Banner Estrella
Medical Center

MEDICAL STAFF GENERAL RULES AND REGULATIONS

ARTICLE I. GENERAL RESPONSIBILITIES OF ACTIVE STAFF MEMBERSHIP

1.1 Active Staff Requirement. The Active Medical Staff must admit other otherwise be involved in a minimum of 25 patient admissions, consultations or inpatient/outpatient procedures at the Medical Center per calendar year. Any Medical Staff Member who does not meet the preceding patient contact requirements may submit documentation of other activities demonstrating substantial involvement in the affairs of the Medical Staff and/or the Medical Center to request Active Medical Staff membership. The Medical Executive Committee, or its designee, shall in its discretion determine if such other activities are sufficient to satisfy the requirements necessary to achieve or maintain Active Medical Staff membership. Each Medical Staff Member must meet the above criteria during the previous calendar year to achieve and maintain Active Medical Staff membership. Continuation of membership on the Active Medical Staff may be forfeited by any member who fails to comply with these Bylaws, Rules and Regulations or any other departmental requirements.

1.2 Emergency Room Call. Physicians serving on the call roster of the Emergency Room are responsible to cover their call or assure coverage by a Banner Estrella Medical Center Medical Staff member who complies with the departmental requirement for emergency room call, and to notify the Medical Staff Services office of any changes prior to changes being made. Physicians who have substantiated health reasons for being excused from call rotation may be excused by the Department Chairman. Specific Call Requirements are described by department in Departmental Rules and Regulations.

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

1.4 Research. All research being conducted at, sponsored by, or otherwise affiliated with BEMC facilities and Medical Staff must be in compliance with 45 CFR 46, 21 CFR 40, 21 CFR 56 of the IRB Guidebook for Protection of Human Subjects, and current Banner Health relevant policies, regardless of funding source. All research activity should be guided by the ethical principles reported by the National Institutes of Health. All research must receive favorable recommendation by the Institutional Review Board of Banner Health and Research and Technology Committee of the Medical Staff that includes a scientific, institutional, human subject, and financial review process, as indicated per regulations and policy.

ARTICLE II. ADMISSION POLICIES

Each inpatient has an attending physician (MD or DO) with clinical privileges who is accountable for the management of medical services delivered to the patient.

2.1 The authority for admission of patients to the Medical Center has been vested in the Medical Center Administrator by the Banner Health Board of Directors. Requests for admission are made by the physician, but the final approval rests with the Medical Center Administrator. Members of the Hospital's Medical Staff may admit patients suffering from

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

2.2 Patients will be attended by members of the Medical Staff regardless of race, creed, sex, national origin, religion, or sources of payment for care. Patients admitted under emergency conditions, who have no attending physician, shall be treated and admission arranged for by the doctor on duty in the Emergency Department at the time and assigned to members of the Medical Staff on duty in the service to which the illness of the patient indicates assignment.

2.3 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.

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

2.5 Admission testing will be done only upon specific order of the physician. Lab reports from a certified laboratory, with adequate documentation for the chart, will be accepted.

2.6 Patients admitted to the Critical Care Unit must be seen by the patient's admitting/consulting or attending physician within 6 hours or as clinically appropriate. The patient must be seen sooner if the patient's condition warrants physician intervention. Patients must be seen daily thereafter by the physician, or more often if the patient's condition warrants.

2.7 Attending physicians or their physician designees are required to see patients within 24 hours of admission and daily thereafter. Allied Health staff visits shall not suffice for physician rounding. The appropriate department chairman is to be notified by Administration if a patient is not visited by the attending physician or his physician designee within 24 hours of admission and daily thereafter.

2.8 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.

2.8.1 Obtain pre-admission or pre-procedure certification if necessary.
2.8.2 Admit patients on the day of their elective surgery or procedure or provide documented reasons of medical necessity for earlier admission.
2.8.3 Facilitate, when possible, the appropriate pre-admission testing and medical clearance for elective surgical admissions.
2.8.4 Cooperate with physician advisors when issues or questions arise regarding necessity for admission or continued stay.
2.8.5 Participate in appeal of outside denials if the denial is felt to be unjustified.

2.9 It is the goal of the Medical Staff that patients are cleared for discharge by 11:00 A.M. whenever possible.

2.10 The practitioner is not required to visit his/her medically stable patient on the day of discharge as long as the practitioner visits the patient on the day prior to discharge. Exception is made for psychiatrists functioning as an attending practitioner for psychiatric patients where patients are visited five days per week.

2.11 Admission of Obstetrical Patients

2.11.1 If the patient has an obstetrical problem at any gestational age (vaginal bleeding, SAB, hyperemesis, etc.), the OB physician must be the admitting physician.

2.11.2 An obstetrical patient less than 20 weeks gestation with a non-obstetrical problem will be admitted by the medical hospitalist. OB physician may be consulted if needed.

2.11.3 An obstetrical patient greater than 20 weeks gestation with non-obstetrical problem will be admitted by an obstetrician. In this case, the obstetrician may request medical hospitalist or subspecialty consultation for general medical conditions.

2.11.4 When an obstetrical patient is admitted to the ICU, she will be admitted to the intensivist. When released from the ICU to the floor, if the patient is greater than 20 weeks and her primary problem is not directly OB related, the obstetrician will be the attending physician, with the medical hospitalist consulted if needed. If she is less than 20 weeks gestation, the medical hospitalist will be the attending physician with the OB physician consulted.

2.11.5 The above does not prohibit obstetrician from directly admitting at any gestational age regardless of specific condition.

2.12 Admission of Pediatric Patients

2.12-1 Pediatric Patient: a patient less than 18 years of age.

2.12-2 Pediatrics is not an organized service at BEMC, therefore patients under the age of 18 are not admitted to BEMC with the exception of:

a) Obstetrical patients
b) Emancipated minors
c) Neonatal patients
d) Surgical patients 16 years of age and older, who in the belief of the treating physician can be treated appropriately on an adult unit, and who do not require ongoing medical management.

2.12-3 During periods of increased capacity at other hospitals, emergent pediatric patients, requiring inpatient admission, who cannot be transferred due to lack of bed availability, will remain in the Emergency Department until transfer can be completed.

2.12-4 Standard policy and procedures relating to transfer and transport of the pediatric patient will be followed.

2.12-5 To ensure the health and safety of the pediatric patient, parents or their assigned designee will be encouraged to stay with the ill child as much as possible.

ARTICLE III. CONSULTATIONS

3.1 Consultation is encouraged for all patients whose medical problem is not within the scope of the attending physician. Instances of inappropriate consultation will be reviewed by the Professional Review Committee.

3.2 In each case, the consulting physician is responsible for making sure the consultant is contacted in a timely manner, with the appropriate patient information including the reason, urgency, and contact information for the consulting physician. The consulting

physician should directly communicate with the consultant whenever possible. All ICU consults require physician to physician communication.

To accomplish adherence to these Rules and Regulations, the following process must be followed:

- Only the attending physician can request a consult. If a consultant feels other expertise is needed, the consultant can recommend this to the attending physician either through direct communication or by documenting the recommendation in the consultation report or progress notes. A consultant may not order another consultation except in emergent situations. This will improve coordination of care.
- When a consultation is required, the attending physician will place an order and include a telephone number and a preference for texting or phoning for the consultant to contact the attending physician. A nurse or health unit coordinator may then contact the consultant with this information. The attending physician may contact the consultant directly at his/her option, but the order for consult should still be entered. The request for consultation is not considered complete until the attending physician and consultant have directly communicated. It is recommended physicians share cell phone numbers and indicate their preference for texting or phoning.
- When the consultation has been performed, the consultant must directly communicate with the attending physician, as well as document the consultation in the EMR.

3.3 For inpatient admissions, physician consultation must be rendered and electronically recorded or dictated within 24 hours of notification. A physician assistant or nurse practitioner may see the patient at the discretion of the consulting physician. The consultant will see the patient as often as is clinically indicated.

3.4 For observation patients, it is the goal of the Medical Staff for consultants to see patients in Observation Status within 12 hours of notification whenever possible. If the consultant is not available within the desired timeframe, another consultant may be considered.

3.5 The consultant shall make and sign a record of his/her findings and recommendations in every case.

3.6 Every effort should be made to coordinate orders between multiple consultants and the attending physician. The attending physician will coordinate orders unless he or she specifies differently.

3.7 Upon signing off of a case, the consultant must either: 1) call the attending physician; or 2) add to the depart portion of the EMR regarding medications to be prescribed upon discharge and any follow-up instructions recommended for the patient. The above information must be included in the consultant's sign-off note.

3.8 When a patient attempts suicide while in the Hospital, it is recommended that a psychiatric consultation be obtained. Patients who have attempted suicide or are thought to be suicidal must be cleared for discharge from the Emergency Room via phone consultation or in person by a psychiatrist, psychologist, or trained behavioral health professional who is a member of the Medical Staff or Allied Health Staff of Banner Estrella Medical Center.

3.9 Patients seen in the Emergency Room for any other psychiatric problems must be cleared for discharge from the Emergency Room via phone consultation or in person by a physician who is a member of the Medical Staff of Banner Estrella Medical Center.

ARTICLE IV. MEDICAL RECORD POLICIES

A. General Provisions

4.1 General

4.1.1 A Medical Record is established and maintained for each patient who has been treated or evaluated at the Medical Center. The Medical Record, including electronic data, medical imaging, pathological specimens and slides, are the property of the Medical Center.

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

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

4.2.1 To serve as a detailed data base for planning patient care by all involved practitioners, nurses and ancillary personnel.

4.2.2 To document the patient's medical evaluation, treatment and change in condition during the Medical Center stay or during an ambulatory care or emergency visit,

4.2.3 To allow a determination as to what the patient's condition was at a specific time,

4.2.4 To permit review of the diagnostic and therapeutic procedures performed and the patient's response to treatment,

4.2.5 To assist in protecting the legal interest of the patient, Medical Center and practitioner responsible for the patient and to provide data for use in the areas of quality and resource management, billing, education, and research.

4.3 Electronic Medical Record (EMR) – Banner Health is a "paper light" organization. As such, physicians must 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.

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

4.4.1 Documents from contracted/credentialed external sources that pertain to the delivery of patient care, such as radiology and telemedicine reports and select physician orders, with approval by the BH System Forms Committee. These reports must meet the time requirements and contain the data elements specified in the Medical Staff Rules and Regulations.

4.4.2 Banner Health approved forms and templates that are pre-populated and maintained by the provider with physician specific information such as consents and discharge instructions. These forms will be required to meet Banner Health forms template guidelines for bar-coding/scanning purposes and should not be photocopied by the provider. This exception does not apply to pre-populated forms maintained by Standard Register.

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

4.5 Access to the EMR - Access to patient information on the EMR will be made available to Medical Staff and Allied Staff members and their staff through Clinical Connectivity. All

access to electronic records is tracked and unauthorized access to a patient's record is not tolerated.

4.6 EMR Training - Practitioners who are appointed to the Medical Staff or Allied Health Staff 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 CEO or designee.

4.7 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.

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

4.9 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.

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

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

4.12 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" List.

4.13 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.

4.14 Counter-authentication (Endorsement)

4.14.1 Physician Assistants - history and physical reports, operative/procedural notes, consultations and discharge summaries must be counter-authenticated timely by the physician according to individual facility medical staff policies. Each clinical event must be documented as soon as possible after its occurrence. Requirements for countersignature of progress notes will be established and monitored by the supervising physician.

4.14.2 Nurse Practitioners - history and physical reports, operative/procedural notes, consultations and discharge summaries must be counter-authenticated timely by the physician according to individual facility medical staff policies. Each clinical event must be documented as soon as possible after its occurrence. Requirements for countersignature of progress notes will be established and monitored by the supervising physician.

4.14.3 Medical Students

4.14.3.1 1st and 2nd Year – Access to view the patient chart only. May not document in the medical record.

4.14.3.2 3rd and 4th Year – any and all documentation and orders (if permitted) must be endorsed (countersigned, counter-authenticated) timely by the physician.

4.14.4 House Staff, Resident, and Fellows – Requirements for countersignatures 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 countersignatures by House Staff, Resident or Fellows. Appropriate action will be taken by the specific training programs.

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

B. Medical Record Content

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

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

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

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

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

4.16.5 Accurate coding diagnosis in response to coding queries.

4.17 History and Physical Examination ("H&P") - A history and physical examination must be performed within 24 hours after admission or registration for inpatients or observation or prior to surgery or invasive procedure, or any procedure in which IV Moderate Sedation or anesthesia will be administered. The H&P shall be completed by a physician, or Allied

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

4.17.1 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. 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.

4.17.2 The Obstetrical H&P will consist of the prenatal record, where applicable, updated in the EMR by the responsible physician or Allied Health professional.

4.17.3 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.

4.18 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 responsible 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. A podiatrist may perform the complete History and Physical or H&P update for outpatient podiatric surgical cases.

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

4.19.1 Medical history
4.19.2 Chief complaint
4.19.3 History of current illness, including, when appropriate, assessment of emotional, behavioral and social status
4.19.4 Relevant past medical, family and/or social history appropriate to the patient's age.
4.19.5 Review of body systems.
4.19.6 A list of current medications.
4.19.7 Any known allergies including past medication reactions and biological allergies
4.19.8 Existing co-morbid conditions
4.19.9 Physical examination: current physical assessment
4.19.10 Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
4.19.11 Initial plan: Statement of the course of action planned for the patient while in the Medical Center.

4.20 Behavioral Health Documentation (This section 4.20 only applies to inpatient behavioral health units.)

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

a) Time and means of arrival

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

4.22 Progress Notes - Progress notes should be electronically created with a frequency that reflects appropriate attending involvement but at least every day except as outlined in Section 2.10. For rehabilitation admissions a physician progress note must be documented by the responsible physician a minimum of every 5 days. Progress notes should describe not only the patient's condition, but also include response to therapy.

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

4.23 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). For consults on observation patients, see section 3.4 above.

4.24 Pre-Operative Anesthesia/Sedation Evaluation - A preanesthesia/sedation evaluation must be conducted and documented by an individual qualified to administer anesthesia or IV Moderate Sedation within 48 hours prior to the procedure. A pre-anesthesia/sedation evaluation of the patient must include review of the medical history, including anesthesia, drug and allergy history; review and examination of the patient; notification of anesthesia risk (per ASA classification); identification of potential anesthesia problems, particularly those that suggest potential complications or contraindications; additional pre-anesthesia as applicable; and development of the plan for anesthesia care, including type of anesthetic planned, type of medications of inductions, maintenance, postoperative care, and discussion with the patient (or patient's representative) 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 the 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.

4.24.1 The intraoperative anesthesia/sedation record will also include the name of the practitioner who administered anesthesia and the name of the supervising anesthesiologist and 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.

4.24.2 The post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services and, for outpatients, prior to discharge. The record must include respiratory function, including respiratory rate, airway patency and oxygen saturation; cardiovascular function, including pulse rate and

blood pressure; mental status; temperature; pain; nausea and vomiting; and postoperative hydration.

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

4.25.1 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.

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

4.25.3 The operative or other high-risk procedure report included the following information:

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

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

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

4.27 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.

4.28 Discharge Documentation – A discharge summary must be documented at the time of discharge but no later than 24 hours 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.

4.28.1 The discharge summary shall include:

4.28.1.1 Reason for hospitalization.

4.28.1.1 Concise summary of diagnosis including any complications or co-morbidity factors.

4.28.1.2 Hospital course, including significant findings.

4.28.1.3 Procedures performed and treatment rendered.

4.28.1.4 Patient's condition on discharge (describing limitations).

4.28.1.5 Patients/Family instruction for continued care and/or follow-up.

4.28.2 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 final discharge note shall include:

4.28.2.1 Final diagnosis (es).
4.28.2.2 Condition of patient.
4.28.2.3 Discharge instructions.
4.28.2.4 Follow-up care required.

4.29 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 24 hour thereafter by the responsible practitioner. In the case of the death of a pre-term newborn infant less than 3 hours after birth, a final discharge progress note will be documented by the physician who pronounced the death.

4.30 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.

4.31 Amending Medical Record Entries

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

- Once an entry has been authenticated and an error is found, the EMR will force the author to record his/her comments in the form of an electronic addendum in which the individual will document the erroneous information, authenticate the entry and the system will be date and time stamp the entry.
- If information is found to be recorded on the wrong patient, regardless of the status of the entry, the EMR will not allow deletion of any entries. The entry recorded in error must be documented as such by the author, and re-enter the information on the correct patient.

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

- Errors or omissions discovered at a later time shall be corrected by the individual with a new entry. The person making the change shall sign and note the date of the change and reason for the change. The new entry shall also state who was notified of the change and the date of such notification. The individual must notify the HIMS Department to permit a review of the erroneous documentation for recording in-error criteria within the EMR.
- Any physician who discovers a possible error made by another individual should immediately upon discovery notify the supervisor of that clinical or ancillary area.
- Upon confirmation of the error, the patient's attending physician and any other practitioners, nurses or other individuals who may have relied upon the original entry shall be notified as appropriate.

C. Timely Completion of Medical Records

4.32 Copying and Pasting – Medical staff members and Allied Health Professionals may not indiscriminately copy and paste documentation from other parts of the applicable patient's records. If copying a template, the practitioner shall make modifications appropriate for the patient. If copying a prior entry, the practitioner shall make

appropriate modifications based upon the patient's current status and condition. The practitioner must reference the date of a prior note as appropriate. When copying patient data into the medical record from another provider, the practitioner must attribute the information to the person who performed the task unless it is readily apparent, based upon the nature of the information copied, that the data was entered by another provider. If referencing a form within the record, the form must be referenced with sufficient detail to identify the source. Example: "for review of systems, see form dated 6/1/10."

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

4.34 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	Must be performed within 24 hours after admission or registration for inpatients or observation or prior to surgery or invasive procedure, or any procedure in which IV moderate sedation or anesthesia will be administered.	
Consultation Reports	Documented within 24 hours of consultation	For consults on observation patients, see section 3.4 above.
Post op Progress Note	Documented immediately post-op when there is a delay in the availability in the full report	
Provider Coding Clarification	Completed within 7 days of notice	
Operative Report	Documented immediately post-op and no later than 24 hours after the procedure	
Special Procedures Report	Documented within 24 hours of notice	
Discharge Summary Report	Documented at the time of discharge but no later than 24 hours after 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 but no later than 24 hours after discharge for all admissions less than 48 hrs or for normal vaginal deliveries and normal newborns	

Death Summary	Documented at the time of death/disposition but no later than 24 hours after death.	
Death Pronouncement Note	Completed at the time the patient is pronounced or within 24 hours	
Home Health (Face to Face Discharge Documentation)	Completed within 30 days of discharge	
Transfer Summary	Documented at the time of transfer or no later than 24 hours thereafter	
Signatures	Authentication of transcribed or scanned reports and progress notes, within 7 days from the date of notice	
Verbal Orders	Dated, timed and authenticated within 72 hours	
Psychiatric Evaluation	Documented within 24 hours of admission	

4.35 Medical Record Deficiencies – Physicians are advised of incomplete documentation via the physician inbox. The Health Information Management Services Department shall advise physicians, by fax, mail or electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has met or exceeded the timeframes in section 4.34. The notice will include a due date and a list of all incomplete and delinquent medical records. No additional notification is given.

- 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 suspension/sanction will remain in effect until the documentation is completed.
- If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the physician or the physician's office must notify the Health Information Management Services Department.

4.36 Medical Record Suspensions - A medical record is considered eligible for temporary suspension based on the timeframes in section 4.34. If the delinquent records are not completed timely, providers will receive a notice and their admitting and surgical/procedure scheduling privileges will be temporarily suspended until all medical records are completed. A suspension list will be generated weekly and made available to Administration, Medical Staff Services, Patient Registration, Patient Placement, Emergency Department, inpatient and outpatient surgery and other procedural areas.

- Upon temporary suspension, the delinquent member shall have no admitting, surgical and/or consultative privileges, other than patients in labor or patients needing emergent care, until delinquent records have been completed. A member whose privileges have been suspended under this Section shall be allowed to continue the medical and surgical care only of patients who were in the hospital under their care prior to imposition of the temporary suspension of privileges, or for those patients who are pre-scheduled for surgery/procedures. Specifically, a suspended physician shall not: schedule new admissions, schedule admissions under an associates/covering physician's name, perform consultations, schedule inpatient or outpatient surgeries or other procedures, assist in surgery, administer anesthesia, or round on patients of associates/covering physician's patients. Exceptions to the preceding will be for physicians who are on ED call for their respective specialty; these practitioners will only be permitted to accept unassigned patients through the Emergency Department. ED

providers and hospitalists who are temporarily suspended may not be scheduled for work until privileges are reinstated.

- Restoration of admitting privileges can be accomplished only by completion of all available records assigned to the suspended physician. It shall be the responsibility of the Health Information Management Services Department to immediately notify appropriate parties upon completion of delinquent records so that the name of the practitioner may be removed from the suspension list.
- If a practitioner accumulates 45 days of consecutive or intermittent days of temporary suspension in a calendar year, the respective Department Chair may contact the practitioner.
- Automatic Termination of Privileges for Delinquent Medical Records
  Should a provider accumulate 60 days of temporary suspension within a year, the practitioner's privileges will automatically move to permanent suspension and the practitioner will be required to pay a fee of $150 to be reinstated. All records must be completed and such fee must be paid within 30 calendar days of notification to the practitioner. Once all delinquent records have been completed and the fee has been paid, the number of suspension days will reset to zero (0). Practitioners who do not complete all delinquent medical records and pay the reinstatement fee within 30 calendar days shall be deemed to have voluntarily resigned from the staff and, to regain membership and privileges, must reapply and pay the application fee to the CVO. Such practitioners shall also be reported to the Arizona Medical Board or Arizona Osteopathic Board as required by law.

  Should a practitioner accumulate another 60 days within the year, the above process will be followed; however the reinstatement fee will be $300. In addition, he/she will be required to submit a letter of explanation and a plan of correction for review by the Medical Executive Committee. The Medical Executive Committee can determine further action, up to and including termination from the Medical or Allied Health Staff.
- 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. Physicians may submit evidence demonstrating why the suspension/revocation is unwarranted to the Medical Executive Committee pursuant to Article 6.7 of the Bylaws.

4.37 Physician Orders – BEMC seeks to facilitate timely and accurate execution of physicians' orders to deliver quality patient care, and to provide guidelines within which its medical staff, nursing service, and employees can best accomplish this objective. Orders for treatment shall be routinely entered electronically into the clinical information system and shall be dated, timed and authenticated. If the clinical information system is unavailable for any reason and orders are written on paper, each entry must be dated, timed and authenticated. It is the responsibility of the physician who is transferring the patient to a new level of care to review all active orders for clinical accuracy and appropriateness. Orders for outpatient invasive procedures may only be given by attending, consulting or covering physicians who are members of the Medical Staff, with appropriate privileges.

4.37.1 An admission order shall be documented by the attending/consulting or covering physician for all inpatient or observation patients.
4.37.2 Transfer of a patient's care to another physician must be documented via a physician order.
4.37.3 Physician orders are required for all tests, services and procedures.
4.37.4 Patients shall be discharged only on the order of the attending, consulting or covering physician.
4.37.5 Inpatient orders may be generated by members of BEMC Medical Staff. Allied Health Staff (NPs, PAs) may write orders according to their scope of practice.
4.37.6 Orders for outpatient diagnostic services may be accepted from Medical Staff members, non-staff physicians, out of state physicians and those licensed within

Arizona with prescriptive authority (including PAs and NPs). Practitioners ordering the services must be responsible for the follow-up care of the patient.

4.37.7 Orders for outpatient procedures must include information about the medical necessity or clinical indications for the service or procedure.

4.37.8 If verbal orders are used, they are to be used infrequently and must only be accepted by persons who are authorized to do so in this section. Verbal orders should be used only to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to enter the order without delaying treatment, and should not be used for the convenience of the ordering practitioner. Verbal and telephone orders must be dated, timed and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the patient and authorized by the hospital to write orders. Verbal orders must be authenticated within 72 hours.

4.37.9 Telephone and verbal orders shall be considered valid when dictated to one of the following practitioners:

4.38.9.1	Registered Nurse
4.38.9.2	Licensed Practical Nurse
4.38.9.3	Pharmacist (limited to medications, chemotherapy and clarifications of such only)
4.38.9.4	Physical Therapist (limited to physical therapy orders)
4.38.9.5	Occupational Therapist (limited to occupational therapy orders)
4.38.9.6	Speech Pathologist (limited to speech therapy orders)
4.38.9.7	Arizona State Licensed Respiratory Care Practitioners (limited to respiratory care modalities)
4.38.9.8	Dieticians (limited to diet orders and nutrition support)
4.38.9.9	Laboratory Personnel Qualified to Accept Lab Orders
4.38.9.10	Radiology Techs (limited to radiology orders)

ARTICLE V. GENERAL PHARMACY POLICIES

5.1 General Information

All medication administered to patients at Banner Estrella Medical Center (BEMC) will be supplied by the BEMC 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 Pharmacy & Therapeutics Committee. The formulary is an established compendium of approved medications available at BEMC 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 Pharmacy & Therapeutics Committee. Medications ordered by trade name may not necessarily be filled by that name unless the physician states "do not substitute" within the order. The pharmacy will be permitted to make therapeutic substitutions of medications only within clearly defined parameters established by the Pharmacy & Therapeutics Committee and approved by the Executive Committee. Medication samples shall not be used for patients of the hospital.

5.2 Medications

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

a) 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.

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

c) Outpatient prescriptions, with the few exceptions defined in pharmacy policy, will not be filled at Banner Estrella Medical Center. If a medication is to be sent home with a patient, a prescription must be written.

5.3 Medication Orders

a) Written orders for medications must be legible, clear and accurate. It must include date, time, and the prescriber's signature. All medication orders must be complete, including patient name (present on order sheet or prescription); age and weight of patient, when applicable; medication name; dosage form, dose, strength, route, frequency, rate and method. Medications ordered by "PRN" must specify frequency and indication. The use of abbreviations should be minimized and only standard abbreviations on the Medical Center's approved list can be used. Medication dosages should be expressed in the metric system and a leading zero must always precede a decimal expression of less than one (i.e., 0.1 mg not .1 mg). A terminal or trailing zero is never to be used after a decimal (e.g., 1 mg never 1.0 mg). There must be documentation of medical necessity or clinical indications in the medical record for all medication orders.

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

c) All medication orders must be reviewed and updated when a patient is transferred from one medical service to another, to or from Intensive Care Units, and pre- and post- surgery.

d) Specific post-op orders must be entered, dated and signed by a physician.

5.4 Authorization to Order Medications

Practitioners licensed by the State of Arizona to prescribe medications may write orders for medications, if they satisfy the requirements for privileges on the Medical Staff of Banner Estrella Medical Center consistent with their scope of practice. 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.

5.5 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/or diagnostic contrast media. (Administration of medications will be in response to an order by an authorized individual, as set forth above.)

5.6 Reporting Adverse Drug Events

All adverse drug events shall be reported using the approved system as per BEMC Pharmacy policy.

ARTICLE VI. GENERAL SURGICAL POLICIES

6.1 When a history and physical examination, as stated in these rules and regulations, is not available prior to the surgery/invasive procedure, the surgeon may complete a comprehensive hand written history and physical, or complete the approved History and Physical form prior to surgery. If no history and physical is available prior to surgery, the procedure shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient. A preoperative diagnosis shall be recorded

before surgery by the physician responsible for the patient. H&P Requirements are outlined in Section 4.17 above.

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

6.3 The hospital will not perform any pre-surgical testing except on the specific written order of the physician.

6.4 All specimens removed during a surgical procedure shall be sent to the Pathology Laboratory for gross and/or microscopic examination except at the discretion of the surgeon. The surgeon may choose not to send to the Pathology Laboratory specimens such as prosthetics, implants, cataracts, foreign bodies, teeth, scars and traumatically injured members, placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics. If the surgeon chooses not to send the specimens to the lab, he/she shall dictate a descriptive note of the specimen in the operative report.

6.5 Operative reports are addressed in Section 4.26 above.

6.6 Physician First Assistant: A physician member of the Medical Staff in any specialty, who has an active Arizona Medical License, may assist in surgery.

6.7 <u>OPERATIVE AND HIGH RISK INVASIVE PROCEDURE SITE IDENTIFICATION</u>

a) The correct surgical or invasive procedure site will be marked. 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 and verbally confirm the correct site, correct patient and procedure prior to incision and verification will be documented in the medical record.
d) Compliance with this policy will be monitored concurrently.

6.8 <u>RESTRAINTS</u>

a) The use of restraint or seclusion may only be implemented with the order of a physician or other licensed independent practitioner (LIP). Protocols are allowed; however, if restraints are included in the protocol, the physician or LIP must still write an order for the restraint.
b) PRN and standing orders for restraint or seclusion are NOT permitted.
c) There is no distinction between "medical restraints" and "restraints and seclusion for behavior management." Physician orders are required regardless of whether the restraint is for medical management.
d) Seclusion may ONLY be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.
e) Physicians are no longer solely responsible for performing the face-to-face assessment within an hour of initiating restraints or seclusion for the management of violent patients. The face-to-face assessment may be performed within 1 hour after the initiation of the restraint or seclusion by a physician, an LIP, a PA or a trained RN. 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 the completion of the evaluation.

f) Trial releases are NOT permitted. If a patient is released from restraints when family members are present and must subsequently be restrained after they depart, the physician will need to provide a new order for those restraints.

g) Restraint or seclusion ordered for the management of violent or self-destructive behavior must be time limited and may only be renewed in accordance with the following limits for up to a total of 24 hours:
   - Up to 4 hours per episode for adults 18 years of age or older;
   - Up to 2 hours per episode for children and adolescents 9 to 17 years of age; or
   - Up to 1 hour per episode for children under 9 years of age.

h) The order need not be for the entire time period limit. However, after 24 hours, before writing a new order for the application of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other LIP must see and assess the patient.

i) Hospitals are required to report deaths associated with the use of seclusion or restraint, including deaths within 24 hours of the removal of restraints.

ARTICLE VII. AUTOPSIES

7.1 Autopsies will be encouraged for inpatients (ED patients are not considered inpatients) as part of the facility's quality assurance and educational program and at no cost to the family under the following circumstances:

a) Deaths in which an autopsy helps explain unknown and unanticipated medical complications.

b) Deaths in which the cause is not known with certainty on clinical grounds.

c) Unexpected and unexplained deaths occurring within 48 hours after any medical, surgical or dental, therapeutic or diagnostic procedures that do not fall under medico-legal jurisdiction.

d) Death occurring in patients who are at time of death, participating in clinical trials (protocols) approved by institutional review boards.

e) Sudden, unexpected, or unexplained deaths which are apparently natural and not subject to forensic medical jurisdiction.

f) Natural deaths that are subject to, but waived by medico-legal jurisdiction.

g) Deaths resulting from high risk infectious and contagious diseases which have been waived by the Medical Examiner.

h) All obstetric deaths.

i) All neonatal and pediatric deaths.

7.2 Attending physician or their designee requests and obtains permission for an autopsy from the family.

7.3 Signed consent required. A valid consent must meet the following criteria:

a) Signed by the patient's immediate next of kin (father, mother, spouse, or adult child) or an individual providing proof of power of attorney or guardianship.

b) It must be witnessed by at least one person present at the time of signing.

c) Any exclusions (e.g. brain) or "none" must be noted on the autopsy consent form at the time of signing.

d) In situations where it is not possible or it is extremely inconvenient for the family to come to the facility to sign the consent, a fax giving autopsy permission and indicating any exclusions is submitted directly to the HIMS Department.

7.4 In certain instance, patient advanced directives, physician preference, and family requests may preclude performing an autopsy.

7.5 A Pathologist may refuse to perform an autopsy under the following situations:

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

7.6 The pathologist determines who can be present during an autopsy.

7.7 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.

7.8 The Pathology Department of the hospital will notify the medical staff, specifically the attending physician, when an autopsy is being performed.

ARTICLE VIII. INTERN, RESIDENT AND FELLOW ROTATIONS

8.1 Supervision of Interns, Residents and Fellows

Professional Graduate Medical Education Programs wishing to rotate Interns, Residents or Fellows through Banner Estrella Medical Center (BEMC) will require approval by the Medical Education Committee, appropriate Department Committee, the Medical Executive Committee and Hospital Administrator. This approval will be based upon information provided by the GME training program and whether an affiliation agreement is in place. Once the program is approved, the Program Director or Academic Officer will provide a statement confirming competencies of interns, residents, or fellows who may rotate at BEMC. Interns, residents, and fellows who will be entering orders and notes must complete CPOE/EMR training.

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

Interns, Residents and Fellows are not members of the Medical Staff and therefore may not admit patients, hold elected office or vote, and are not required to pay staff dues. They may attend meetings or serve on committees if invited by the organized medical staff. Physicians in training are not entitled to the rights outlined in Article Three, Section 3.2 of the Medical Staff Bylaws.

8.2. Documentation By Interns, Residents And Fellows

The attending physician shall be responsible for each patient's medical record. When interns, residents or fellows are involved in patient care at BEMC, sufficient evidence is documented in the health record to substantiate active participation and supervision of the patient's care by the attending physician. The teaching physician must personally document his/her participation in three (3) key components of the service provided by interns, residents or fellows, ie. history, exam, and medical decision making. In surgery, the teaching surgeon must be present during all critical or key portions of the procedure.

During non-critical or non-key portions of the surgery, if not physically present, the teaching surgeon must be immediately available to return to the procedure. If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

8.3. Orders and Operative Reports

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

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

ARTICLE IX. MEDICAL STUDENTS, NP, PHYSICIAN ASSISTANT STUDENTS

9.1 MEDICAL STUDENT, NP AND PHYSICIAN ASSISTANT STUDENT LEVEL OF PARTICIPATION

9.1.1 Medical Student Rotations through Banner Estrella Medical Center will be in accordance with the Banner Health Clinical Education Rotation Agreement.

9.1.2 Students will work under the direct supervision of a College participating teaching faculty member, according to specific clinical goals and objectives developed by the College for each rotation.

9.1.3 Clinical goals and objectives will be reviewed, in advance, by the Graduate Medical Education Committee at Banner Good Samaritan Medical Center or a subcommittee to include interested BEMC medical staff members for medical students and PA students. The Banner RN Professional Practice team will review clinical goals and objectives for nurse practitioner students.

9.1.4 Participation in specific types of rotations at BEMC is subject to prior approval of the Medical Executive Committee.

9.2 SPECIFIC MEDICAL STUDENT ACTIVITIES

9.2.1 Year one and two medical students may observe only.

9.2.2 Year three and four medical students must participate in care and management of patients.

9.2.3 Year three and four medical students may document in the medical record. Electronic Medical Record training must be completed.

9.2.4 Documentation is countersigned by faculty promptly. Faculty members are ultimately responsible for all required components of the medical record.

9.2.5 Students may observe or assist in surgery if it is a requirement of the rotation.

9.2.6 Students may assist in surgery if a faculty member is participating and the patient has consented to this.

9.2.7 All activities are under the direct guidance and supervision of faculty.

9.3 SPECIFIC PHYSICIAN ASSISTANT STUDENT ACTIVITIES

9.3.1 PA students may participate in care and management of patients.

9.3.2 At the discretion of the preceptor, PA students may obtain Powernotes training and document in the electronic medical record. Otherwise, they will be granted view-only training and access.

9.3.3 Documentation is countersigned by faculty promptly. Faculty members are ultimately responsible for all required components of the medical record.

9.3.4 PA students may not dictate.

9.3.5 PA students may assist in surgery if completing a family practice, obstetrics/gynecology or surgical rotation and if assisting the faculty member.
9.3.6 PA student must be able to document education of aseptic technique prior to assisting in surgery.
9.3.7 All activities are under the direct guidance and supervision of faculty.

9.4 SPECIFIC NURSE PRACTITIONER STUDENT ACTIVITIES
9.4.1 NP students may participate in care and management of patients.
9.4.2 At the discretion of the preceptor, NP students may obtain Powernotes training and document in the electronic medical record. Otherwise, they will be granted view-only training and access.
9.4.3 Documentation is countersigned by faculty promptly. Faculty members are ultimately responsible for all required components of the medical record.
9.4.4 NP students may not dictate.
9.4.5 All activities are under the direct guidance and supervision of faculty.

9.5 SPECIFIC MEDICAL STUDENT ACTIVITIES
9.5.1 Medical Students may, at the discretion of the supervising Emergency Department physician, attempt direct laryngoscopy and Endotracheal intubation in the Emergency Department.

9.6 RESTRICTIONS
9.6.1 Students may not write discharge summaries or operative reports;
9.6.2 Students may not write orders.
9.6.3 Students may not independently perform procedures without direct supervision.

9.7 STUDENT RESPONSIBILITIES
9.7.1 Students are required to comply with all BEMC policies and procedures during the clinical experience.
9.7.2 Students shall have access only to patient information that is a necessary part of the approved rotation.
9.7.3 Students, as participants in an educational program, must at all times wear a Student Identification Badge issued by Medical Staff Services.

9.8 APPLICATON AND APPROVAL PROCESS
9.8-1 A request for approval for medical and physician assistant student rotation at BEMC must be submitted to the Medical Staff Services Department for processing at least one month in advance of the rotation. NP student applications will be processed by the RN Clinical Educator and forwarded to Medical Staff Services for tracking.
9.8-2 Students, with the assistance of their school, will supply documentation as required by the affiliation Clinical Education Rotation Agreement prior to starting the clinical experience.
9.8-3 Once a specific program has received approval from the BGSMC GME Committee and the BEMC Medical Executive Committee, individual students may be accepted for rotation upon successful completion of the above application process.

9.9 ORIENTATION
Medical, NP and PA Students will be oriented to Banner Health policies, programs, and channels of communication.

9.10 FEES AND SERVICES
For Medical Students, a facility stipend will apply, in the amount provided in the Clinical Education Rotation Agreement, to offset expenses involved in the student rotation for those core rotations and other rotations in which the student spends a substantial amount of their time in the hospital. This fee covers services provided by Banner Estrella Medical

Center including access to: patient (with consent); education and teaching areas; computer systems and training, and meals.

ARTICLE X. TRANSFER OF CARE

10.1 Patient care is routinely transferred between various providers during any given hospital stay and may include referral of complete responsibility, transfer of on-call responsibility and transfer of a patient to a separate unit. Patient "hand-off" is the opportunity to convey critical information to the assuming provider. Hand-off Reports are to be interactive and should include critical information about the patient in regard to diagnosis, treatment plan, anticipated follow-up, pending test results, discharge plans, medication/treatment list.

10.2 Any physician designating cases to the care of another physician shall ensure that the physician is a member of the Medical Staff of Banner Estrella Medical Center. In case of failure to name such designee, the Chief Executive Officer shall have the authority to call any member of the Medical Staff to attend these patients.

10.3 A physician order is required for transfer/transport of a patient to a different level of care within the facility and/or to another facility in accordance with Hospital policies.

ARTICLE XI: ADVANCE PRACTICE PROFESSIONALS DEFINED

Advance Practice professionals (APPs) are individuals who (a) are qualified by training, experience, and current competence in a discipline permitted to practice in the Medical Center; and (b) function in a medical support role to physicians who have agreed to be in a collaborative relationship responsible with such APPs and serve as their sponsor. APPs are not members of the Medical Staff.

11.1 **Categories of APPs Currently Credentialed by the Medical Staff and Authorized to Function in the Medical Center**

11.1.1 The following are the only categories of APPs currently authorized to provide services in the Medical Center, whether privately employed or employed by the Medical Center: clinical perfusionists, certified nurse midwives, nurse practitioners, physician assistants, surgical first assistants, private surgical scrub technicians, crisis counselors/social workers, certified registered nurse anesthetists, intra-operative monitoring technicians and radiology practitioner assistants.

11.1.2 If and when appropriate, the Medical Executive Committee may recommend the addition or elimination of categories of APPs authorized to provide services at the Medical Center. Any such recommended change in authorized categories of APPs shall become effective upon Board approval and shall not require formal amendment of these Rules and Regulations.

11.2 **Scopes of Practice**

11.2.1 A scope of practice for each category of APP shall be developed by the appropriate Department and representatives of management, if applicable, and subject to approval by the Medical Executive Committee and approval of the Board. Each statement must:

(a) Be developed with input, as applicable, from the physician director of the clinical unit or service involved, the physician collaborator of the APP and other representatives of the Medical Staff, Medical Center management, and other professional staff;

(b) Must include specifications of categories of patients for whom services may be provided;

(c) Must include a description of the services to be provided and procedures to be performed, including any special equipment, procedures, or protocols that specific tasks may involve, and responsibility for documenting the services provided in the medical record;
(d) Must include a description of the scope of assistance that may be provided to a physician and any limitations thereon, including the degree of physician supervision required;
(e) Must include the services provided by APP's who are not Banner employees must be commensurate with the qualifications and competencies required of medical center employees who perform the same or similar services
(f) Require the individual APP hold a current license, certificate or such other credential, if any, as may be required by state law; and
(g) Satisfy the qualifications as are set forth for Medical Staff appointment, including appropriate professional liability insurance coverage, or for Medical Center employment, as applicable.

11.3 **Prerogatives of Advance Practice Professionals**

11.3.1 The prerogatives of an APP are to provide such specifically designated patient care services as are granted by the Board upon recommendation of the Medical Executive Committee and consistent with any limitations stated in the Bylaws, the policies governing the APPs practice in the Medical Center, and other applicable Medical Staff or Medical Center policies;

11.4 **Obligations of Advance Practice Professionals**

11.4.1 Each APP member shall:
(a) meet the basic responsibilities required by Section 3.3 for Medical Staff members;
(b) retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Medical Center for whom such APP provides services;
(c) participate when requested in quality review program activities and in discharging such other functions as may be required from time to time;
(d) when requested, attend meetings of the staff, the department, and the section;
(e) fulfill the applicable attendance requirements of these Bylaws and the rules and regulations of the department to which assigned;
(f) provide services within the scope of practice for the APP as approved by the Board and directed by the sponsor; and
(g) refrain from any conduct or acts that could be reasonably interpreted as being beyond the scope of service authorized by the Board.

11.5 **Terms and Conditions of Affiliation**

11.5.1 An APP member shall be individually assigned to the clinical department appropriate to his or her professional training and subject to formal periodic (biennial) review, and disciplinary procedures as determined for the category.

11.5.2 An APP is not entitled to the procedural hearing rights provided in the Fair Hearing Plan.

11.6 **Procedure for Credentialing**

11.6.1 The procedures for processing individual applications from APPs, for reviewing ongoing performance, for periodic reappraisal, and for disciplinary action shall be established:

(a) by the Department, the Medical Executive Committee, and the Board for APPs who are not Medical Center employees; or
(b) by the CEO or his designee for APPs who are Medical Center employees.

11.6.2 The process for credentialing, privileging and reappointment will be equivalent, regardless of whether it is performed by the Medical Center or the Medical Staff. At a minimum, the process shall include an evaluation of the applicant's credentials and current competence, including peer recommendations, and involves communication with and input from Medical Staff leadership including the Medical Executive Committee.

11.7 **Adverse Action Review**

11.7.1 APPs who are subject to adverse action (other than non-reviewable action as defined these Rules and Regulations and the Allied Health Rules and Regulations which includes automatic suspension due to the loss of the sponsoring physician) shall be afforded a limited review process as described below in this Section. Adverse action includes denial of a request to provide any patient care services within the applicable scope of service or revocation, suspension, reduction, limitation or termination of permission to provide any patient care services within the applicable scope of service. APPs are not entitled to due process rights as set forth in the Bylaws, and none of the procedural rules set forth therein shall apply. APPs whose applications are not processed because of their failure to meet the qualifications to provide patient care services are not entitled to due process rights. Where nonreviewable action has been taken, the affected APP member may request that the adverse action be reviewed and may submit information demonstrating why the adverse action is unwarranted. The Medical Executive Committee, in its sole discretion, shall decide whether to review the submission and whether to take or recommend any action. The affected APP shall have no appeal or other rights in connection with the Medical Executive Committee's decision.

APPROVALS:
Board of Directors: 1/12/05; 5/4/05; 5/19/05; 11/05; 01/06; 03/06; 11/06; 4/18/07; 5/17/07; 7/19/07; 8/16/07; 10/18/07; 12/20/07; 3/12/08; 4/10/08; 5/8/08; 6/11/08; 1/15/09; 4/09/09; 11/12/09; 8/12/10; 9/9/10; 10/14/10; 11/11/10; 4/14/11; 10/13/11; 12/18/11; 2/9/12; 5/10/12; 5/9/13, 09/19/13; 1/9/14, 7/21/14; 10/09/14; 03/12/15

REVISED: Medical Executive Committee – 01/06/16; 3/2/16
Out to Medical Staff for comment (Rules & Regs) - 01/07/16; 3/2/16
Board – 2/11/16; 4/14/16

REVISED: Medical Executive Committee – 12/7/16
Out to Medical Staff for comment – 12/21/16
Board – 1/12/17

REVISED: Medical Executive Committee – 1/11/17
Out to Medical Staff for comment – 2/16/17
Board – 3/9/17

REVISED: Medical Executive Committee – 4/5/17
Out to Medical Staff for comment – 4/25/17
Board – 5/11/17

REVISED: Medical Executive Committee – 5/3/17
Out to Medical Staff for comment – 5/22/17
Board – 6/7/17