeries or perform other non-emergent/elective procedures, assist in elective surgery, administer anesthesia, or round on patients of associates/covering physicians. Upon resignation by a practitioner, records that remain incomplete thirty (30) days after the resignation will result in notification of the appropriate licensing board by the Chief Executive Officer.

(b) If the practitioner accumulates 45 consecutive or intermittent days of suspension in a rolling calendar year, the Department Chairman or designee will attempt to contact the practitioner informing him/her of their medical record responsibilities and further consequences of accumulating 60 days of suspension. Documentation of this communication will be placed in the practitioner's peer log.

(c) If the practitioner accumulates 60 consecutive or intermittent days of suspension in a calendar year, he/she will be fined $500 and will remain on automatic suspension until the fine has been paid. Once the fine has been paid and the records have been completed the automatic suspension will be lifted. If a practitioner accumulates an additional 60 days of suspension in the same calendar year for a total of 120 days of suspension, the practitioner will be deemed to have voluntarily resigned from the Medical Staff. A certified or hand delivered letter indicating that the voluntary resignation was accepted will be delivered to the practitioner and will explain that the practitioner's resignation will be effective 15 days after receipt of the letter. In the event that the practitioner elects to appeal the decision, the practitioner's appointment and privileges will be extended until the next Medical Executive meeting. The Medical Executive Committee will review appeals requested by the practitioner and determine whether to uphold or rescind the resignation.

(d) If the physician voluntarily resigns for accumulating 60 days of suspension, the practitioner's licensing body will be notified by the Chief Executive Officer.

(e) Restoration of suspended privileges can be accomplished only by completion of all delinquent records assigned to the suspended physician. It shall be the responsibility of the Health Information Management Services Department to immediately notify appropriate parties upon completion of delinquent records so that the name of the practitioner may be removed from the suspension list.

(f) Privileges of members of the Allied Health Staff shall be suspended in accordance with the policy above for incomplete records.

4.47 **Relinquishment of Privileges and Membership for Delinquent Medical Records**

Practitioners who have been resigned due to automatic suspension may request reinstatement during a period of 30 calendar days following deemed resignation if all incomplete and delinquent records have been completed. In addition, the practitioner must pay a $500 fine. The request for reinstatement must include assurance to the Medical Executive Committee of the practitioner's ability to stay in compliance with the medical record completion requirements outlined in these Rules and Regulations.

Neither temporary nor permanent suspension of privileges or revocation of membership and privileges under this Section entitles a staff member to rights pursuant to the Fair Hearing Plan.

Privileges of members of the Allied Health Staff shall be suspended in accordance with the policy above for incomplete records.

## ARTICLE 5 : INPATIENT ORDERS

5.1 Orders may be generated only by members of the Medical Staff with Medical Staff privileges or by Allied Health Staff (NP's, PA's) according to their scope of practice. All orders will be entered electronically.

The Medical Center seeks to facilitate timely and accurate execution of physician and Allied Health Practitioner orders to deliver quality patient care, and to provide guidelines within which its Medical Staff, Allied Health staff, nursing service, and employees can best accomplish this objective. Orders for treatment shall be dated, timed and authenticated. It is the responsibility of the physician who is transferring the patient to a new level of care to review all active orders for clinical accuracy and appropriateness. New orders must be generated after a surgical procedure or the transfer to a new level of care. Where a practitioner has written a set of orders that continues on an additional page or several pages, the practitioner must authenticate the last page of the orders (last page should identify the total number of pages in the order set). Where the practitioner adds, deletes or modifies an order set or if the order set contains selections, the practitioner must authenticate (dated, times and signed) the page and where any change was made.

5.1.1 An admission order shall be documented by the attending/consulting or covering physician for all inpatient or observation patients.

5.1.2 Physician or Allied Health Practitioner orders are required for all tests, services and procedures.

5.1.3 Transfer of a patient's care to another physician must be documented via an order.

5.1.4 Physician or Allied Health Practitioner orders are required for transfer of a patient to a different level of care within the facility. It is the responsibility of the physician or Allied Health Practitioner who is transferring the patient to a new level of care to review and generate new orders for clinical accuracy and appropriateness. Exceptions may be made through a Medical Staff approved Standing order or Protocol.

5.1.5 Physician or Allied Health Practitioner orders are required for transfer/transport a patient to another facility. For transfer/transport of an inpatient to another facility, the physician or Allied Health Practitioner must explain the risks and benefits of the transfer/transport and should ensure that the patient is assessed timely and appropriately prior to transport. For transfer of an inpatient to another facility for acute inpatient medical services the physician or Allied Health practitioner must also converse with the accepting physician to ensure continuity of care.

5.2 **Orders for Inpatient Medical Imaging Tests/Procedures**

5.2.1 An order must be received prior to performing inpatient procedures/tests.

5.2.2 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 a physician or Allied Health Professional licensed and credentialed within Arizona with prescriptive authority (PA's and NP's).

5.3 **Orders for Surgery**

5.3.1 A physician order is needed for the Medical Center to complete a consent for surgery form, which confirms that the physician has obtained informed consent. The order will state the specific procedure to be performed. The procedure listed on a signed fax pre-operative order form can serve as the order to obtain the surgical consent form. The surgeon is responsible for signing, dating and timing the orders and for telephone orders verifying that the correct surgical procedure has been indicated.

5.3.2 Anesthesia medication orders given by the anesthesiologist during the case will take precedence over other pre-anesthesia medication orders.

5.3.3 The surgeon should give all routine admission orders such as diet, etc.

5.3.4 For patients who have had a major surgical procedure, the attending surgeon will be in charge of the management of the patient's surgical care. The surgeon and/or the attending physician will be responsible for designating which physicians will be participating in the patient's care.

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

5.4 **Orders for Outpatient Tests/Procedures or Services**

5.4.1 A signed order must be received prior to performing any outpatient procedure, test or service.

5.4.2 Orders must be dated, timed and signed by the physician or Allied Health Practitioner. Exception: Orders written prior to the patient's arrival (e.g., scheduled services) do not require time to be included on the order. The time of the order will be documented in the Medical Center's patient registration system upon scheduling or registration of the patient. All other outpatient orders written while the patient is on site being treated will require time.

5.4.3 Orders for Outpatient tests/procedures may be accepted from physicians, PA's and NP's licensed either in Arizona or in another state.

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

5.4.5 Orders must include a statement of the reason for the test and/or diagnosis and it must be authenticated and dated by the physician or licensed Allied Health Professional within the prescribed timeframes.

5.4.6 The following facsimiles or original orders are accepted and scanned into the clinical information system:
(a) Outpatient scheduling form
(b) Prescription forms
(c) Referral forms (can be payor specific)
(d) Notation in patient's history and physical
(e) Physician order sheet
(f) Physician order documented on office letterhead (stationery)

5.5 **Verbal and Telephone Orders**

5.5.1 Verbal (face to face) orders should be limited and should be authenticated before the practitioner leaves the area. Verbal orders will be accepted only by a registered nurse (RN) or licensed practical nurse (LPN). Licensed Respiratory Care Practitioners (RCP) and registered pharmacists can accept verbal orders provided the orders are directly related to their specialized discipline.

5.5.2 Verbal Orders must identify the ordering practitioner's name and must be authenticated (countersigned) by the ordering practitioner promptly.

5.5.3 Verbal or telephone orders for chemotherapy and initial parenteral nutrition may not be accepted. Chemotherapy dose modifications may be accepted.

5.5.4 Only physicians and authorized Allied Health Professionals are permitted to give telephone orders for inpatient services. Office staff are not permitted to give telephone orders.

5.5.5 Registered pharmacists are permitted to give telephone orders under physician ordered pharmacotherapy consultation.

5.5.6 RNs or LPNs are permitted to accept telephone orders on nursing units. Registered pharmacists, Occupational Therapists, Physical Therapists, Registered Dietitians, Speech Therapists and Respiratory Care Practitioners (RCPs) can accept telephone orders directly related to their specialized discipline. All telephone orders must be read back to verify accuracy and signed by the receiving individual. Telephone orders will be authenticated by the responsible physician or Allied Health Practitioner.

5.5.7 In areas other than nursing units, certain non-clinical 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.

5.6 <u>No Code Orders (Do Not Resuscitate (DNR))</u>
No Code/DNR orders are entered in the patient's medical record and authenticated, timed and dated by the responsible physician. A properly documented No Code/DNR order will include the physician's medical reasons for the order and his/her discussion with the patient's family, or with the patient. Verbal order Do Not Resuscitate (DNR) and withdrawal of life support must be authenticated within 24 hours (for withdrawal of life support see 9.1).

5.7 <u>Telephone No Code Orders</u>
Telephone no code/AND orders are discouraged. However, if no code/AND orders must be placed by telephone, the RN taking theorder willhave a witness on the telephone to verify and document the no code/AND status. The ordering physicians will authenticate the no code/AND telephone order upon his/her next visit even though the patient may have already expired.

## ARTICLE 6: GENERAL PHARMACY POLICIES

6.1 <u>General Information</u>

6.1.1 Pharmacy Services primarily provides pharmaceutical care for inpatients admitted to the Medical Center and those being treated in the Emergency Department 24 hours a day, seven days per week. In addition, services are provided to the Ambulatory Treatment Unit and other ancillary areas. Physicians and Allied Health Practitioners may consult Pharmacists to assist in a variety of activities including the procurement of medications, answering of medication related questions, the provisions of therapy using clinical programs approved through the oversight of the Pharmacy and Therapeutics Committee and patient counseling when indicated.

6.2 <u>Medication Management</u>

6.2.1 Formulary - All medication administered to patients at the Medical Center will be supplied by the Medical Center's Pharmacy Services unless otherwise defined by policy or by pharmacy approval. Pharmacy Services maintains a formulary as authorized by the Pharmacy and Therapeutics Committee. The formulary is an established compendium of approved medications available at the Medical Center for diagnostic, prophylactic, therapeutic or empiric treatment of patients. A list of standard concentrations for intravenous infusions will be reviewed and approved for use at the Medical Center. The pharmacy will be permitted to make therapeutic substitutions of medications within clearly defined parameters established by the Pharmacy and Therapeutics Committee.

6.2.2 All medication orders must be reviewed by a Pharmacist prior to the administration of the medication unless a physician controls the ordering, dispensing, and administration of the medication, such as in the operating room, ED, or cath lab; or, in emergency situations in which the clinical status of the patient would be significantly compromised by the delay that would result from the pharmacy review.

6.2.3 Samples – Medication samples will not be used for the management of patients at the Medical Center.

6.2.4 Outpatient Prescriptions - Outpatient prescriptions will not be filled by the Medical Center Pharmacy.

6.2.5 Clinical Services – Medical Center Pharmacy Services performs clinical functions such as kinetics dosing and monitoring, therapeutic interchange, and intravenous to enteral transition as approved by the Pharmacy and Therapeutic Committee.

6.2.6 Arizona State Board of Pharmacy rules and regulations will be followed with regard to prescribing medications. Medications are defined as any prescription medication, herbal remedy, vitamin, nutriceutical, over the counter medication, vaccine, diagnostic and contrast agent used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions, radioactive medication, respiratory therapy treatments,

parenteral nutrition, blood derivatives, intravenous solutions, and any product designated by the Food and Drug Administration (FDA) as a medication.

6.3 Home Medications

6.3.1 Medications brought into the Medical Center by patients must be specifically ordered by the physician or Allied Health Practitioner and identified by Pharmacy according to approved policy before being administered by the Medical Center personnel. Use of a blanket statement is not allowed. For example, "Use patient's home medications" is not acceptable.

6.3.2 These medications will be secured in an automated dispensing device or bin on the nursing unit. Medications may be kept at the patient's bedside for self-administration only upon specific written orders of the physician or Allied Health Practitioner.

6.3.3 Medications brought in by the patient that cannot be identified will not be administered to the patient by Medical Center personnel nor should they be taken by the patient.

6.4 Medication Orders: Physician Responsibilities

6.4.1 All medication orders must be complete, including medication name, dose, route, and, frequency.

6.4.2 Medications ordered by "PRN" must specify route, frequency and indication.
**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). Where a Discern Advisor has been triggered orders must be reviewed to avoid duplication.

6.4.3 There will be no automatic stop order except for those medications defined by the Pharmacy and Therapeutics Committee or the medication order indicates the exact number of doses to be administered or an exact period of time for the medication is specified.

6.4.4 Medication orders using the words "per protocol" constitute an invalid order and must be clarified by the pharmacist before processing, unless the order refers to a specific Medical Staff approved protocol or an approved investigational drug protocol and specifies the name and/or number of the protocol; and a written copy is available for review.

6.4.5 **Range Orders**
Routine range orders are discouraged but permitted if indicated. If the Physician uses a range order, it must specify indication and appropriate dose range and frequency suitable for the specific medication.

6.4.6 **Prescriber Identification**
The prescriber's name/signature must be legible and the name should be either printed or stamped in addition to the signature.

6.5 Standing Orders

The Medical Executive Committee may adopt standing orders and protocols which are implemented unless expressly overridden by the physician.

6.6 Pharmacy Orders

6.6.1 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.

6.6.2 Pharmacy Services will automatically review medication orders for duration of therapy.

6.6.3 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.

6.7 **Authorization to Order Medications**

6.7.1 Practitioners licensed by the State of Arizona to prescribe medications may write orders for medications, if they satisfy the requirements for privileges on the Medical Staff of Medical Center. Allied Health Practitioners, as defined by the Medical Staff Bylaws, may write orders if granted authority by Arizona state and/or federal law and with privileges granted by the Medical Staff. Pharmacists are permitted to order medications and labs under physician ordered pharmacotherapy consults.

6.8 **Authorization to Administer Medications**

6.8.1 The following categories of personnel may administer medications at the Medical Center under the order of a qualified, licensed practitioner:

(a) Physicians.
(b) Physician Assistant, Registered Nurse, Licensed Practical Nurse, or Nurse Practitioner. Administration of chemotherapeutic agents shall only be performed by nurses certified in chemotherapy.
(c) Respiratory Care Practitioners (medications related to respiratory therapy treatments only).
(d) Radiology Technologist and Nuclear Medicine Technologist (medications related to radiology/nuclear procedures only).
(e) EEG Technician and Cardiovascular Technician (CVT) (oral medications only) and Anesthesia Technicians (medications related to EEG and Cardiovascular therapy treatments only).
(f) Physical Therapist (topical medications related to physical therapy treatments only).

## ARTICLE 7: GENERAL SURGICAL POLICIES

7.1 The provisional diagnosis and the history and physical must be in the chart before surgery or an invasive procedure. When the history and physical examination, as stated in these Rules and Regulations, is not available before surgery/invasive procedure, the procedure shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

7.2 It is at the discretion of the surgeon as to whether or not an assistant is required for any surgical procedure, and if there is an assistant, it is at the surgeon's discretion as to whether or not anesthesia may be started before the assistant is present in the operating suite. Anesthesia will not be administered before the attending surgeon is present.

7.3 The Medical Center will not perform any pre-surgical testing except on specific written order of the physician.

7.4 A post operative progress note shall be entered into the medical record immediately (before the patient is transferred to the next level of care) after the procedure. Operative reports shall be dictated or electronically created within 24 hours after surgery.

7.5 Surgical Specimens - All tissue or foreign bodies (exclusive of intraocular lenses, cataract lenses, pacemakers, orthopedic hardware and foreign bodies retrieved under endoscopy) removed at operation shall be sent to the Medical Center pathologist who shall make such examination as may be considered necessary to arrive at a pathological diagnosis. Scars removed for cosmetic purposes, superficial debridement specimens, or arthroscopy shavings need not be sent to Pathology. The pathological report signed by the pathologist shall be added to the medical record. Specimens are the property of the Medical Center.

## ARTICLE 8: RESTRAINTS

Restraints or seclusion may only be used to ensure the immediate physical safety of the patient, a staff member or others and may be used only when less restrictive interventions have been determined to be ineffective. Restraints must be discontinued at the earliest possible time. Restraints may not be used for coercion, discipline, convenience, or retaliation.

PRN or standing orders will not be accepted. Qualified Medical Center staff may initiate restraints or seclusion without an order by a physician, but must consult with the physician as soon as possible thereafter to obtain the order.

8.1 **Restraints for Physical Safety**

8.1.1 As per Banner Health policy, restraints may be applied as necessary to maintain a patient's physical safety or the safety of other patients, staff, or others. Restraints include soft restraints for intubated patients used to prevent invasive device removal as well as the use of all 4 bed rails to protect cognitively impaired patients at risk for falling. Restraints require a physician or nurse practitioner order and must be renewed for every episode of restraint. PRN orders are not acceptable. If physician is not available to write an initial order, restraints may be initiated and a telephone order may be given. The physician must perform face-to-face patient assessment within 24 hours of application.

8.1.2 Summary of Physician/NP Actions

(a) Give order for initial episode of restraint.
(b) Restraints include medications and physical means of restricting freedom of movement or normal access to one's body.
(c) Within 24 hours: If not performed by the physician, NP or specially trained RN or PA, perform face to face assessment of patient and document type and need for restraint and authenticate (if verbal) previous order.
(d) Every 24 hours: perform face to face assessment of patient and enter a new order for restraints if need continues.

8.2 **Restraints for Violent or Self-Destructive Behavior and/or Seclusion**

8.2.1 Per Banner Health policy, restraints may be applied as needed to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient or others.

8.2.2 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. If physician or NP is not available to write an initial order, the physician, NP, or specially trained RN or PA must perform face-to-face patient assessment within one hour of initiation of the restraint and/or seclusion, even if the restraint and/or seclusion ends within one hour of initiation, and again prior to writing renewal order. The assessment must be conducted to evaluate the patient's immediate situation, reaction to the intervention, medical and behavioral condition, and the need to continue or terminate restraint or seclusion.

8.2.3 Summary of Physician/NP actions

a) Give order for initial episode of restraint.
b) Within one hour: perform face to face assessment of patient and document type and need for restraints/seclusion and authenticate (if verbal) previous order, and again:
    (1) Every four hours for adults 18 years of age or older.
    (2) Every two hours for patients between the ages of 9 and 17 years of age.
    (3) Every one hour for children under the age of 9 years.
    (4) Every 24 hours and before writing new order, assess the patient.

## ARTICLE 9: ADVANCE DIRECTIVES AND END OF LIFE

The Medical Center provides written information to each patient, prior to or at the time of admission as an inpatient or observation status, describing the person's rights under Arizona law to make decisions concerning his/her health care, including the right to accept or refuse medical or surgical treatment and the right to formulate or revise Health Care Directives. Information regarding the written policies of the facility for the implementation of these rights is also provided. (See BH Health Care Directives policy for further information).

9.1 **Withdrawal of Life Support**

9.1.1 Withdrawal of life support should occur in conjunction with best efforts to ascertain the wishes of the patient given the circumstances of his/her illness. If the patient is unable to speak on his/her own behalf, decisions

should be made by the legal guardian, designated agent under a medical power of attorney, or statutory surrogate (in that order). Discussions with patient, family members or surrogate decision maker should be documented in the medical record. If the physician cannot locate the family member or surrogate decision maker, the physician may make health care decisions for the patient after a consultation with and recommendation of the Bioethics Committee. The decision to withdraw the artificial administration of food and fluid already initiated may not be made by a statutory surrogate in the absence of a Medical Advanced Directive expressing the patient's desire to forgo such food and fluid.

9.1.2 The primary responsibility for coordinating withdrawal of life support in a humane and ethical fashion lies within the attending physician. Other clinicians involved in the care of the patient (including nurses, respiratory therapists and others) are not obliged to participate in or carry out withdrawal of life support unless they are comfortable with the level of involvement of the attending physician.

9.1.3 The spiritual and emotional well being of the patient and family should be addressed. Appropriate resources that may be called upon to assist in this regard include social services, pastoral care, palliative care services and hospice.

9.1.4 All efforts should be undertaken to ensure that the patient does not suffer during withdrawal of life support. Analgesic and sedative medications should be administered when necessary in order to alleviate suffering. The doses used should be guided by direct observation of the patient. In general, doses should be sufficient to minimize pain, dyspnea, anxiety, and other symptoms that may accompany withdrawal of life support.

9.2 <u>Pronouncement of Death</u>
In the event of a Medical Center death, pronouncement of death shall be made by the attending physician or nurse practitioner with appropriate credentials within a reasonable time. If the physician is not present, two (2) registered nurses will assess the vial signs (BP, apical pulse and aspirations), and will document this in the nurses' progress notes. The RN will place a call to the attending physician and obtain a physician order to accept 2 RN's assessment of the death if appropriate.

9.3 <u>Autopsies</u>
Every member of the Medical Staff is expected to be actively interested in securing autopsies for inpatients (ED patients are not considered inpatients) as a part of the facility's quality assurance and educational program and at no cost to the family under the circumstances below. The attending practitioner will be notified when an autopsy is performed. All autopsies shall be performed by a Medical Center pathologist, by a practitioner whose credentials file documents his qualifications in anatomic pathology or by a pathology resident under the direct supervision of a Medical Center pathologist. The attending physician or his/her designee requests and obtains permission for an autopsy from the family.

(a) Deaths in which an autopsy would help explain unknown and unanticipated medical complications.
(b) Deaths in which the cause is not known with certainty on clinical grounds.
(c) Unexpected and unexplained deaths occurring within 48 hours after any medical, surgical, dental, therapeutic or diagnostic procedures that do not fall under medico- legal jurisdiction.
(d) Deaths occurring in patients who are at time of death participating in clinical trials (protocols) approved by institutional review boards.
(e) Deaths resulting from high risk infectious and contagious diseases which have been waived by the Medical Examiner.
(f) All obstetric deaths.
(g) All neonatal and pediatric deaths.

9.4 **<u>Signed consent required</u>**. No autopsy shall be performed without written consent of the appropriate relative or legally authorized agent. A valid consent for an autopsy must meet the following criteria:

(a) Signed by the patient's immediate next of kin (father, mother, spouse, or adult child) or an individual providing proof of power of attorney or guardianship.
(b) It must be witnessed by at least one person present at the time of signing.
(c) Any exclusion (e.g. brain or "none") must be noted on the autopsy consent form at the time of signing.
(d) In situations where it is not possible or it is extremely inconvenient for the family to come to the facility to sign the consent, a fax giving consent to the autopsy and indicating any exclusions is submitted directly to the HIMS Department.

In certain instances, patient advanced directives, physician preference, and family requests may preclude performing an autopsy. A pathologist may refuse to perform an autopsy under the following situations:

(a) The case meets the criteria of a Medical Examiner's case and the case has been accepted by the Medical Examiner.
(b) The case was waived by the Medical Examiner's office, but appears to have criminal and/or other legal implications.
(c) The Consent for Autopsy appears to be invalid, incomplete, or questionable.
(d) The pathologist believes that the case represents a risk to him/her or Medical Center personnel that the facility is not equipped to handle (e.g. Cruetzfeidt-Jacob Disease).
(e) Autopsy fails to meet quality assurance or education criteria.

The pathologist determines who can be present during an autopsy. Families requesting an autopsy when the attending physician or pathologist will not authorize the autopsy may contact an independent pathologist to perform the post mortem exam. A list of outside pathologists will be provided. The Medical Center will not be responsible for any arrangements or charges associated with independent autopsies. Pathologist may discuss the case with the attending physician. The attending physician may attend the autopsy.

## ARTICLE 10: RESIDENT AND FELLOW ROTATIONS

10.1 <u>Supervision of Interns, Residents and Fellows</u>

10.1.1 Professional Graduate Medical Education Programs wishing to rotate residents or fellows at the Medical Center will require approval by the appropriate Department, Committee, the Medical Executive Committee and Medical Center CEO. This approval will be based upon information provided by the GME training program. Once approved, the professional liability coverage and competencies of each resident or fellow will be confirmed. Successful completion of training on Banner's electronic medical record is required before start of the assigned rotation.

10.1.2 Residents and fellows shall function within the Medical Center under an approved job description and must be supervised by an attending or supervising physician with appropriate clinical privileges. The descriptions shall include identification of mechanisms by which the supervisor(s) and graduate eduction program director make decisions about each participant's progressive involvement and independence in specific patient care activities. The Supervising Physician, who is a member in good standing of the Medical Center Medical Staff, shall communicate information to the graduate medical education (GME) training program about the quality of care, treatment, and services and educational needs of the participants he/she supervises.

10.1.3 It is the responsibility of the Graduate Medical Education Committee to communicate with the medical staff and governing body about the care, treatment, and services provided by, and the related educational and supervisory needs of its participants in the professional graduate education programs. This information will be reported annually to the Medical Executive Committee and the Board.

10.2 <u>Documentation by Residents And Fellows</u>

10.2.1 The attending physician shall be responsible for each patient's medical record. When residents or fellows are involved in patient care at Medical Center, sufficient evidence is documented in the health record to substantiate active participation and supervision of the patient's care by the attending physician. The teaching physician must personally document his/her participation in three (3) key components of the service provided by residents or fellows, ie. history, exam, and medical decision making. In surgery, the teaching surgeon must be present during all critical or key portions of the procedure. During non-critical or non-key portions of the surgery, if not physically present, the teaching surgeon must be immediately available to return to the procedure. If circumstances prevent a teaching surgeon from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

10.3 <u>Orders and Operative Reports</u>

10.3.1 Residents and fellows approved for rotation through the Medical Center, who are appropriately registered with the Arizona Medical Board or the Arizona Osteopathic Medical Board and who are participants in an accredited training program, may enter patient care orders as determined by the supervising physician and the training program.

10.3.2 If designated by the supervising physician and the training program, residents or fellows may be responsible for operative reports for surgeries performed by the surgeon they have assisted. The surgeon may modify a statement recorded by the resident or fellow and authenticate change or addendum. The attending/supervising physician will be notified of incomplete or delinquent records assigned to residents, or fellows he/she supervises. Final responsibility for care of the patient rests with the supervising physician or his/her designee.

## ARTICLE 11: MEDICAL AND PHYSICIAN ASSISTANT STUDENTS

11.1 **Medical Students, Nurse Practitioner Students & Physician Assistant Student Level of Participation**

11.1.1 Level of Participation

(a) Student rotations through the Medical Center will be in accordance with the Banner Health Clinical Education Rotation Agreement.

(b) All student activities will be under the supervision of a College participating teaching medical staff member, according to specific clinical goals and objectives developed by the College for each rotation and approved by the Graduate Medical Education Committee at Banner University Medical Center – Phoenix or a subcommittee to include interested BBWMC medical staff members. The Banner RN Professional Practice Team will review clinical goals and objectives for nurse practitioner students. A PA student may also have a Physician Assistant with active Banner Boswell privileges as a secondary preceptor with the supervising physician. The physician preceptor(s) must be immediately available in the hospital. In any situation where a third or fourth year medical student or an Allied health student is scrubbed into or observing any surgical or invasive procedure, the student will be in the physical presence of the physician preceptor(s) at all times.

(c) Clinical goals and objectives will be reviewed, in advance, by the Graduate Medical Education Committee at Banner Good Samaritan Medical Center or a subcommittee to include interested Medical Center Medical Staff members.

(d) Participation in specific types of rotations at the Medical Center is subject to prior approval of the Medical Executive Committee.

11.1.2 Specific Medical/Surgical Student Activities

(a) Year one and two medical students may observe only.

(b) Year three and four medical students may participate in care and management of patients. These students may "follow" patients from admission throughout hospitalization and may observe and assist in procedures as appropriate, at the discretion of and under the direct supervision of the preceptor(s).

(c) Year three and four medical students may document in the progress notes only. Documentation is countersigned by the preceptor promptly. The preceptor(s) are ultimately responsible for all required components of the medical record.

(d) Year three and four students may scrub into surgery and assist in procedures if it is a requirement of the rotation and if the preceptor is participating and the patient has consented to have medical student's participation on his/her procedure. The level of surgical assisting will be at the discretion of and under the direct supervision of the physician preceptor(s) at all times.

(e) All activities are under the direction of and in the presence of the physician preceptor(s).

11.1.3 Podiatric Students

(a) Year one and two Podiatric students may observe only. Year three and four students may participate in care and management of the patient, including invasive and non-invasive procedures, under the auspice/direct supervision of the supervising podiatrist at all times.

(b) May assist in procedures with assigned supervising podiatrist and with patient consent.

(c) Year three and four podiatry students may document in the medical record the following: brief operative notes and progress note if the supervising podiatrist is present and immediately reviews and countersigns the entry. Podiatry students may not write orders.

11.1.4 Specific Physician Assistant Student Activities

(a) Physician Assistant students may participate in care and management of patients.

(b) At the discretion of the preceptor, PA students may obtain Powernotes Training and document in the electronic medical record. Otherwise, PA students will be granted view-only access. Electronic medical

record training (view only) must be completed prior to beginning any patient care. Documentation is countersigned by the preceptor promptly. The preceptor(s) are ultimately responsible for all required components of the medical record.

(c) Physician Assistant students may scrub into surgery and hold retractors if completing a surgical rotation and if the preceptor is participating and the patient has consented to have the Physician Assistant student participate on his/her procedure.
(d) With the patient's consent Physician Assistant students may assist faculty members with procedures within the scope of the faculty member's scope of practice.
(e) All activities are under the direction of and in the presence of the physician preceptor(s).

11.1.5 Nurse Practitioner Students

Prerequisites: Nurse Practitioner Students will be allowed a clinical rotation provided the following have been satisfactorily completed:

(a) The Banner Student Center of Excellence will review clinical goals and objectives for nurse practitioner students.
(b) The NP student applications will be processed and tracked by the Student Coordinator and copies will be forwarded to Medical Staff Services. The Student Coordinator will coordinate the gathering of documentation required as required by the affiliation Clinical Education Rotation Agreement prior to starting the clinical experience and provide orientation to Banner Health policies, programs and channels of communication.
(c) Qualifications and responsibilities of the Preceptor: The NP student preceptor is a member in good standing of the Medical Staff (physician) of the Banner facility in which the NP will train. The preceptor must have unsupervised clinical privileges in the functions and procedures he or she will be supervising. The preceptor shall complete and sign the Preceptor Participation Acknowledgement prior to the start of the preceptorship and provide a copy to the hospital's Student Coordinator.

11.1.6 Nurse Practitioner Student Activities

(a) NP students may participate in care and management of patients.
(b) At the discretion of the preceptor, NP students may obtain Powernotes training and document in the electronic medical record. Otherwise, they will be granted view-only training and access.
(c) Documentation is countersigned by faculty promptly. Faculty members are ultimately responsible for all required components of the medical record.
(d) NP students may not dictate.
(e) All activities are under the direct guidance and supervision of faculty.

11.1.7 Restrictions

(a) Students may not write or dictate discharge summaries, history & physicals, or operative reports.
(b) Students may not write orders, give orders or accept verbal/telephone orders.
(c) Students may not be given responsibility for obtaining informed consent for procedures or surgery or for disclosing adverse events or unanticipated outcomes to patients or family.
(d) A student may not act as a surgical first assistant.
(e) Surgical students completing a surgical rotation must complete the Medical Center orientation on surgical technique and provide documentation prior to the rotation.
(f) All patient-related work performed by students and all student entries in the medical record must be reviewed and countersigned, and amended if necessary, by the preceptor. The preceptor is responsible for all required components of the medical record.
(g) Entries by students in the medical records must be legible, dated, signed and timed and include identification of student status.
(h) The only portion of a student's assessment that may be incorporated in a note by the preceptor is the review of systems and past family/social history. The preceptor may not refer to a student's documentation of physical exam findings or medical decision-making in his or her personal note. The preceptor must verify and re-document the history or present illness as well as perform and re-document the physical exam and medical decision making activities.

11.1.8 Responsibilities of Students

(a) Students are required to comply with all Medical Center policies and procedures during the clinical experience.
(b) Students shall have access only to patient information that is a necessary part of the approved rotation.
(c) Students, as participants in an educational program, must at all times wear a Student Identification Badge issued by Medical Staff Services.
(d) Students must complete the Banner Online Compliance Lessons prior to beginning their rotation.

11.1.9 Application and Approval Process
(a) A request for approval for student rotation at the Medical Center must be submitted to the Medical Staff Services Department for processing at least two weeks in advance of the rotation. NP student applications will be processed by the RN Clinical Educator and forwarded to Medical Staff Services for tracking.
(b) Students, with the assistance of their school, will supply documentation as required by the affiliation Clinical Education Rotation Agreement prior to starting the clinical experience.
(c) Once a specific program has received approval from the BGSMC GME Committee or the RN Professional Practice Team for NP Students and the Medical Center Medical Executive Committee, individual students may be accepted for rotation upon successful completion of the above application process.

11.1.10 Orientation
Medical students and physician assistant students will be oriented to Banner Health policies, programs, and channels of communication.

11.1.11 Fees and Services
A facility stipend will apply, in the amount provided in the Clinical Education Rotation Agreement, to offset expenses involved in the student rotation for those core rotations and other rotations in which the student spends a substantial amount of their time in the Medical Center. This fee covers services provided by Medical Center including access to: patient (with consent); education and teaching areas; computer systems, training and meals.

## ARTICLE 12: STUDENTS CRNAs

12.0 Level of Participation

12.1 Student CRNA rotations through Banner Boswell will be in accordance with the Banner Health Clinical Education Rotation Agreement.

12.2 All student CRNA activities will be conducted under the supervision of a College participating teaching medical staff member, according to specific clinical goals and objectives developed by the College for each rotation. A CRNA may act as a supervisor or preceptor to student CRNA. Student CRNAs must be continuously supervised in the OR by an approved preceptor. However, an anesthesiologist with active Banner Boswell privileges shall serve as a secondary preceptor if the primary supervisor or preceptor is a CRNA. The secondary physician preceptor(s) must be immediately available in the hospital. If the primary supervisor or preceptor is an anesthesiologist, theymust continuously supervise the student CRNA in the OR.

12.3 Clinical goals and objectives will be reviewed, in advance, by the Graduate Medical Education Committee at Banner University Medical Center Phoenix or a subcommittee to include interested BBWMC medical staff members.

12.4 Participation in specific rotations at BBWMC is subject to prior approval of the Medical Executive Committee.

12.5 Specific Student CRNA
(a) Student CRNAs may participate in care and management of patients.
(b) Student CRNAs may document in the progress notes only. Documentation is countersigned by the preceptor promptly. The preceptor(s) are ultimately responsible for all required components of the medical record.

12.6 The patient's willingness to have a Student CRNA participate in their care will be documented on the Patient Consent Form. The surgeon must give approval for the Student CRNA to participate in their patient's care.

12.7 Student CRNAs may perform regional anesthesia (including spinal and epidural anesthesia, and regional nerve blocks), IV sedation and general anesthesia on appropriate patients only in the presence of the preceptor. The Student CRNA will present and discuss the anesthetic plan with the preceptor. Only with the approval of the preceptor will the Student CRNA student proceed with the administration of anesthesia.
(a) All activities are under the direction of the preceptor(s).

12.8 Restrictions for Student CRNAs
(b) Student CRNA's must complete the BBWMC orientation on surgical technique and provide documentation prior to the rotation.

12.9 Responsibilities for Student CRNAs
(a) Student CRNAs are required to comply with all BBWMC policies and procedures during the clinical experience.
(b) Student CRNAs shall have access only to patient information that is a necessary part of the approved rotation.
(c) Student CRNAs, as participants in an educational program, must at all times wear a Student Identification Badge issued by Medical Staff Services.
(d) Student CRNAs must complete the Banner Online Compliance Lessons prior to beginning their rotation.

12.10. Orientation
Student CRNAs will be oriented to Banner Health policies, programs, and channels of communication.

## ARTICLE 13: MORTALITY AND MORBIDITY CONFERENCES

13.1 Ongoing M&M conferences will provide a potential forum for improving the quality of care that is delivered to our patient population.
13.2 Time/Frequency – To be determined by the appropriate Chairman.
13.3 Attendance – All members of the section or department as defined by the Chair and key nursing and administrative representatives as defined by the Chair. Attendance must be recorded for each meeting. Attendance is optional.
13.4 Moderator – Chair or co-chairs to be appointed by Department Chair. The Chair will be charged with maintaining confidentiality and creating a supportive atmosphere for case presentation.
13.5 Confidentiality Executive Session – pursuant to ARS 36.445.01. Cases discussed will be tracked and recorded however minutes of the discussion will not be kept. Chair will be charged with communicating confidentiality process to all members. Members will also be reminded the purpose of an M&M conference is educational and not peer review in nature. Systems issues identified needing further review and action can be moved forward without identifying the specific case.
13.6 Case Selection – Chair will select a wide variety of cases for presentation. Chair will work with designated hospital representative to track cases for presentation and notify attending physician/surgeon of the request to present case at the next M&M conference.
13.7 Case Presentation/Format – The first part of the presentation will be to describe the case as it presented and was initially evaluated. To include: Identification, Chief complaint, Brief History of the present illness, Significant past medical history, Appropriate family, social, developmental and diet histories, Physical examination, laboratory studies and Imaging Studies if applicable. The second part of the case should discuss the hospital course; describe the evaluation and the decision-making. The third part of the case will be education and a literature review of the problem presented by the case.
13.8 Reporting – Chair will attend department meeting on a regular basis and provide a report of the ongoing functionality of the conference.

## ARTICLE 14: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

All members of the Medical Staff are participants in the Banner Health Organized Healthcare Arrangement (OHCA). All members of the Medical Staff are required to follow the Banner Health Policies as to Protected Health Information (PHI) they generate or receive from the Medical Center including access for patient care, payment information, peer review or other legitimate patient care activities.

**AMENDMENT:**

These Rules and Regulations of the Medical Staff may be amended or repealed, in whole or part, by a resolution of the Medical Executive Committee recommended to and adopted by the Board.

APPROVED: Medical Executive Committee: 09/10
Board: 09/10
APPROVED: Medical Executive Committee: 01/11
Board: 01/11
APPROVED: Medical Executive Committee 01/11
Board: 01/11
APPROVED: Medical Executive Committee 07/11
Board: 07/11
APPROVED: Medical Executive Committee 04/12
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APPROVED: Medical Executive Committee 01/16
Board 01/16