



Banner Good Samaritan Medical Center

RULES AND REGULATIONS

ADMISSION POLICIES

The authority for admission of patients to the Medical Center has been vested in the Medical Center Administrator by the BH Board of Directors. Requests for admission are made by the physician, but the final approval rests with the Medical Center Administrator. The Medical Center shall admit patients with all types of diseases, providing facilities are available for care of the patient and protection of Medical Center personnel. Patients may be treated only by physicians who have submitted proper credentials and have been duly appointed to membership on the Medical Staff.

Private patients shall be attended by their own physicians. Private patients applying for admission who have no attending physician shall be assigned to members of the Medical Staff on duty in the service to which the illness of the patient indicates assignment.

Patients admitted for dental service must be admitted by a Medical Staff physician. A Medical Staff physician is responsible for the care of any medical problem that may be present or arise during hospitalization. As in all cases, an adequate medical survey is required on each patient.

Medically indigent and charity patients shall be attended by members of the Medical Staff, and shall be assigned to the Department concerned in the treatment of the disease which necessitated admission.

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.) Physicians admitting private patients will 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 whatever. They shall be responsible for seeing their patients within a reasonable length of time following admission.

Routine laboratory procedures performed on admission of a patient shall be determined by the Medical Staff Executive Committee.

In the management of any admission, it is the attending physician's responsibility as stated in 2.2-1(d) of the Bylaws of the Medical Staff, to utilize medical resources efficiently. This may involve activities listed below which are commonly needed in accomplishing the utilization management goals of the hospital and its Medical Staff.

Obtain pre-admission or pre-procedure certification if necessary.

Admit patients on the day of their elective surgery or procedure or provide documented reasons of medical necessity for earlier admission.

Initiate timely discharge planning.

Facilitate, when possible, the appropriate pre-admission testing and medical clearance for elective surgical admissions.

Cooperate with physician advisors when issues or questions arise regarding necessity for admission or continued stay.

Participate in appeal of outside denials if the denial is felt to be unjustified.

PHYSICIAN ORDERS

BGSMC seeks to facilitate timely and accurate execution of physicians' orders to deliver high quality patient care, and to provide guidelines within which its medical staff, house staff, nursing service, and employees can best accomplish this objective.

General Information

- A. Admitting orders are provided by the responsible physician or housestaff.
- B. All physician orders are to be written in dark ink. Felt pens and pencils will not be accepted.
- C. All physician orders will be dated, timed and signed within the prescribed time frames.
- D. Orders as originally written cannot be changed or added to at some future time. When it is necessary to change an order, it must be completely rewritten with the current date.
- E. Nurses have the responsibility of questioning any order that they feel might harm the patient.
- F. Orders which are not legible will be clarified with the responsible physician before they are carried out.
- G. Orders written on another facility's transfer form are confirmed with the admitting physician. Verification of appropriateness is written on BGSMC's physician order sheet. Transfer orders do not need to be rewritten.

Orders for Surgery

- A. A physician order is needed to obtain a consent for surgery. 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 surgical consent order. The surgeon is responsible for signing, dating and timing the orders and verifying that the correct surgical procedure has been indicated for telephone orders.
- B. Anesthesia medication orders given by the anesthesiologist doing the case will take precedence over other pre-anesthesia medication orders.
- C. The surgeon should give all routine admission orders such as diet, etc.
- D. No "On Call" orders for preoperative medications will be accepted on regularly scheduled cases. The exception to this is as follows: Cases that are scheduled to follow which are patients of the same surgeon, etc., or when the surgeon wishes to hold medication until the patient leaves for surgery.
- E. For patients who have had a major surgical procedure, the attending surgeon will be in charge of the management of the patient's care. The surgeon will be responsible for designating which physicians will be participating in the patient's care.

Orders for Inpatient Medical Imaging Tests/Procedures

- A. A signed order must be received prior to performing inpatient procedures/tests.
- B. 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.

Orders for Outpatient Tests

- C. A signed order must be received prior to performing outpatient procedures/tests.
- D. 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.
- E. The following facsimiles or original orders are accepted:
 - 1. Outpatient scheduling form
 - 2. Prescription forms
 - 3. Referral forms (can be payor specific)
 - 4. Notation in patient's history and physical
 - 5. Physician order sheet
 - 6. Physician office letterhead (stationary)

Guidelines for Outpatient Tests/Procedures

- 1. Written orders are generally valid for six months unless a timeframe is specified within the order or there are extenuating circumstances (i.e. scheduling difficulties).

2. Rescheduled tests/procedures that are performed greater than the six month interval are permissible. Documentation of reason for rescheduling is contained within the medical record when feasible.

Preprinted and Faxed Orders

- A. Preprinted orders may be used by the medical staff after review and approval of the Pharmacy & Therapeutics (P&T) Committee (applies to orders with medications only) and Health Information Management Services (HIMS) Committee. These orders will be individualized for each patient by the ordering physician by drawing a line through the unwanted items and adding any additional orders as indicated. The physician orders must be signed, timed and dated.
- B. If faxed orders are transmitted to BGSMC by the attending physician, his/her orders will be transmitted on the attending physician's letterhead or on the BGSMC physician order sheet. The order will be dated, timed, signed and placed in the patient's medical record.

Verbal and Telephone Orders

- A. Verbal (face to face) orders are not acceptable except in the case of an emergent situation. 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. The prescribing practitioner or another practitioner who is responsible for the care of the patient will authenticate these orders within 48 hours.
- B. 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.
- C. Registered pharmacists are permitted to give telephone orders under physician ordered pharmacotherapy consultation.
- D. 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 pertaining to their specialty. All telephone orders will be written by the person receiving the order on the physician order sheet then the entire order must be read back to verify accuracy and signed by the receiving individual. Telephone orders will be authenticated by the responsible physician.
- E. In areas other than nursing units, certain telephone orders may be taken by the personnel in each department most qualified to accept them. The director of the department will be responsible for the acceptance of such orders, and for the designation, if necessary, of personnel with the appropriate skills to accept telephone orders. All such orders will be strictly limited to the area of expertise of the department. Bed placement, registration staff and unit secretaries may accept admission orders from physicians only related to the type of bed needed (telemetry vs ICU, etc.) and specifying the reason for the admission.

Transcribing Orders

- A. Registered nurses (RNs), licensed practical nurses (LPNs), registered pharmacists and health unit secretaries (HUS) are permitted to transcribe orders.
- B. A registered nurse will review and co-sign physicians' orders transcribed by a LPN or a health unit secretary.

No Code Orders

- A. No code orders are entered in the patient's health record and signed, timed and dated by the responsible physician. A properly documented no code order will include the physician's medical reasons for the order and his/her discussion with the patient's family, or with the patient. This should be documented in the progress note.
- B. Orders written by house staff are signed by the responsible physician upon their next visit.
- C. Telephone no code orders are discouraged. However, if no code orders must be placed by telephone, the house staff or RN taking the order will have a witness on the telephone to verify and document the no code status. Physicians will sign the no code telephone order upon their next visit and document the reasons (as in paragraph A above) even though the patient may have already expired.

House Staff

- A. House staff of the teaching programs at BGSMC who are appropriately registered with the Arizona Board of Medical Examiners, may write all orders for diagnostic procedures, diets, activity status, treatments, medications and all other physician-ordered procedures for inpatients, outpatients, and emergency center patients.
- B. Individual departments and teaching programs may modify these responsibilities as needed. Residents and fellows may write controlled substance orders for inpatients and outpatients. Each resident and fellow will be given a designated identifying number by the Graduate Medical Education department as required by Federal and State laws. This number is valid only when the house staff is working for the Medical Center in the usual course of his/her hospital practice. With this number, controlled substance orders written by the house staff need not be counter authenticated by the attending physician.

HEALTH RECORD

General 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

For purposes of this Medical Records section, practitioner includes physicians, dentists, podiatrists, advanced practice nurses, physician assistants, and other credentialed practitioners to give orders, provide consultations and/or perform surgical procedures.

Purpose of the Medical Record The purposes of the medical record are:

1. To serve as a detailed data base for planning patient care by all involved practitioners, nurses and ancillary personnel.
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,
3. To allow a determination as to what the patient's condition was at a specific time,
4. To permit review of the diagnostic and therapeutic procedures performed and the patient's response to treatment,
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.

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. Selectively referred to herein as EMR.

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

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

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 tolerated.

EMR Training Practitioners who are appointed to the Medical Staff or Allied Health Staff after November 11, 2010, pending Banner electronic medical record training (EMR) 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 Chief Executive Officer or Chief of Staff.

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 Records Retention Policy.

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.

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 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.

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

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.

Abbreviations Practitioners shall be responsible to use only approved symbols or abbreviations in the medical record. See Banner Health's policy "**Medical Record Abbreviations and Symbols.**"

Responsibility The attending physician is responsible for each patient's medical record. The medical record must identify who is primarily responsible for the care of the patient. Transfers 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; group signing of documentation is not permissible. 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.

Counter-authentication (Endorsement)

Physician Assistants- History and Physical Reports, Operative/Procedural 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. Requirements for counter-authentication of Progress Notes will be established and monitored by the supervising physician.

Nurse Practitioners- History and Physical Reports, Operative/Procedural 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.

Medical Students

1. 1st & 2nd Year- Access to view the patient chart only. May not document in the medical record.
2. 3rd & 4th Year- Any and All documentation and orders (if permitted) must be endorsed (countersigned, counter-authenticated) timely by the physician.

House Staff, Resident, and Fellows Requirements for counter-authentication will be established and monitored by specific training programs. Each clinical event must be documented as soon as possible after its occurrence. The Health Information Management Services Department does not monitor counter-authentication by House Staff, Resident or Fellows. Appropriate action will be taken by the specific training programs. When a teaching service is involved in patient care, sufficient evidence is documented in the health record to substantiate active participation and supervision of the patient's care by the attending physician. House staff is responsible for completing the history and physical examination for the teaching service. Surgery residents are responsible for operative reports of surgeries performed by teaching staff whom they have assisted.

If the attending physician supervises a procedure (i.e. insertion of ART line, lumbar puncture, etc.) he should countersign the report. All house staff not credentialed to perform procedures need supervision. As house staff document procedure notes, he/she should not specify the name of the attending physician unless that physician participated in the case. The reports written by house staff are reviewed and countersigned by the responsible member of the attending staff.

Non-Physician Entries Non-physicians will record information in the EMR. Opinions requiring medical judgment must be written by medical staff, house staff, and individuals who have been granted clinical privileges.

Nursing Documentation The health record will contain pertinent, meaningful observations and information. Nursing documentation requirements are developed by nursing service.

Surgical Assisting Any member of the medical staff with clinical privileges may assist in surgery.

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

Medical Record Content:

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:

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.
2. A consultant to render an opinion after an examination of the patient and review of the health record.
3. Another practitioner to assume care of the patient at any time.
4. Retrieval of pertinent information required for utilization review and/or quality assurance activities.
5. Accurate coding diagnosis in response to coding queries.

Transplants/Implants Medical record documentation on donor and recipients of transplants will be consistent with state reporting law A.R.S. 36-849. Information regarding implants should be documented in the medical record.

History and Physical Examination (H&P) A history and physical examination in all cases shall be completed by a physician, or Allied Health who is approved by the medical staff to perform admission history and physical examinations, and placed in the patient's medical record within 24 hours after admission or registration for all inpatients and observation patients. The completed H&P must be on the medical record prior to surgery or invasive procedure (see "invasive procedures") or any procedure in which conscious sedation will be administered or the case will be cancelled unless the responsible physician documents in writing that such delay would constitute a hazard to the patient. For patients admitted to a Rehabilitation Unit, the admitting rehabilitation physician must conduct an H&P that includes all required elements. A physician extender 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. A legible office history and physical performed within 30 days (7 days for Nevada) prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. If approved by the Medical Staff, the Emergency Room Report, or Consultation report may be used as the H&P as long as all the elements in section 4.19 are included and the document is filed as a History and Physical on the EMR. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services. The Obstetrical H&P will consist of the prenatal record, where applicable, updated in the EMR by the responsible physician or Allied Health professional.

Invasive Procedure Invasive procedures which require an H&P prior to being performed, except in an emergency, include but are not limited to:

1. Main OR procedures
2. Ambulatory Surgeries
3. C-section deliveries/tubal ligations
4. Endoscopies
5. Interventional Cardiac Procedures – Permanent Pacemakers
6. Interventional Radiology Procedures: Percutaneous Transluminal Angioplasty (PTA), Nephrostomy Tube Insertion, Transjugular Intrahepatic Portosystemic Shunt (TIPS), CT Guided Biopsies, Thoracentesis, Paracentesis, Epidural Blocks, Nerve Root Blocks, Facet Infections, Angiograms
7. Venograms
8. Transesophageal Echocardiogram (TEE)
9. Cardioversions
10. Bone Marrow Studies
11. Lumbar Puncture

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. H&Ps performed prior to admission by a practitioner not on the medical staff are acceptable provided that they are updated 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, and, if authorized by the Medical Staff, may be responsible for the complete H&P.

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

1. Chief Complaint.
2. Medical History.
3. History of the current illness, including, when appropriate, assessment of emotional, behavioral and

social status.

4. Relevant past medical, family and/or social history appropriate to the patient's age.
5. Review of body systems.
6. A list of current medications.
7. Any known allergies including past medication reactions and biological allergies.
8. Existing co-morbid conditions.
9. Physical examination: current physical assessment.
10. Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination.
11. Initial plan: Statement of the course of action planned for the patient while in the Medical Center.
12. For other outpatient (ambulatory) surgical patients, as necessary for treatment
 - i. Indications/symptoms for the procedure.
 - ii. A list of current medications.
 - iii. Any known allergies including past medication reactions
 - iv. Existing co-morbid conditions
 - v. Assessment of mental status
 - vi. Exam specific to the procedure performed.
13. IV Moderate Sedation - For patients receiving IV moderate sedation, all of the above elements in section above and the following:
14. Examination of the heart and lungs by auscultation.
15. American Society of Anesthesia (ASA) status
16. Documentation that patient is appropriate candidate for IV moderate sedation.

Behavioral Health Documentation (This section only applies to inpatient behavioral health units.) A psychiatric evaluation including an initial plan of treatment, mental status examination, diagnosis and estimated length of stay, shall be completed and documented within 24 hours after admission of the patient. Physicians will complete the psychiatric evaluation and above documentation.

A physical examination shall be performed and documented within 24 hours of admission or registration of the patient. Physical examinations may be used from the previous hospitalization if the examination was within 30 days. Physical examinations may be accepted from a doctor's office if the examination was done within 30 days of admission and meets the standards as defined by hospital policy and procedure. If the patient was transferred from another hospital, the physical examination may be accepted if done within the last 30 days provided they are updated within 24 hours of admission or registration by the attending physician.

In the above three cases, the attending physician must validate the physical examination in the medical record (on the physical exam) by noting that there are no significant findings or changes and signs and dates the report.

Pertinent progress notes related to diagnosis and to treatment plan goals and objectives, sufficient to permit continuity of care shall be recorded at the time of observation. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress note and correlated with specific orders, as well as results of tests and treatments. A progress note shall be documented, authenticated and dated after each visit by the attending physician.

Physicians shall document abnormal diagnostic values and their response to such. Consultants shall document, authenticate, time, and date all assessments, diagnostic tests, and treatments, etc. whenever they see a patient.

All entries must be dated, timed and authenticated by the person making the entry and must include his/her discipline.

Therapeutic Leaves of Absences (Passes) The attending physician shall write an order specifying date and length of the pass, therapeutic goals and the identity of any person to accompany the patient. The attending physician will indicate any medication to be taken by the patient during the pass by a specific

order.

Discharge Documentation

1. Patients shall be discharged only on given order of the attending physician.
2. AMA discharge orders must be given by the attending physician or his/her designee. Exceptions may only be made by the Medical Director who has the authority to discharge a patient for administrative reasons.
3. At the time of discharge, the attending physician shall complete the discharge summary according to the approved guidelines and state final diagnoses on all five DSM-IV Axes. The patient's record shall be completed 14 days post discharge. Incomplete records exceeding 14 days following discharge will be considered to be delinquent. Disciplinary measures may be evoked against any physician who fails to complete his/her records within the specific time frame described above. Such measures may include suspension of admitting and consulting privileges.
4. A category of disposition must be included in the discharge summary.
5. Discharge Summaries may be constructed by an approved non-physician. Utilizing a non-physician for medical record analysis, information compilation and discharge summary construction is the prerogative of the attending physician. Physicians who chose this practice must give prior authorization of their intent, obligation and responsibility of their intent, obligation and responsibility to read, review, approve and authenticate every clinical resume.
6. The attending physician ensures that the content of the dictated discharge summaries (M.D. dictated and non-M.D. dictated) is accurate, complete, and meets all pertinent requirements.
7. Against Medical Advice (AMA) Discharged at insistence of self or family when patient is not considered imminently suicidal or homicidal, but is in such a condition that there is serious risk of rapid relapse or other clinical complication.

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

1. Time and means of arrival
2. 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
3. Clinical observations, including results of treatment
4. Diagnostic impressions
5. Condition of the patient on discharge or transfer
6. Whether the patient left against medical advice
7. The conclusions at the termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment and services

A copy of the Emergency Department transcription is provided to the follow up and/or referring physician or upon transfer to another facility when requested by the responsible physician.

Progress Notes Progress notes should be electronically created with a frequency that reflects appropriate attending involvement but at least every day. For rehabilitation admissions a physician progress note must be documented by the responsible physician a minimum of every 5 days. Exceptions may be given to an obstetrical patient that has a discharge order entered from the day before or for a patient admitted to a psychiatric unit. Progress notes should describe not only the patient's condition, but also include response to therapy.

1. 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.

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 procedures are involved, the consultation shall be recorded prior to the operation (except in an emergency).

Consultation Process

Direct physician to physician communication when requesting a consultation from a colleague is optimal for enhancing efficiency, quality and safety of patient care.

1. Direct physician to physician communication is *encouraged* for all physician consultations at BGSMC. For routine consultations (consultant expected to see patient within 24 hours for situations that are not considered imminently serious or potentially life-threatening), the decision to speak directly with the consultant physician will be left to the discretion of the referring physician. This also applies to the Critical Care Units. Ideally, the specific reason for the consultation should be included with the written or verbal order for the consultation.
2. Except where patient care situations dictate otherwise, direct physician to physician communication is *expected* for all urgent or emergent consultations at BGSMC. Urgent/emergent consultations are those situations where the referring physician believes the patient needs to be seen by the consultant as soon as possible for an imminently serious or potentially life-threatening situation. This applies to all patient care areas.

Except in an emergency, consultations with another qualified physician should be obtained for cases on all services in which, according to the judgment of the physician: 1) the patient is not a good medical or surgical risk, 2) the diagnosis is obscure, 3) there is doubt as to the best therapeutic measures to be utilized. All consultations shall be requested by specifying the individual physician or physician group name. Each Clinical Department of the Medical Staff may develop its own consultation requirements with approval of the Executive Committee.

Pre-Operative, Intraoperative & Post Anesthesia/Sedation Record for General, Regional or Monitored Anesthesia:

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 evaluation of the patient must include review of the medical history, including anesthesia, drug and allergy history; review and examination of the patient; notification of anesthesia risk (per ASA classification); identification of potential anesthesia problems, particularly those that suggest potential complications or contraindications; additional pre-anesthesia as applicable; and development of the plan for anesthesia care, including type of medications for induction, maintenance, and post-operative care and discussion with the patient of risks and benefits. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before pre-operative medication has been administered. Immediately prior to the induction of anesthesia while the patient is on the procedure table, the patient's vital signs, airway and response to pre-procedure medication must be assessed and the equipment checked.

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

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

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.

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 24 hours of the procedure.
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.
3. The operative or other high-risk procedure report includes the following information:
 - a) The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
 - b) The name of the procedure performed
 - c) A description of the procedure
 - d) Findings of the procedure
 - e) Any estimated blood loss
 - f) Any specimen(s) removed
 - g) The postoperative diagnosis

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, specimens removed, and postoperative diagnosis.

Prior to any operative/invasive procedures, the medical record must contain an informed consent.

Special Procedures: EEG's, EKG's, treadmill stress tests, echocardiograms, tissue, 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.

Tests Performed

A professional interpretation is to be included automatically with orders for the following studies:

83020	Hemoglobin electrophoresis
84165	Protein electrophoresis, fractionation and quantitation
84181	Protein Western Blot with interpretation and report
84182	Protein Western Blot with interpretation and report, immunological probe for band interpretation, each
85576	Platelet aggregation, any agent
86255	Fluorescent antibody, screen
86256	Fluorescent antibody, titer
86334	Immunofixation electrophoresis
87164	Dark field examination, any source
87207	Smear, any source with interpretation, special stains for inclusion bodies or intracellular parasites
89060	Crystal identification, by light microscopy with or without polarizing lens analysis, any body fluid

Discharge Documentation - A discharge summary must be documented at the time of discharge but no later than 7 days thereafter by the responsible practitioner on all Inpatient and Observation hospitalizations 48 hours or greater in length. Normal newborns and normal vaginal deliveries do not require a discharge summary regardless of the length of stay. Any newborn patient admitted to the Special Care Unit or transported from the Newborn Nursery to a Level III Nursery will be required to have a dictated discharge summary. Exception is newborns admitted to the Special Care Nursery for observation of eight (8) hours or less.

The discharge summary shall include:

- i. Reason for hospitalization
- ii. Concise summary of diagnoses including any complications or co-morbidity factors
- iii. Hospital course, including significant findings
- iv. Procedures performed and treatment rendered
- v. Patient's condition on discharge (describing limitations)
- vi. Patients/Family instructions for continued care and/or follow-up

The final discharge progress note should be documented immediately upon discharge for inpatient stays less than 48 hours, observations, extended recovery, normal newborns and normal vaginal delivery cases. The note shall include:

Final Discharge Progress note should include:

- i. Final diagnosis(es)
- ii. Condition of patient
- iii. Discharge instructions
- iv. Follow-up care required

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 but no later than 7 days thereafter by the responsible practitioner.

Documentation for Inpatient Transfers to Another Facility - The transferring physician must dictate or electronically create a transfer summary at the time of transfer regardless of length of stay to include documentation that patient was advised of risks/benefits of transfer.

Amending Medical Record Entries:

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.

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.

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. No medical record shall be considered complete without fulfilling the documentation requirements except on order of the Medical Executive Committee.

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 when there is a delay in the availability of the full report	
Provider Coding Query	Documented response no later than 7 days post notification to the provider	
Operative Report	Documented within 24 hours of 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 7 days post discharge	Not required on all admissions less than 48hrs, or for normal vaginal deliveries and normal newborns
Discharge Progress Note	Documented at the time of discharge/disposition but no later than 7 days post discharge for all admissions less than 48hrs or for normal vaginal deliveries and normal newborns	
Death Summary	Documented at the time of death/disposition but no later than 7 days post discharge	
Death Pronouncement Note	Completed at the time the patient is pronounced but no later than 7 days	
Transfer Summary	Documented at the time of transfer	
Signatures	Authentication of transcribed or scanned reports and progress notes, within 15 days from the date of discharge	
Verbal Orders	Dated, time and authenticated within 48 hours from order	

Psychiatric Evaluation	Documented within 24 hours of admission	
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Copying and Pasting - Medical Staff members, 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 source. Example: "for review of systems, see form dated 6/1/10."

Medical Record Deficiencies - Physicians are advised of incomplete documentation via the physician inbox. The Health Information Management Services Department shall advise physicians, by phone, fax, mail or electronic notice of incomplete medical records. If a vacation prevents the practitioner from completing his/her medical records the physician must notify the Health Information Services Department in advance of the vacation; otherwise the temporary suspension will remain in effect until the delinquent documentation has been completed.

If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the physician or the physician's office must notify the Health Information Management Services Department. Request for deferment from temporary suspension may be granted by the Chairman of the Health Information Management Committee or his/her designee.

Medical Record Suspensions/Sanctions - If medical records are not completed providers will be temporarily suspended 22 days, or 15 days for Behavioral Health (as required by Centers for Medicare and Medicaid CMS), from the date the deficiency is assigned (allocation date). This includes loss of privileges including but not limited to admitting, treating, consulting, surgical and anesthesia privileges. Temporarily suspended providers may admit and treat emergency patients (including imminent deliveries.) Requests for deferment from temporary suspension may be granted by the Chairperson of the Health Information Management Committee or his/her designee. Notice of temporary suspension will be sent to all appropriate Departments within the Medical Center. Upon completion of the delinquent medical records, the provider's staff privileges will be reinstated. When a physician is temporarily suspended for a continuous period of 60 days, he/she may be deemed to have voluntarily resigned from the medical staff.

Temporary suspension shall become automatic permanent suspension following 60 cumulative days of temporary suspension within a calendar year. At that time, the practitioner's privileges will automatically move to permanent suspension for failure to complete medical records. Effected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if, all delinquent records have been completed. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff. In order to reinstate their staff privileges, the practitioner will be required to reapply for medical staff membership, including the reapplication fee. 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. Physician may submit evidence demonstrating why the suspension/revocation is unwarranted to the Medical Executive Committee pursuant to Article 6.8 of the Bylaws. Permanent suspensions will be reported to the applicable licensing/certification board if required by law.

Administrative Sign Off - When a physician is no longer on the Medical Staff, is unavailable or required information is not available to complete an outstanding record, the record(s) may be signed off administratively as incomplete through the HIMS Committee. This information will be recorded in the HIMS Committee minutes. Refer to the Banner Administrative Closure of Incomplete Records Policy.

PHARMACY & THERAPEUTICS

General Information

All medications administered to patients at BGSMC will be supplied by the BGSMC Department of Pharmacy Services unless otherwise defined by policy or by pharmacy approval. The Department of Pharmacy Services maintains a formulary as authorized by the P&T Committee and the Drug Resource Management Team. The formulary is an established compendium of approved medications available at BGSMC for diagnostic, prophylactic, therapeutic or empiric treatment of patients. The pharmacy is not required to stock more than one brand of an individual medication as approved by the P&T Committee. Medications ordered by trade name may not necessarily be filled by that name unless the physician states "do not substitute" on the

order. The pharmacy will be permitted to make therapeutic substitutions of medications only within clearly defined parameters established by the P&T Committee and approved by the Executive Committee.

Medications brought into the hospital by patients must be specifically ordered by the physician and identified according to approved policy before being administered by the Medical Center personnel. These medications will be kept at the nursing unit. Medications may be kept at the patient's bedside for self-administration only upon specific written orders of the physician. Medications brought in by the patient which cannot be identified will not be administered to the patient by Medical Center personnel nor should they be taken by the patient. All outpatient prescriptions must be labeled by the Pharmacy, unless the prescribing physician indicates otherwise. In addition, all medications taken out of the Medical Center by a patient on a pass must be property labeled.

Medication Orders

In order to reduce the potential for a medication error and provide institution-wide standards for safe medication practices, orders for medications must be written clearly and accurately, including date, time and signature.

1. All orders for medications must be complete including:
 - a. Medication name
 - b. Dosage form and dose
 - c. Strength
 - d. Route (if medications can be administered by more than one route)
 - e. Frequency
 - f. Rate
 - g. Method
 - h. Site of administration
 - i. Medications ordered as "PRN" must specify frequency and indication.
2. The use of abbreviations should be minimized and only standard abbreviations on the Medical Center's approved list can be used. Abbreviations on the commonly misinterpreted abbreviations and symbols list will not be accepted.
3. Medication dosages should be expressed in the metric system and the use of unnecessary decimal points or zeros after a decimal point should be avoided. A zero should be placed in front of a leading decimal point.

All medication orders must be reviewed by a pharmacist prior to the administration of the drug unless: A physician controls the ordering, dispensing, and administration of the drug, such as in the OR, ED or Endoscopy suite; 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. Any problems or questions concerning a medication order must be resolved by the pharmacist in direct contact with the prescriber and/or the nurse caregiver. Nursing personnel should not be used as an intermediary in the resolution of those questions regarding pharmacotherapy or dosing. The pharmacist must contact the prescriber directly.

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 BGSMC 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.

If the pharmacist is requested by the prescriber to dose the medication, or take any changes in the original medication orders, the pharmacist involved is responsible for writing the revised order on a Physicians' Order sheet and placing it into the patient's medical record.

Verbal/Telephone Medication Orders

Refer to the Verbal and Telephone Orders section under PHYSICIAN ORDERS.

- The name of the medication should be confirmed by any of the following: spelling, providing both brand or general name of medication, and/or providing the indication for use.

- The entire order should be written down by the person receiving the order and then the entire order must be read back to the prescriber to verify accuracy.
- Orders should be documented in the patient's medical record, reviewed, and countersigned by the responsible physician as soon as possible.

Authorization to Order Medications

Medical practitioners, licensed by the State of Arizona to prescribe medications, may write orders for medications, if they satisfy the requirements for membership in the Medical Staff as set forth by Article Three of the Medical Staff Bylaws and have clinical privileges at BGSMC. House staff in the teaching program at BGSMC may write orders for inpatients and outpatients, including patients seen in the Emergency Center and the Outpatient Clinics as part of their teaching program. Allied Health Professionals as defined in the Bylaws may write orders under the policies outlined in the AHP Rules and Regulations. Registered pharmacists are permitted to order medications under physician ordered pharmacotherapy consults.

Authorization to Administer Medications

Only appropriately licensed personnel or approved personnel working under the direction of a licensed person may be allowed to administer medications and diagnostic contrast media. (Administration of medications will be in response to an order by an authorized individual, as set forth above.)

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

1. Physician, including house staff officers and Physicians' Assistants.
2. Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Certified Registered Nurse Anesthetist and Clinical Perfusionist. Administration of chemotherapeutic agents can only be performed by nurses certified in chemotherapy.
3. Respiratory Care Practitioners, Levels 1, 2, 3 & 4 (medications related to respiratory therapy treatments only).
4. Respiratory Care Coordinator, Supervisor and Education Coordinator (medications related to respiratory therapy treatments only).
5. Respiratory Technical Specialists (medications related to respiratory therapy treatments only).
6. Radiology Technologist and Nuclear Medicine Technologist (medications related to radiology/nuclear procedures only).
7. EEG Technician and Cardiovascular Technician (CVT) (oral medications only) and Anesthesia Technicians.
8. Physical Therapist (topical medications only)
9. Nursing and Respiratory students under direct supervision of a preceptor.

For those job categories, listed above, not licensed by the State of Arizona to administer medications and whose educational preparations do not include training in administering medication, a training and skills assessment program should be in place.

Authorization to Administer Medications and Perform Medical Procedures in the Academic Ambulatory Clinics

Medical Assistants (MA) may perform the following medical procedures under the direct supervision of a doctor of medicine, physician assistant or nurse practitioner. Direct supervision is defined as the physical presence of a doctor, physician assistant or nurse practitioner in the office before, during and after administration of medication or therapeutic modalities.

1. Take body fluid specimens, specifically phlebotomy;
2. Administer medications and immunizations where orders are written or generated electronically:
 - a) Administration of oral subcutaneous, intradermal, inhaled, (i.e. SVN) or I.M. medications with the exception of High Risk, High Alert Medications (see Policy and Procedure 3653 – version 3653.6)
 - b) Administer SQ Insulin and allergy shot injection using the double check method. A second licensed staff (LPN, RN or M.D./D.O.) must verify the dose and type of Insulin. Documentation must occur by the verifying the individual.

3. Assists with office procedures including minor surgical procedures.

House Staff

All House Staff members, before ordering any medications, should check the patient's chart, and if it is a drug that would alter the therapy prescribed by the attending physician, the patient must be checked personally by the House Staff member and the attending physician notified.

HEALTH CARE DIRECTIVES

All Banner Health facilities provide 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. (Please see BH Health Care Directives policy for further information).

CONSENT

Consent forms should be in writing and properly signed and witnessed. It is acceptable practice for someone other than a physician to obtain and witness a patient's signature on a consent form. However, it is essential that the physician provide the medical explanation including the risk, benefits, and potential complications associated with procedures leading to the patient's consent for surgeries or other significant procedures. Signed consent forms will be made a part of the patient's permanent medical record.

The patient, or in special circumstances, someone acting for the patient, gives consent. Spouses and other family members do not have the right to consent or refuse consent for most patients. For unemancipated minors and wards, parents or guardians generally have the right to consent. (See Banner Good Samaritan Medical Center policies on consent for further information.)

SURGICAL

In surgical cases, the provisional diagnosis shall be recorded by the surgeon before operation. When the history and physical examination is not recorded or stated in writing to have been dictated before the time stated for operation, the operation shall be cancelled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

All operations performed in the Medical Center shall be dictated and fully described by the operating surgeon the day of the operation. All orders for patient care will be cancelled at the time of surgery and it will be the responsibility of the attending surgeon to write new orders for continuation of the patient's care. Tissues and foreign bodies removed during a surgical procedure shall be sent to the Medical Center pathologist for evaluation. Such specimens shall be properly labeled, packaged in preservative as designated, and identified as to patient and source in the operation room at the time of removal. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. Receipt by the laboratory of surgically removed specimens for examination shall be documented, and identity of the specimens and patients shall be assured throughout the processing and storage.

Specimens sent to the laboratory shall be examined by a pathologist. The determination of which categories of specimens require only a gross description and diagnosis shall be made conjointly by the pathologist and the medical staff, and documented in writing. Categories of specimens that are exempted from the requirement to be examined by a pathologist are the following:

- A. Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance;
- B. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;
- C. Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;

- D. Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant;
- E. Placentas that are grossly normal and have been removed in the course of operative and nonoperative obstetrics;

OPERATIVE AND HIGH RISK INVASIVE PROCEDURE SITE IDENTIFICATION

- A. The correct surgical or invasive procedure site will be marked for those cases involving right/left distinction, or multiple structures (toes/fingers), or levels (spine) – the general level of the procedure (cervical, thoracic, or lumbar) as well as anterior vs. posterior or right or left. The physician, patient and the surgical or invasive procedure team will verify that the correct site is marked prior to the start of the procedure.
- B. Laterality of all procedures will be verified and spelled out in its entirety on the consent form.
- C. Prior to the start of the procedure, the surgical or invasive procedure team will pause (conduct a “time-out”) and using active communication will prior to the incision:
 1. Verify that relevant documentation, images, implants or special equipment is readily available;
 2. Verbally confirm the correct patient, correct side and site, correct patient position and correct procedure as identified on the consent for operation. Verification will be documented in the medical record.
 3. Resolve any questions or discrepancies prior to start of the procedure.
- D. The exact interspace to be operated on will be identified intraoperatively via x-ray.
- E. Compliance with this policy will be monitored concurrently.

RESTRAINTS AND SECLUSION

- A. **General:** Restraints and seclusion may only be imposed to ensure the immediate physical safety of the patient, staff or others and when less restrictive interventions have been determined to be ineffective. Restraint and seclusion may not be used as a means of discipline, convenience or retaliation, and may not be used solely based on prior history of violent or self-destructive behavior. Seclusion may only be used for the management of violent or self-destructive behavior.
- B. **Restraint (Non-Violent, Non-Self-Destructive):** Restraints may only be implemented with the order of a physician or other licensed independent practitioner (LIP) with renewal every 24 hours. PRN orders are not permitted. This category applies to any device that reduces the ability of a patient to move his/her arms, legs, body or head freely, including soft restraints for intubated patients and to prevent NG or IV removal as well as the use of all bed side rails to prevent falling or other accidental injury.

Summary of physician actions:

 - Give an order (written or telephone) to restrain the patient, using the least restrictive type or technique appropriate.
 - Every 24 hours – see and assess patient, sign previous order and write a new order for restraints if need continues.
- C. **Violent Behavior Restraint or Seclusion:** Restraints or seclusion needed to control violent or self-destructive behavior may only be implemented with the order of a physician or other licensed independent practitioner (LIP) with renewal every 2 hours (adolescent) or 4 hours (adult). PRN orders are not permitted. This category would apply to patients who need to be forcibly put in restraints because of threat of physical injury to self or others, or destruction of property. A bedside assessment must be conducted by a physician, LIP, trained RN, or PA within 1 hour of restraint application or seclusion. If this evaluation is conducted by a trained RN or PA, the RN or PA must consult the attending physician or LIP as soon as possible after completion of the evaluation.

Summary of physician actions:

- Order restraint or seclusion as required;

- Conduct face-to-face assessment within one hour of order. If trained RN or PA conduct assessment, consult the attending physician or LIP as soon as possible after completion of the evaluation.
- For patients 18 years of age and older: renew order every 4 hours if required;
- For patients under 18: renew order every two hours if required;
- 24th hour – see and assess patient, sign telephone orders and write new order if continued restraint or seclusion is required.

WITHDRAWAL OF LIFE SUPPORT

- A. 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 with appropriate family members or defined surrogate (e.g. designated medical power of attorney). Discussions with patient, family members or surrogate decision maker should be documented in the medical record.
- B. 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 housestaff, 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.
- C. 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.
- D. 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.

AUTOPSIES

- A. Autopsies will be encouraged 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 following circumstances:
 - 1. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.
 - 2. Deaths in which the cause is not known with certainty on clinical grounds.
 - 3. Unexpected and unexplained deaths occurring within 48 hours after any medical, surgical or dental, therapeutic or diagnostic procedures that do not fall under medico-legal jurisdiction.
 - 4. Deaths occurring in patients who are at time of death, participating in clinical trials (protocols) approved by institutional review boards.
 - 5. Sudden, unexpected, or unexplained deaths which are apparently natural and not subject to forensic medical jurisdiction.
 - 6. Natural deaths that are subject to, but waived by medico-legal jurisdiction.
 - 7. Deaths resulting from high risk infectious and contagious diseases which have been waived by the Medical Examiner.
 - 8. All obstetric deaths.
 - 9. All neonatal and pediatric deaths.
- B. Attending physician or their designee requests and obtains permission for an autopsy from the family.
- C. Signed consent required. A valid consent must meet the following criteria:
 - 1. 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.
 - 2. It must be witnessed by at least one person present at the time of signing.
 - 3. Any exclusions (e.g. brain) or "none" must be noted on the autopsy consent form at the time of signing.
 - 4. 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 autopsy permission and indicating any exclusions is submitted directly to the HIMS Department.

- D. In certain instances, patient advanced directives, physician preference, and family requests may preclude performing an autopsy.
- E. A Pathologist may refuse to perform an autopsy under the following situations:
 - 1. The case meets the criteria of a Medical Examiner's case.
 - 2. The case was waived by the Medical Examiner's office, but appears to have criminal/and/or other legal implications.
 - 3. The Consent for Autopsy appears to be invalid, incomplete, or questionable.
 - 4. The pathologist believes that the case represents a risk to himself/herself or hospital personnel that the facility is not equipped to handle (e.g. Cruetzfeldt-Jacob Disease).
 - 5. Autopsy fails to meet quality assurance or education criteria.
- F. The pathologist determines who can be present during an autopsy.
- G. Families requesting an autopsy when the attending physician 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 hospital will not be responsible for any arrangements nor charges associated with independent autopsies.
- H. The pathology department of the hospital will notify the medical staff, specifically the attending physician and appropriate housestaff when an autopsy is being performed.

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. (See Patient/Visitor Incidents: Reporting, Monitoring, Analysis and Disclosure Policy.) The physician will develop a plan for disclosure in collaboration with other caregivers and hospital 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.

STANDING COMMITTEES

1. The **BIOETHICS COMMITTEE** shall consist of:
 - A Chairman appointed by the Chief of Staff
 - Physician membership shall represent the Departments of Medicine, Obstetrics-Gynecology, Pediatrics, Surgery, Family Practice and other departments or sections as deemed appropriate.
 - Critical Care Committee representative
 - Graduate Medical Education Committee representative
 - Physician Liaison member (or members) from Phoenix Children's Hospital appointed by the Chief of Staff of BGSMC in consultation with the Chief of Staff of PCH.

Committee composition may include:

- Administration
 - Housestaff
 - Legal profession
 - Nursing
 - Pastoral Care
 - An philosopher/ethicist
 - A lay representative of a handicapped group
- Resource individuals may be asked to participate in the committee's deliberations without becoming members of the committee.

Functions of the Committee:

- A. Education is the first priority
 1. Development of information to clarify issues and to aid in the decision-making process.

2. Utilization of any medico-legal and/or ethical authorities for the benefit of the committee itself or for the dissemination of information to any involved group of professional and/or lay individuals.
 3. Make known the existence of the committee and its availability for augmenting the education of the Medical Staff, Nursing and Administration of the hospital.
 4. Any decision or recommendation of a consulting group may be presented to the committee for education purposes.
 5. Development of guidelines for the committee or, as later indicated, for any subcommittees.
 6. Development of guidelines for the Medical Staff and, if applicable, for presentation to other hospital departments.
- B. Consultation of individual cases when requested or to ensure that consultation is consistent with Federal or State requirement.
1. There would be no infringement on the physician's authority in dealing with the patient.
 2. All decisions would be made by the patient or responsible party with the guidance of the physician, considering appropriate consultation(s).
 3. The decisions and/or recommendations of the consultants would be by consensus and not be vote.
- C. Standing Subcommittees
1. The chairman of the committee, with the approval of the committee, may appoint any standing subcommittee as required for continuing specific duties.
 2. All members need not be members of the committee. At least one member of the subcommittee shall be a member of the full committee.
 3. The chairman of the committee shall formulate guidelines, with the consent of the committee, for the direction of any subcommittee.
2. The **CRITICAL CARE COMMITTEE** shall consist of:
Chairman and at least four other members from the medical staff. Director of nursing and such members from his or her nursing staff as he or she may wish to designate

Functions of the Committee:

- A. The Critical Care Committee shall supervise and review all critical care activities within the Medical Center.
 - B. Shall formulate such Rules and Regulations as are necessary for the proper conduct of the critical care activities within the Medical Center with the approval of the Executive Committee.
3. The **HEALTH INFORMATION MANAGEMENT SERVICES (HIMS) AND UTILIZATION MANAGEMENT (UM) COMMITTEE** shall consist of:
- Chairman and three other members of the Medical Staff, appointed by the Chief of Staff
 - Director of Graduate Medical Education, (Ex-officio)
 - HIMS Director
 - Chief Medical Officer
 - Case Management Director
 - Nursing representative
 - Administrative Representative
 - House Staff Representatives

Functions of the Committee:

- A. The Committee will meet to review clinical documentation to ensure compliance with required standards and evaluate the quality of medical care in the Medical Center.
- B. The Committee will report to the Executive Committee the names of any members who are chronically delinquent in completion of their records.

- C. The Committee will coordinate with HIMS and the Deployment Team (Care Transformation) to implement the Banner franchise model with respect to the electronic health record.
- D. The Committee will identify information needs, whether electronic or paper based, to address patient confidentiality, security, and integrity of information.
- E. The Committee will review for appropriate allocation of hospital resources in a cost-effective manner and facilitate reimbursement for services rendered to patients.
- F. The Committee will address appropriate admissions, services, care settings, and length-of-stay concerns.
- G. The Committee will address the early initiation of discharge planning through the case management process to ensure that patients progress through the continuum of care in a timely and effective manner.
- H. The Committee primarily reviews the appropriateness of:
 - Admissions
 - Level of Care
 - Continued Stays
 - Procedures
 - Testing and Treatment
 - Discharges
 - Transfers

4. The **INFECTION CONTROL COMMITTEE** shall consist of:

- Chairman and at least one additional physician member of the Medical Staff whose credentials demonstrate experience in infection control
- Administrative representative
- Nursing representative
- Microbiology/Pathology representative
- Epidemiology representative
- Occupational Health representative
- Quality Resource Management representative
- Representatives from other patient/resident care services (on a consultative basis when discussions are pertinent to their department)

Functions of the Committee:

- A. Determine surveillance activities and interventions to promote a safe environment for patients and employees and improve trends in nosocomial infection rates as a part of the facilities organization wide approach to designing, measuring, assessing, and improving its performance.
- B. Using CDC definitions (see attachment), determine mechanisms for nosocomial infection surveillance, analysis, and reporting.
- C. Establish infection control policies throughout the hospital, including review of aseptic, isolation and sanitation techniques, in consultation with individual department managers.
- D. Review of antimicrobial susceptibility profiles of pathogens identified in the laboratory.
- E. Provide consultation regarding equipment and supplies used for sterilization and decontamination purposes.
- F. Evaluate the hospital disposal systems for liquid and solid waste.
- G. Make recommendations and direct the Infection Control Program in corrective action based on review of infections and potential for infection among patient/residents and hospital personnel.
- H. Review and implement proposals for all special infection control studies and any subsequent findings.
- I. Provide input into the scope and content of the Occupational Health Program.
- J. Provide communication and advisement to hospital managers regarding the provision of supplies and equipment necessary to maintain Standard Precautions throughout the facility.

- K. Institute appropriate control measures or studies when there is a potential danger to a patient/resident or employee's safety.
 - L. Review written policies and procedures relating to the facility's Infection Control Program at least every two years; revise as necessary and develop new policies and procedures where appropriate.
5. The **OPERATING ROOM (OR) COMMITTEE** shall consist of:
- A Chairman appointed by the Chief of Staff
 - Membership of at least one member of each surgical specialty and anesthesia.
 - O.R. Nursing Director
 - O.R. Service Manager
 - Materials Management representative
 - Administrative representative

Functions of the Committee:

- A. O.R. functions - nurse/physician problems, relations
 - B. Review and assess equipment and supply issues
 - C. Oversee/facilitate day-to-day functioning; scheduling issues for the O.R.
 - D. Review capital priorities, requests
 - E. Oversee policies and procedures that may affect O.R. function
6. The **Pathology, Radiology, Nuclear Medicine, Transfusion (PRNT) COMMITTEE** is the oversight committee for transfusion services and the departments of Pathology and Radiology Support Services.

The Committee shall consist of:

- Committee Chairman
- Radiology Department Chairman
- Pathology Department Chairman
- Medical Staff Members from radiology, pathology, oncology and emergency services.
- Nursing representative
- Blood Bank Medical Director
- Laboratory representative
- Nuclear Medicine representative
- Radiation Oncology representative
- Positron Emission Tomography (PET) Center representative
- Quality Resource Management (QRM) representative
- Administrative representative

Functions of the Committee:

- A. Measuring, assessing and improving the medical assessment and treatment of patients. Ensure communication of findings, conclusions, recommendations and actions taken to improve organization performance.
 - B. The Department Chairman is responsible for the professional functions, duties, and responsibilities within the department as outlined in Section 8.3 of the Medical Staff Bylaws.
 - C. Review of transfusion services includes but is not limited to justification of blood use; blood ordering practices; adequacy of transfusion services; and policies related to blood use and transfusion.
7. The **PHARMACY AND THERAPEUTICS COMMITTEE** shall consist of:
- Chairman and at least two more members of the Medical Staff
 - The Medical Center Pharmacist, ex-officio

Functions of the Committee:

- A. Assume responsibility for supervision of the Medical Center Formulary.
- B. Shall meet at least quarterly to formulate regulations concerning administration of drugs in order to safeguard patients and improve their care.
- C. Suggest means to economize on the cost of drugs to the patient.

- D. Discuss pertinent matters with regard to the Pharmacy.

The **Antimicrobial Committee** shall be a subcommittee of the Pharmacy & Therapeutics Committee.

Functions of the Committee:

- A. Review formulary recommendations regarding antibiotics and establish policy for those who wish to add drugs to the formulary (after reviewing efficacy, cost, etc.)
- B. Look at antibiograms and ways to educate physicians and nursing staff on use of antibiograms.
- C. Be the mainstream as to what is going on with susceptibility patterns and give guidance to the P & T Committee.
- D. Address issues of resistance within various groups of microorganisms. Make recommendations of handling resistance in future.

8. The **PROFESSIONAL HEALTH COMMITTEE** shall consist of:

- A Chairman appointed by the Chief of Staff
- Membership of at least five members chosen at large by the Chief of Staff, upon recommendation of the Chairman of the Professional Health Committee.
- Members shall serve for at least two (2) years.
- Whenever possible, at least two Committee members shall be professionals who are in recovery from chemical dependency.
- Those who have recovered from emotional or physical impairment shall be considered for membership.

Functions of the Committee:

- A. Provide ongoing education to the Medical Staff and Administrative leadership on physician and AHP health and impairment recognition issues; on the different kinds and levels of impairment and the problems of impairment; and on resources available for the diagnosis, prevention, treatment and rehabilitation of impairment.
- B. Recommend available resources for diagnosis and/or treatment of physicians and AHP experiencing possible illness and impairment issues;
- C. Serve as a resource for physicians and AHP experiencing illness and impairment issues;
- D. Assist the Medical Staff in evaluating potential illness and impairment and in monitoring ongoing compliance with treatment recommendations which may include a signed monitoring agreement;
- E. Assist Medical Staff leadership with an intervention, when so requested by a department chairman or Chief of Staff/designee;

The Committee ***will not*** have any disciplinary authority, but will have the responsibility for:

- 1) recommending to the affected practitioner that either a psychological, psychiatric and/or physical examination is obtained;
- 2) ensuring the recommendations of the committee/subcommittee are being followed;
- 3) requiring the affected practitioner to obtain a report from his or her treating physician/psychologist stating the practitioner is able to engage safely in the practice of medicine and obtain subsequent periodic reports from his or her treating physician/psychologist for a period of time specified by the PHC or appropriate department chairman; and
- 4) advising the appropriate Department Chairman/Executive Committee of the affected practitioner's failure of adhere with the recommendations.

If the Committee does not feel that its recommendations are being followed, the Committee Chairman will notify the practitioner's Department Chairman for consideration of appropriate corrective action in accordance with Article 6 Corrective Action as set forth in the Medical Staff Bylaws.

DIVISIONS

A division represents an interdepartmental component of the medical staff that is formed to further development and program planning of a multi-disciplinary program.

Any interested member of the medical staff may become a division member; however, such member shall retain his or her department assignment and remain under that department's jurisdiction.

It shall be the responsibility of each division to maintain and improve the quality, scope, and accessibility of the services within the purview of the division.

Each division shall be responsible for review of all administrative matters pertaining to the activities of the division and shall formulate such policies or rules and regulations as are necessary with the approval of the Executive Committee.

Each division shall consist of:

- A chairman
- At least one representative from each clinical department concerned with the activities of the division.
- Such liaison members from other departments as are desirable.
- Hospital personnel from pertinent areas shall be encouraged to participate.

I. The **DIVISION OF ONCOLOGY** will be an interdepartmental division.

-Any interested physician member of the Medical and Dental Staff may become a member upon request to the Division, but will retain his departmental designation and remain under its jurisdiction. The Division of Oncology Committee shall be a standing committee and shall consist of:

- A Chairman of the Division
- Medical staff members from the following departments: surgery, gyn, medical oncology, diagnostic radiology, radiation oncology and pathology.
- Other interested physician members as appropriate.
- Non-physician members from administration, nursing, social services, palliative care, rehabilitation, oncology data management, cancer registry and quality assurance.
- Other interested non-physician members as appropriate.
- Shall meet at least quarterly each year.
- Responsible for the American College of Surgeons (ACoS), Commission on Cancer, academic accreditation regulatory compliances, (please refer to the current edition of the cancer program standards manual for compliances).
- Members shall attend 50% of the annual quarterly meetings which are 2 of the 4 annual meetings.

Functions of the Division:

- A. Develop and evaluate the annual goals and objectives for clinical educational and programmatic activities related to cancer.
- B. Promote a coordinated, multidisciplinary approach to patient management.
- C. Ensure that education and consultative cancer conferences include the 5 major cancer sites presented with national treatment guidelines and TNM staging is discussed. 10% of the analytic volumes are presented with 75% of the analytic case presentation are prospective presentations and monitor case mix presentations and specialty in attendance,
- D. Ensure that an active supportive care system is in place for patients, families and staff.
- E. Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.
- F. Promote clinical research.
- G. Supervise the cancer registry. Ensure accurate and timely abstracting, staging, follow-up reporting, and perform quality control of registry data.
- H. Ensure content of the annual report; publish the annual report by November 1 of the following year; and encourage data usage and regular reporting.
- I. Uphold medical ethical standards.

- J. The Division of Oncology Committee shall supervise and review all administrative matters pertaining to the activities of the Division.
 - K. Shall formulate such Rules and Regulations as are necessary with the approval of the Executive Committee.
 - L. Responsible for the American College of Surgeons (ACoS), Commission on Cancer, academic accreditation regulatory compliance, (please refer to the current edition of the cancer program standards manual for compliances).
 - M. Responsible for the new patient care standards related to cancer care.
2. The **DIVISION OF NEUROSCIENCES** will be an interdepartmental division including:
- A Chairman of the Division
 - Neurology, neurosurgery, physiatry members of the medical staff.
 - Any other interested physician member of the Medical and Dental Staff upon request to the Division, physician members will retain his departmental designation and remain under its jurisdiction.
 - Such liaison members from other departments as are desirable.

Functions of the Division:

- A. To improve the quality, scope and accessibility of all neuroscience services.
- B. The Division of Neurosciences Committee shall supervise and review all administrative matters pertaining to the activities of the Division .
- C. Shall formulate such Rules and Regulations as are necessary with the approval of the Executive Committee.

STAFF CATEGORIES

Active staff must have attended at least twenty patients in the medical center in the previous twelve month period; less than this amount will result in assignment to the Associate or inactive staff. A waiver to this requirement may be granted in special circumstances where a practitioner has demonstrated a genuine concern and interest through substantial involvement in the affairs of the medical staff or Medical Center in the previous twelve month period.

Associate staff must have attended at least one patient in the Medical Center in the previous twelve month period. Less than this amount may result in expiration of privileges or assignment to the inactive staff. (The following shall be defined as "attended" for the purposes of staff category designation: admissions, consultations, inpatient and outpatient surgeries, assisting in surgery, patients anesthetized, diagnostic or therapeutic procedures performed, emergency room or clinic patient visits).

Adopted and recommended to the Banner Health Board of Directors by the Executive Committee, **April 23, 2012.**

David M. Paul, M.D.
Chief of Staff

Approved and adopted by resolution of the Banner Health Board of Directors **May 10, 2012**, upon recommendation of the Executive Committee.

David Bixby
General Counsel/Secretary

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