MEDICAL STAFF RULES AND REGULATIONS

BANNER DEL E. WEBB MEDICAL CENTER
Sun City West, Arizona

ARTICLE 1: GENERAL

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

1.2 **Emergency Department Call:**

1.2.1 Coverage Responsibilities. Physicians serving on the call roster of the Emergency Room are responsible to cover their call or assure coverage by a Banner Del E. Webb Medical Center Medical Staff member with appropriate privileges, and to notify the Medical Staff Services' office of any changes prior to any changes being made.

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

1.3 **Emergency Department Response Requirements:**
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, sponsored by, or otherwise affiliated with BDWMC facilities and Medical Staff must be in compliance with current Banner policies.

1.5 **Disclosure**: The attending physician will disclose a serious incident to the patient, if competent or to the patient's designated decision-maker or family if the patient is not competent. A serious incident is an unintended or unanticipated event not consistent with routine care that resulted in the need for further treatment and/or intervention or caused temporary or permanent patient harm, loss of function or death. The physician will develop a plan for disclosure in collaboration with other caregivers and Medical Center personnel. The physician will document or assure documentation in the medical record of the facts disclosed to the patient, the response and identity of those in attendance.

1.6 **Consent**: 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 Health policies on consent for further information.) 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. A physician may delegate his/her responsibility to obtain Informed Consent to his/her Physician Assistant or Nurse Practitioner. Signed consent forms will be made a part of the patient's permanent medical record. A copy of consent forms, including discussions concerning risk, benefits and alternatives of surgery, documented in the surgeon's office must be provided to the Medical Center to be placed on the patient record.

1.7 **Availability**: Physicians with patients in the hospital must be readily accessible by pager or cell phone or have call coverage by a physician on the Medical Staff with the same privileges.

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

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

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

ARTICLE 2: ADMISSION POLICIES

2.1 The authority for admission of patients to the Medical Center has been vested in the Medical Center CEO by the Banner Health Board of Directors. Requests for admission are made by the physician, but the final approval rests with the Medical Center CEO. Members of the Medical Center's Medical Staff may admit patients suffering from all types of diseases, injuries and conditions provided proper facilities and personnel are available to handle such patients. Physicians shall be held responsible for giving such information as may be necessary to assure the protection of other patients and 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 treated only by physicians who have submitted proper credentials and have been duly appointed to membership on the Medical Staff or have been granted temporary privileges.

2.2 Each patient in the hospital is assigned one attending physician. The attending physician is considered the primary physician and shall be responsible for the primary care from admission through discharge.

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

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

2.5 In consultation with the physician, an obstetrical nurse with demonstrated competencies in aspects of labor assessment may perform medical screening examinations on obstetrical patients. The OB physician on-call will be contacted upon admission for any pregnant patient 24 weeks or greater who is directly admitted to the facility to a service other than Labor & Delivery or who are admitted through the Emergency Department for reasons that may not be related to their pregnancy. The OB physician will determine if the L&D triage nurse can complete the initial assessment.

2.6 Patients admitted for dental service must be admitted by a Medical Staff physician. Patients admitted for podiatric surgical procedures must be admitted with a physician member of the Medical Staff. A Medical Staff physician is responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization and determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient.

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

2.7 Physicians must respond to calls from the nursing unit within thirty (30) minutes from the time the nurse has placed the call.

2.8 When a patient has been admitted from the Emergency Department and arrives to the nursing unit, nursing staff will contact the patient's attending or treating physician, or the physician's covering physician, who is required to respond within thirty (30) minutes from the time the nurse has placed a call to the physician's service or office.

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

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

2.11 Attending physicians or their similarly credentialed physician designees are required to see patients each calendar day following admission. Physicians are required to see behavioral health patients at least five days per week. Patients in the acute rehabilitation unit must be visited by a physiatrist at least once every 72 hours. Physician assistants and nurse practitioners may substitute for attending rounds if the patient is an elective surgical patient. If the patient is not discharged by the third midnight or if there is a surgical complication or deviation from expected post-operative course, the attending physician or physician designee must round on the patient a minimum of every 48 hours thereafter.

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

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

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

2.12.3 Cooperate with case manager and/or physician advisors when issues or questions arise regarding necessity for admission or continued stay.

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

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

2.14 The appropriate section or department chairman is to be notified by Administration if a patient is not appropriately visited by the attending physician or physician designee.

2.15 Patient care is routinely transferred between various providers during any given 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. Any staff member transferring cases to the care of another practitioner shall determine that the practitioner is a member of the Medical Staff of Banner Del E. Webb Medical Center or has temporary privileges for the care of these patients only.

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

ARTICLE 3: 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 physician requesting the consult 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 physician requesting the consult for follow up purposes. The physician requesting the consult should directly communicate with the consultant whenever possible. All ICU consults require physician to physician communication.

3.3 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. 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 communicate with the attending physician, as well as document the consultation in the EMR.

3.4 Physician/psychiatric NP consultation must be rendered and electronically recorded or dictated within 24 hours of notification or sooner if necessary.

3.5 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. No consulting physician is required when a psychiatric nurse practitioner consultation is requested.

3.6 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 Del E. Webb Medical Center. Patients who are emotionally ill or who suffer the results of alcoholism or drug abuse will have a written plan defining the care, treatment or appropriate referral.

3.7 Patients seen in the Emergency Room for other psychiatric problems must be cleared for discharge from the Emergency Room via phone consultation or in person by the patient's PCP or psychiatrist or psychiatric nurse practitioner who must be a member of the Medical Staff or Allied Health Staff of Banner Del E. Webb Medical Center. If the patient's responsible physician does not have privileges at Banner Del E. Webb Medical Center or the patient does not have a responsible physician, a trained

behavioral health professional or the psychiatrist on call will be contacted to clear the patient for discharge.

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

3.9 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.

ARTICLE FOUR: MEDICAL RECORD POLICIES

4.1 **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.

Electronic Medical Record (EMR) Training – Effective August 1, 2010, new Medical Staff and Allied Health applicants may not exercise their privileges at the Medical Center until the practitioner has successfully completed Banner's electronic medical record/computerized physician order entry (CPOE) training. Practitioners who are appointed to the Medical Staff or Allied Health Staff after 8/1/2010 who do not complete 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. Effective December 1, 2010, physicians will be required to use Powernotes or enter typewritten notes into the Electronic Medical Record.

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 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.

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:

a) 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 Systems Forms Committee. These reports must meet the time requirements and contain the data elements specified in the Medical Staff Rules and Regulations.
b) 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.
c) 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

Providers documenting in the EMR must avoid indiscriminately copying and pasting documentation from other parts of the applicable patient's records. Potential issues of copy/paste functionality being used inappropriately will be referred to the HIMS Director and Medial Staff Services.

a) If the provider uses information from a prior note, he/she must reference the date of the previous note.
b) Providers are responsible for clearly identifying who performed each service documented within the note. When copying patient data into the medical record that the provider did not personally take or test, the provider must attribute the information to the person who did unless it is readily apparent, based upon the nature of the information copied, that the data was entered by another provider
c) If the provider references a form within the record, he/she must reference the form with sufficient detail to uniquely identify the source. Example: "for review of systems, see form dated 6/1/10."

If the provider copies a template, the provider shall review the template in its entirety and make modifications appropriate for the patient. If a provider copies a prior entry that the provider authored, the provider shall review the entry in its entirety and make appropriate modifications based upon the patient's current status and condition.

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

4.7 **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.

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

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

4.10 **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.

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

4.12 **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.

4.13 **Counter-authentication (Endorsement)**

4.13.1 **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 countersignature of progress notes will be established and monitored by the supervising physician.

4.13.2 **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. Requirements for countersignature of Progress Notes will be established and monitored by the supervising physician.

4.13.3 **Medical Students**

4.13.3.1 1st & 2nd Year - Access to view the patient chart only. May not document in the medical record.

4.13.3.2 3rd & 4th Year - Any and All documentation and orders must be endorsed (countersigned, counter-authenticated) timely by the physician.

4.13.4 **Residents 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 Residents or Fellows. Appropriate action will be taken by the specific training programs.

4.14 **Legibility** - All practitioner entries in the record must be legible, pertinent, complete and current. Ongoing legibility issues (more than 3 events in a period of six months) will be forwarded to the Peer Review Committee.

4.15 **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:

4.15.1 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.

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

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

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

4.15.5 Accurate coding diagnosis in response to coding queries.

4.16 **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 conscious 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 prior to surgery or

invasive procedure (see 4.17.1), or any procedure requiring anesthesia services 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. For patients receiving electroconvulsive therapy in a behavioral health unit, a current H&P must be completed prior to each treatment. A legible history and physical performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services. If an attending or consulting physician's written documentation meets all of the required elements, it may be considered a History and Physical. 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 **Responsibility for H&P** – The attending medical staff member is responsible for the H&P, unless it was already performed by the admitting medical staff member. Physician Assistants and Nurse Practitioner's may complete the History and Physical if permitted in their position summary. H&Ps performed prior to admission by a practitioner not on the medical staff are acceptable provided that they are updated 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.

4.18 **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:

4.18.1 Medical history
4.18.2 Chief complaint
4.18.3 History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status
4.18.4 Relevant past medical, family and/or social history appropriate to the patient's age.
4.18.5 Review of body systems.
4.18.6 A list of current medications.
4.18.7 Any known allergies including past medication reactions and biological allergies
4.18.8 Existing co-morbid conditions
4.18.9 Physical examination: current physical assessment
4.18.10 Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
4.18.11 Initial plan: Statement of the course of action planned for the patient while in the Medical Center.

4.19 **Behavioral Health Documentation**

4.19.1 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.

4.19.2 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.

4.19.3 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.

4.19.4 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.

(a) Physicians shall document abnormal diagnostic values and their response to such;
(b) Consultants shall document, authenticate, time, and date all assessments, diagnostic tests, and treatments, etc. whenever they see a patient.
(c) All entries must be dated, timed and authenticated by the person making the entry and must include his/her discipline.

4.19.5 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.

4.19.6 **Discharge Documentation**

4.19.6.1 Patients shall be discharged only on given order of the attending physician.

4.19.6.2 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.

4.19.6.3 At the time of discharge but no later than 24 hours after, the attending physician shall complete the discharge summary according to the approved guidelines and state final diagnoses on all five DSM-IV Axes.

4.19.6.4 A category of disposition must be included in the discharge summary.

4.19.6.5 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.

4.19.6.6 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.

4.19.6.7 Against Medical Advise (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.

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

4.20.1 Time and means of arrival

4.20.2 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

4.20.3 Clinical observations, including results of treatment

4.20.4 Diagnostic impressions

4.20.5 Condition of the patient on discharge or transfer

4.20.6 Whether the patient left against medical advice

4.20.7 The conclusions at the termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment and services

4.21 **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.

4.22 **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).

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

4.24.1 **Pre-Operative Anesthesia/Sedation Evaluation** – A pre-anesthesia/sedation evaluation must be conducted and documented by an individual qualified to administer anesthesia or conscious sedation within 48 hours prior to the procedure. A pre-anesthesia/sedation evaluation of the patient must include review of the medical history, including anesthesia, drug and allergy history; review and examination of the patient; notification of anesthesia risk (per ASA classification); identification of potential anesthesia problems, particularly those that suggest potential complications or contraindications; additional pre-anesthesia as applicable; and development of the plan for anesthesia care, including type of medications for induction, maintenance, and post-operative care and discussion with the patient of risks and benefits. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before 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.

4.24.2 **Intraoperative & Post 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.

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

4.25 **Operative and Procedure Reports** - An operative or other high-risk procedure report is documented within 24 hours of 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 but before the patient is transferred to the next level of care and made available in the record for use by any practitioner who is required to attend the patient; in this case the full report can be documented within 24 hours of the procedure. This progress note must be documented before the patient is transferred to the next level of care and must include the name(s) of the primary surgeon(s) and assistant(s), procedures performed and a description of each procedure finding, estimated blood loss, specimen(s) removed and postoperative diagnosis.

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 For routine, uncomplicated surgeries/procedures, where the post-operative progress note is completed with all of the required elements prior to the patient leaving the PACU or, where the practitioner accompanies the patient to the next level of care and completes the post-operative progress note with all required elements, the PowerNote may function as both the post-operative progress note and the full report. The Operative PowerNote must be saved to the Operative Note folder. Procedures requiring documented operative reports are identified in Section 4.16.1.

4.25.4 The full operative or other high-risk procedure report includes the following information:

(a) The name(s) of the primary licensed independent practitioner(s) who performed the procedure and his or her assistant(s);
(b) The technical procedures performed;
(c) A description of the procedure;
(d) A detailed account of the findings of the procedure;
(e) Any estimated blood loss;
(f) Any specimen(s) removed;
(g) The postoperative diagnosis

4.26 **Consents** – Properly executed informed consent for procedures and treatments is documented in the medical record in accordance with hospital policy. Members of the Medical Staff or authorized Allied Health Professionals must obtain a patient's informed consent, prior to performing any of the operative and/or invasive procedures listed in Section 4.16.1 by discussing with the patient or his/her Legally Authorized Representative adequate information about the procedure(s) so that an informed decision can be made including disclosure of whether practitioners other than the operating practitioner, including students, will be performed important tasks related to the procedure(s).

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 and 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 transported from the Newborn Nursery to a Level III Nursery will be required to have a dictated discharge summary.

4.28.1 The discharge summary shall include:

(a) Reason for hospitalization
(b) Concise summary of diagnoses including any complications or co-morbidity factors
(c) Hospital course, including significant findings
(d) Procedures performed and treatment rendered
(e) Patient's condition on discharge (describing limitations)
(f) Patients/Family instructions 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 note shall include:

(a) Final diagnosis(es)
(b) Condition of patient
(c) Discharge instructions
(d) Follow-up care required

4.28.3 In all cases of dispute regarding who shall assume the responsibility of the discharge summary, the decision of the Chief of Staff or his/her designee shall be final and is not subject to any review.

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 hours 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.

4.29 **Orders**

4.29.1 An order may be communicated verbally by an individual possessing the appropriate clinical privileges and may be carried out as a written order. Verbal orders should be used only to meet the care needs of the patient when the ordering practitioner is unable to write the order him/herself and will not exceed 20% by any one practitioner per quarter.

4.29.2 Orders are to be communicated to a duly authorized person. The order must relate to the scope of practice and department policy in which that person is a practitioner. Such persons may include: registered nurses, licensed practical nurses, respiratory care practitioners, pharmacists, physical therapists, occupational therapists, dietitians, speech therapists, medical imaging technologists, registered cardiac sonographers, registered vascular technologists and registered EEG technologists as outlined in Hospital policy. Additional categories of Hospital staff may be authorized to receive orders with the approval of the Medical Staff. The details of the order will be written in the medical record, read out loud by the person receiving the order, and confirmed by the person giving the order.

4.29.3 Orders for outpatient diagnostic services will be provided in writing either by prescription or facsimile to include full patient name, date, requested treatments/orders, diagnosis and practitioner signature. Orders for outpatient diagnostic services must be from a Physician, Physician Assistant or Advance Practice Nurse. The practitioner's professional license will be verified through primary source verification and an exclusion search will be completed through the Office of the Inspector General.

4.29.4 Orders for outpatient invasive procedures and infusion therapies must be provided in writing (as outlined above) by an identified member of the BDWMC Medical Staff who will be available to intervene for any clinical issues, prior to the procedure being performed.

4.29.5 Where a practitioner has written a set of orders or is using a preprinted order set continued on one page or on several pages, the practitioner must sign, date and time the last page of orders. The last page of the orders must identify the total number of pages in the order set. If the practitioner makes any changes to the order set including additions, deletions or strike-outs of components that do not apply, the practitioner must initial each change.

4.29.6 Verbal orders should be authenticated by the practitioner giving the order as soon as possible, but will be considered delinquent after 72 hours. A covering physician may co-sign the verbal order for his/her colleague in the event that the ordering physician is not on duty for the weekend or an extended period of time.

4.29.7 Verbal orders for restraints, Do Not Resuscitate (DNR) and withdrawal of life support must be authenticated within 24 hours. Verbal orders for cancer chemotherapy drugs may not be given.

4.30 **Amending Medical Record Entries**

4.30.1 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.

4.30.2 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.

4.30.3 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 **Timely Completion of Medical Records**

4.31.1 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.

4.31.2 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 Clarification	Documented 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 completion of procedure	
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 48hrs or for normal vaginal deliveries and normal newborns	
Death Summary Death Pronouncement Note	Documented at the time of death/disposition but no later than 24 hours after death Completed at the same time the patient is pronounced but no later than 7 days.	
Home Health (Face to Face Documentation)	Completed within 30 days of discharge.	
Transfer Summary	Documented at the time of transfer	
Signatures	Authentication of transcribed or scanned reports and progress notes, within 7 days from the date of discharge	
Verbal Orders	Dated, time and authenticated within the timeframe specified by state regulation – Arizona = 72	

	hours	
Psychiatric Evaluation	Documented within 24 hours of admission	

4.31.3 **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 4.31.2. 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.

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

4.31.4 **Medical Record Suspensions** - A medical record is considered eligible for suspension/sanction based on the timeframes in Section 4.31.2. 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) Upon temporary suspension, the delinquent member shall have no admitting, treating, 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 Medical Center 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, accept admissions in transfer or referrals through the Emergency Department, 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. Upon resignation by a practitioner, records that remain incomplete thirty (30) days after the resignation will result in

notification of the appropriate licensing board by the Chief Executive Officer.

(b) If the practitioner accumulates 23 consecutive or intermittent days of suspension in a revolving 12-month period, the Chief of Service or designee will attempt to contact the practitioner informing him/her of their medical record responsibilities and further consequences. Documentation of this communication will be placed in the practitioner's file.

(c) If the practitioner accumulates 40 consecutive or intermittent days of suspension in a revolving 12-month period, 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. If the practitioner fails to submit the required information to the Medical Executive Committee after a second notice, the practitioner shall be deemed to have voluntarily resigned from the Medical or Allied Health Staff and must reapply for Staff membership and privileges.

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

(e) Members of the Allied Health Staff are suspended in accordance with the policy above for incomplete records. The supervising physician is suspended in conjunction with the Allied Health practitioner and accumulates suspension days for his Allied Health practitioner's incomplete medical records, which are attributed to the physician's total suspension days.

(f) A suspension/sanction list will be generated weekly and made available to Administration, Medical Staff Services, Patient Registration, Patient Placement, Emergency Department, Inpatient and Outpatient Surgery areas.

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

Temporary suspension shall become a voluntary resignation following 60 days of cumulative or consecutive suspension within a running year, absent extenuating circumstances. At that time, the practitioner's privileges will automatically terminate for failure to complete medical records. Affected practitioners may request reinstatement or appeal the voluntary resignation during a period of 30 calendar days following termination if all incomplete and delinquent records have been completed. In addition, the practitioner must pay a $500 fine. The request for reinstatement must include assurance to the Medical Executive Committee of the practitioner's ability to stay in compliance with the medical record completion requirements outlined in these Rules and Regulations. The Medical Executive Committee will review any appeals requested by the practitioner. If the practitioner elects to appeal the voluntary resignation, the practitioner's appointment and privileges will be extended until the next Medical Executive Committee. At that time the Medical Executive Committee will determine whether or not to uphold or rescind the acceptance of the resignation. If the practitioner is reinstated to the staff, the applicant will be said to have 0 days of suspension when appointed. Any days of suspension will be counted from that day forth.

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 12.5 of the Bylaws.

No record shall be filed incomplete except by order of the Medical Executive Committee.

ARTICLE 5: ORDERS

5.1 Orders may be generated only by members of the medical staff with medical staff privileges or by Allied Health Staff (NP's, PA's) according to their scope of practice.

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

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

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

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

5.1.4 Physician or Allied Health Practitioner orders are required for transfer of a patient to a different level of care within the facility. It is the responsibility of the physician or Allied Health Practitioner who is transferring the patient to a new level of care to review all active orders for clinical accuracy and appropriateness.

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

5.2 <u>Orders for Inpatient Medical Imaging Tests/Procedures</u>

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

5.2.2 A statement of the reason for the test and/or diagnosis must be indicated on the order and it must also be signed, timed and dated by a physician or Allied Health Professional licensed and credentialed within Arizona with prescriptive authority (PA's and NP's).

5.3 **Orders for Surgery**

5.3.1 A physician order identifying the specific procedure(s) to be performed and blood products, as necessary, is required and will serve as confirmation the physician has obtained informed consent. The Medical Center must then complete consent for surgery form identifying these procedure(s) and the consent for blood as applicable. The surgeon is responsible for signing, dating and timing the orders and for telephone orders verifying that the correct surgical procedure has been indicated.

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

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

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

5.3.5 New physician orders must be generated after a surgical procedure.

5.3.6 Pre Operative orders for surgical cases performed in the main OR shall be entered electronically into the clinical information system by two (2pm) the business day prior to scheduled surgery. Pre Operative orders for non-OR cases shall be entered prior to the patient presenting to facility. The Medical Center will not perform any pre-surgical testing except on the specific electronic order of the physician.

5.4 **Orders for Outpatient Tests**

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

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

5.4.3 Orders for outpatient diagnostic services are acceptable from BDWMC Medical Staff, non-staff physicians, out of state physicians and those licensed within Arizona with prescriptive authority (including PA's and NP's). Orders for outpatient invasive procedures and infusion therapies must be provided in writing as outlined by an identified member of the BDWMC Medical Staff who will be available to intervene for any clinical issues, prior to the procedure being performed.

5.4.4 The practitioner's professional license will be verified through primary source verification and an exclusion search will be completed through the Office of the Inspector General.

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

5.4.6 Unless otherwise specified on the order, for recurring accounts the order will expire after twelve (12) months. If there is a change in the patient's condition which warrants a change in treatment, a new physician order is required.

5.4.7 The following facsimiles or original orders are accepted and scanned into the clinical information system:

- Outpatient scheduling form
- Prescription forms
- Referral forms (can be payor specific)
- Notation in patient's history and physical
- Physician order sheet
- Physician order documented on office letterhead (stationery)

5.5 **Verbal and Telephone Orders**

5.5.1 Verbal (face to face) orders are not acceptable except in the case of an emergent situation where immediate written or electronic communication is not feasible. Verbal orders will be accepted only by a registered nurse (RN) or licensed practical nurse (LPN). In areas other than nursing units, verbal physician orders for admission may be accepted by the personnel qualified to accept them and will be limited to the type of bed needed and the reason for admission. Licensed Respiratory Care Practitioners (RCP) and registered pharmacists can accept verbal orders provided the orders are directly related to their specialized discipline. The physician will authenticate these orders as soon as possible, but will be considered delinquent after 72 hours.

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

5.5.3 Only physicians and authorized allied health professionals are permitted to give telephone orders for inpatient services. Office staff are not permitted to give telephone orders.

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

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

5.6 **No Code Orders**: No code orders are entered in the patient's medical record and authenticated, 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.

ARTICLE 6: 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.

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

6.1.1 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: nurse practitioners, physician assistants, certified nurse midwives, audiologists, and certified registered nurse anesthetists.

6.1.2 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 Bylaws.

6.3 **Qualifications of Advance Practice Professionals**

6.3.1 A statement of qualifications for each category of APP shall be developed by the Credentials Committee, subject to approval by the Medical Executive Committee and 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, Advance Practice Committee and other professional staff;

(b) Require the individual APP hold a current license, certificate or such other credential, if any, as may be required by state law; and

(c) Satisfy the qualifications as are set forth for Medical Staff appointment, including appropriate professional liability insurance coverage, or for Medical Center employment, as applicable.

6.4 **Prerogatives of Advance Practice Professionals**

6.4.1 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;

6.5 **Obligations of Advance Practice Professionals**

6.5.1 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.

6.6 **Terms and Conditions of Affiliation**

6.6.1 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. An APP's qualifications, performance, and clinical competence shall be reviewed and confirmed by the collaborating physician or the APC on an annual basis in addition to their biennial reappointment.

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

6.7 **Definition of Scope of Service Description**

6.7.1 The scope of service that may be provided by any group of APPs shall be developed by the appropriate department and representatives of management or Advance Practice Committee, if applicable, and subject to the recommendation of the Medical Executive Committee and the approval of the Board. For each group, guidelines must include at least:

(a) specifications of categories of patients for whom services may be provided.

(b) 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.

(c) 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.

(d) 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.

6.8 **Procedure for Credentialing**

6.8.1 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.

6.8.2 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 the advance practice committee, Medical Staff leadership including the Medical Executive Committee.

6.9 **Adverse Action Review**

6.9.1 APPs who are subject to adverse action (other than non-reviewable action as defined in these Bylaws and 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 these 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.

ARTICLE 7: GENERAL PHARMACY POLICIES

7.1 General Information

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

7.2 Medication Management

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

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

7.2.3 **Samples** – Medication samples will not be used for the management of patients at BDWMC.

7.2.4 **Outpatient Prescriptions** - Outpatient prescriptions will not be filled by BDWMC Pharmacy.

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

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

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

7.3 **Medications**

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

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

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

7.4 **Medication Orders**

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

7.4.2 Medications ordered by "PRN" must specify route, frequency and indication.

7.4.3 Only standard abbreviations can be used. See Banner Health's "Do Not Use Abbreviations and Symbols List." Medication dosages should be expressed in the metric system and a leading zero must always precede a decimal expression of less than one (i.e., 0.1 mg not .1 mg). A terminal or trailing zero is never to be used after a decimal (e.g., 1 mg never 1.0 mg).

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

7.4.5 No "Per Protocol" - Medication orders using the words "per protocol" constitute an invalid order and must be clarified by the pharmacist before processing, unless the order refers to a specific Medical Staff approved protocol or an approved investigational drug protocol and specifies the name and/or number of the protocol; and a written copy is available for review.

7.5 **Authorization to Order Medications**

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

7.6 **Authorization to Administer Medications**

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

a) Physicians

b) Physician Assistant, Registered Nurse, Licensed Practical Nurse, or Nurse Practitioner. Administration of chemotherapeutic agents shall only be performed by nurses certified in chemotherapy.

c) Respiratory Care Practitioners (medications related to respiratory therapy treatments only).
d) Radiology Technologist and Nuclear Medicine Technologist (medications related to radiology/nuclear procedures only).
e) EEG Technician and Cardiovascular Technician (CVT) (oral medications only) and Anesthesia Technicians (medications related to EEG and Cardiovascular therapy treatments only).
f) Physical Therapist (topical medications only. Medications related to physical therapy treatments only)

ARTICLE 8: GENERAL SURGICAL POLICIES

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

8.2 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.

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

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

8.5 **Surgical Specimens** – Certain tissue or foreign bodies removed at operation shall be sent to the Hospital pathologist who shall make such microscopic examination as may be considered necessary to arrive at a pathological diagnosis. No microscopic examination is required for intraocular lenses, cataract lenses, pacemakers, orthopedic hardware, foreign bodies retrieved under endoscopy, hernia sacs (unless incarcerated or strangulated), fetuses under 20 weeks gestation, and other specimens at the pathologist's discretion. Scars removed for cosmetic purposes, superficial debridement specimens, or arthroscopy shavings need not be sent to Pathology. For patients with the clinical diagnosis of osteoarthritis, routine submission of surgical specimens during total joint replacement will not be performed. Documentation of tissue removal will be included in the operative report, consistent with Banner and JCAHO guidelines. For other diagnoses, or for unexpected or unusual findings during surgery, specimens may be sent at the surgeon's discretion. The pathological report signed by the pathologist shall be added to the medical record. Specimens are the property of the Hospital.

ARTICLE 9: RESTRAINTS

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

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

9.1 **RESTRAINTS FOR PHYSICAL SAFETY**

9.1.1 As per Banner Health policy, restraints may be applied as necessary to maintain a patient's physical safety or the safety of other patients, staff, or others. Restraints include soft restraints for intubated patients used to prevent invasive device removal as well as the use of all 4 bed rails to protect cognitively impaired patients at risk for falling. An order is required and must be renewed for every episode of restraint. If physician is not available to write an initial order, restraints may be initiated and a telephone order may be given. If the physician is not present, the primary RN may initiate restraint and obtain a verbal order immediately after the application. The Physician/NP must perform the face-to-face assessment and sign verbal order for restraint within 24 hours of application.

9.1.2 **Summary of Physician/NP actions:**

(a) Give order (verbal) or enter order to restrain the patient.
(b) Every 24 hours: perform face to face assessment of patient and enter a new order for restraints if need continues.
(c) Restraint orders may not be written as a standing order or a PRN order.
(d) In the event of an emergency the restraint may be initiated by the nurse, after a physical and psychological assessment deems this necessary, the physician will be contacted as soon as possible for the order.

9.2 **RESTRAINTS FOR VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR AND/OR SECLUSION**

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

9.2.3 An order is required before initiating each episode of restraint and/or seclusion and must be renewed within specific time and may not exceed 24 hours. If physician or NP is not available to write an initial order, the physician, NP or specially trained RN or PA must perform face-to-face patient assessment within one hour of initiation of the restraint and/or seclusion, even if the restraint and/or seclusion ends within one hour of initiation, and again prior to writing renewal order. The assessment musts be conducted to evaluate the patient's immediate situation, reaction to the intervention, medical and behavioral condition, and the need to continue or terminate restraint or seclusion.

9.2.4 **Summary of Physician/NP actions**:

a) Give order for initial episode of restraint

b) Within one hour: perform face to face assessment of patient and document type and need for restraints/seclusion and authenticate (if verbal) previous order and again:
c) Every four hours for adults 18 years of age or older,
d) Every two hours for patients between the ages of 9 and 17
e) years of age,
f) Every one hour for children under the age of 9 years.
g) Every 24 hours and before writing new order, assess the patient

ARTICLE 10: ADVANCE DIRECTIVES AND END OF LIFE

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

10.1 WITHDRAWAL OF LIFE SUPPORT

10.1.1 Withdrawal of life support should occur in conjunction with best efforts to ascertain the wishes of the patient given the circumstances of his/her illness. If the patient is unable to speak on his/her own behalf, decisions should be made by the legal guardian, designated medical power of attorney, or statutory surrogate (in that order). Discussions with patient, family members or surrogate decision maker should be documented in the medical record. If the physician cannot locate the family member or surrogate decision maker, the physician may make health care decisions for the patient after a consultation with and recommendation of the Bioethics Committee.

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

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

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

10.2 Pronouncement of Death

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

10.3 **Autopsies**

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

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

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

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

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

(a) The case meets the criteria of a Medical Examiner's case and the case has been accepted by the Medical Examiner.
(b) The case was waived by the Medical Examiner's office, but appears to have criminal and/or other legal implications.
(c) The Consent for Autopsy appears to be invalid, incomplete, or questionable.
(d) The pathologist believes that the case represents a risk to him/her or 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.

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

ARTICLE 11: RESIDENT AND FELLOW ROTATIONS

11.1 **Supervision of Residents and Fellows**

11.1.1 Professional Graduate Medical Education Programs wishing to rotate Residents or Fellows will require approval by the appropriate Department, Committee, the Medical Executive Committee and Medical Center CEO. Notwithstanding the above, blanket approval is granted to Fellows in the St. Joseph's Geriatric Fellowship Program. This approval will be based upon information provided by the GME training program. Once approved, the professional liability coverage and competencies of each resident or fellow will be confirmed. Successful completion of training on Banner's electronic medical record is required before start of the assigned rotation.

11.1.2 Residents and Fellows shall function within the Medical Center under an approved job description and must be supervised by an attending or supervising physician with appropriate clinical privileges. The Supervising Physician, who is a member in good standing of the BDWMC Medical Staff, shall communicate information to the graduate medical education (GME) training program about the quality of care, treatment, and services and educational needs of the participants he/she supervises.

11.2 **Documentation By Residents And Fellows**

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

11.3 **Orders And Operative Reports**

11.3.1 Residents and Fellows approved for rotation through Banner Del E. Webb, 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 and the training program.

11.3.2 If designated by the supervising physician and the training program, residents or fellows may

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

ARTICLE 12: STUDENTS

12.1.1 **Level of Participation**

12.1.1 Student rotations through Banner Del E. Webb Medical Center will be in accordance with the Banner Health Clinical Education Rotation Agreement.

12.1.2 All student activities will be under the direct supervision of a College participating teaching medical staff member, according to specific clinical goals and objectives developed by the College for each rotation. A CRNA may not act as a supervisor or preceptor to an SRNA; however a PA student may also have a Physician Assistant with active Banner Webb privileges as a secondary preceptor with the supervising physician. The physician preceptor(s) must be immediately available in the hospital. In any situation where a third or fourth year medical student or an Allied Health student is scrubbed into or observing any surgical or invasive procedure, the student will be in the physical presence of the physician preceptor(s) at all times.

12.1.3 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 BDWMC medical staff members.

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

12.1.5 The number of students participating will be reevaluated periodically and subject to change.

12.2 **Specific Medical/Surgical Student Activities**

12.2.1 Year one and two medical students may observe only.

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

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

12.2.4 Year three and four students may scrub into surgery and assist in procedures if it is a requirement of the rotation and if the preceptor is participating and the patient has consented to this. The level of surgical assisting will be at the discretion of and under the direct supervision of the physician preceptor(s) at all times.

12.2.5 All activities are under the direction of the physician preceptor(s).

12.3 **Specific Allied Health (PA & NP) Student Activities**

12.3.1 Allied Health students may participate in care and management of patients.

12.3.2 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.

12.3.3 Documentation is countersigned by the preceptor promptly. The preceptor(s) are ultimately responsible for all required components of the medical record.

12.3.4 Allied Health students may not dictate.

12.3.5 Allied Health students may assist in surgery if completing a obstetrics/gynecology or surgical rotation and if the preceptor is participating and the patient has consented to this. The level of surgical assisting will be at the discretion of and under the direct supervision of the physician preceptor(s) at all times.

12.3.6 Allied Health students must be able to document education of aseptic technique prior to assisting in surgery.

12.3.7 All activities are under the direction of the physician preceptor(s).

12.4 Specific SRNA Student Activities

12.4.1 SRNA students may participate in care and management of patients.

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

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

12.4.4 SRNA students may perform regional anesthesia (including spinal and epidural anesthesia, and regional nerve blocks), IV sedation and general anesthesia on appropriate patients only in the presence of the physician preceptor. The student will present and discuss the anesthetic plan with the preceptor. Only with the approval of the preceptor will the SRNA student proceed with the administration of anesthesia.

12.4.5 All activities are under the direction of the physician preceptor(s).

12.5 **Restrictions for Medical/Surgical/Allied Health & SRNA Students**

12.5.1 Students may not write or dictate discharge summaries, history & physicals, or operative reports.

12.5.2 Students may not write orders, give orders or accept verbal/telephone orders.

12.5.3 Students may not be given responsibility for obtaining informed consent for procedures or surgery or for disclosing adverse events or unanticipated outcomes to patients or family.

12.5.3 A student may not act as a surgical first assistant.

12.5.4 Surgical students completing a surgical rotation and SRNA's must complete the BDWMC orientation on surgical technique and provide documentation prior to the rotation.

12.5.5 All patient-related work performed by students and all student entries in the medical record must be reviewed and countersigned, and amended if necessary, by the preceptor. The preceptor is responsible for all required components of the medical record.

12.5.6 Entries by students in the medical records must be legible, dated, signed and timed and include identification of student status.

12.6 **Responsibilities for Medical/Surgical/Allied Health & SRNA Students**

12.6.1 Students are required to comply with all BDWMC policies and procedures during the clinical experience.

12.6.2 Students shall have access only to patient information that is a necessary part of the approved rotation.

12.6.3 Students, as participants in an educational program, must at all times wear a Student Identification Badge issued by Medical Staff Services.

12.6.4 Students must complete the Banner Online Compliance Lessons prior to beginning their rotation.

12.7 **Application and Approval Process**

12.7.1 A request for approval for student rotation at BDWMC must be submitted to the Medical Staff Services Department for processing at least two weeks in advance of the rotation.

12.7.2 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.

12.7.3 Once a specific program has received approval from the BGSMC GME Committee and the BDWMC Medical Executive Committee, individual students may be accepted for rotation upon successful completion of the above application process.

12.8 **Orientation**

Medical, Surgical, Allied Health and SRNA students will be oriented to Banner Health policies, programs, and channels of communication.

12.9 **Fees and Services**

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

ARTICLE 13: HIPAA (Health Insurance Portability and Accountability Act)

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

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

REVISED: Bylaws Cmt – 111/19/14
Medical Executive Committee – 12/4/14
Sent to Medical Staff for comment – 12/10/14
Board – 1/8/15