



Banner Desert[®]
Medical Center

Rules and Regulations

of the

Medical Staff

11/12/2009



RULES AND REGULATIONS

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1.0 GENERAL

- 1.1 DISASTER - Once a disaster has been declared pursuant to the Hospital Disaster Plan, all Medical Staff members may be required relinquish care of their patients in accordance with the Plan. This Rule overrides any other Rule to the contrary.
- 1.2 EXPERIMENTATION - All experimental or research procedures require prior written approval by the Investigational Review Committee.
- 1.3 BRAIN DEATH - Determination of brain death must be documented as described in 9.2.3 (Medical Records: Progress Notes).
- 1.4 ADMITTING MEDICAL STAFF MEMBER is the BDMC Staff member privileged to admit patients who has a current physician-patient relationship with a patient whom the member admits to the Hospital to be attended either by the member or by another Medical Staff Member (attending Physician).
- 1.5 "ATTENDING PHYSICIAN" is limited to the BDMC Staff member licensed to practice medicine or osteopathy who has primary responsibility for a BDMC patient and includes the physician's cover.
- 1.6 "COVER" or "COVERING PHYSICIAN" means a Medical Staff Member with an Arizona license to practice medicine and substantially the same BDMC privileges as the physician in question. Cover must include all patient, regardless of healthplan or third part payor and may require more than one physician to satisfy Bylaws requirement that every member identify which member(s) will provide his/her 24-hour cover, absent departmental exception (Bylaws 5.1.1.2).
- 1.7 'PHYSICIAN' is defined in the Bylaws and does not include "Physician Extenders."
- 1.8 PROFESSIONAL RELATIONS - Medical Staff members who have complaints about operational matters, or who question the professional judgment or conduct of an individual Medical Staff member or Hospital personnel should communicate their opinion as follows:
- 1.8.1 Members should communicate their concerns about other Medical Staff members to the Director of the Medical Staff Office, who will see that it is forwarded to the appropriate Section or Department Chair for review and that its confidentiality is protected to the extent permitted by law, consistent with Medical Staff Services Department policies and procedures approved by the Executive Committee,
- 1.8.2. Members should attempt to resolve concerns about Hospital personnel and operations when and where the issue arises in a respectful manner. If the problem cannot be resolved in that manner, members should communicate their concern (a) via transmittal form, or (b) using the Hotline, or (c) directly to the COO or Administrator on Call, so that and Administrator can resolve the problem promptly.
- 1.9 "PATIENT." Whenever the term "patient" is used in the context of consent, it includes, when appropriate, the patient's authorized representative.
- 1.10 DEALING WITH PLAN DENIALS If a patient's managed care plan ("Plan") denies coverage prospectively for continued hospitalization that the attending physician, guided by standards of good medical practice, believes to be medically necessary, the physician should:
- a) NOT order the discharge of the patient until the physician believes it is medically justifiable.
 - b) Immediately phone the Plan medical director or representative to communicate the justification for continued hospitalization.

- c) Be prepared to provide enough detail to justify continued hospitalization, including the patient's diagnosis, significant history, clinical status, prognosis (with and without recommended medical services).
- d) Document the call and its results.
- e) If the denial stands and the physician still believe continued hospitalization is medically necessary, follow up the phone call by faxing to the Plan the justification for the continued hospitalization. (See Appendix for letter format) The UM Department's help is available on request.
- f) Inform the patient of the Plan's denial, so that the patient may decide to accept the medical services at his/her own expense and/or whether to appeal. The Hospital will also provide the patient with a "form of financial liability" and explain the implications of the Plan's denial.

2.0 ADMISSIONS

- 2.1 PROVISIONAL DIAGNOSIS. Except in an emergency, the admitting Medical Staff member must provide a provisional diagnosis or valid reason for admission before a patient may be admitted.
- 2.2 ADMITTING ORDERS REQUIRED. The Attending Physician is responsible for admitting orders to guide patient care as expeditiously as possible. Admitting orders should direct care pertaining to diagnoses, allergies, diet, activity, ancillary health care needs, diagnostic evaluations and medications. Verbal orders are governed by Rule 10.5.
- 2.3 ADMITTING NOTE WITHIN 24 HOURS. The Attending Physician must see the patient and document an admitting note within 24 hours of admission. (Exception: See Chapter 5 for Critical Care Service Patients.) Required contents of Admitting Note are described in 9.2.3.
- 2.4 REQUIRED PHYSICIAN VISITS.
- A) After the initial visit by the Attending Physician (see 2.3) every patient must be seen daily by attending/consulting physician. Discharging physicians need not visit on day of discharge if order was documented within 24 hours of discharge.
 - B) When a charge nurse (or equivalent) notifies the Attending/consulting Physician of a change in patient status necessitating immediate evaluation by the Attending/Consulting Physician, the Attending/Consulting physician is responsible for coming to the Hospital for a bedside reevaluation.
- 2.5 ADMITTING MEDICAL STAFF MEMBERS. Only Provisional, Active and Courtesy Staff members may admit patients.

3.0 AUTHORITY FOR CONSULTANTS TO ORDER A CONSULTATION

3.0 **CONSULTATIONS, REFERRALS AND PATIENT TRANSFERS** Good medical practice includes proper and timely use of consultations; and effective communications among treating and consulting physicians. Because Desert does not have a mandatory-consultation mechanism (roster), Attending Medical Staff Members are responsible for arranging for necessary consultants.

3.1 **AUTHORITY TO ORDER CONSULTATION.**

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

3.1.2 **Department Chair, Medical Staff President.** The department chairman (or Staff President/designee) may request the consultation, if (a) he/she believes it is required and the Attending Physician fails to obtain the consultation and (b) the patient agrees.

3.1.3 **Not Authorized to Order Consultation:**

1. **Nursing Personnel and Allied are Not authorized to order a Consult.** After appropriate discussion with the Attending Physician, nursing personnel or Allied Professionals with responsibility for a patient who believe that the Attending Physician is not seeking appropriate consultation may contact the appropriate department chairman (or the Staff President/designee) about the need for such consultation.

3.2 **CRITERIA FOR ORDERING CONSULTATION.** Unless the attending physician's expertise is in the area of the patient's problem, consultation with a qualified Medical Staff Member is recommended when requested by the patient or when a significant question exists about:

- 3.2.1 appropriate procedure or therapy.
- 3.2.2 possible treatment/operative risks.
- 3.2.3 diagnosis
- 3.2.4 psychiatric and behavioral issues

3.3 PROCEDURES FOR ORDERING CONSULTATIONS:

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

- 1) The name of the consultant, or, if the ordering physician cannot specify a consultant, the name of the Health Plan that will obtain the consulting Medical Staff Member. (Unit staff will notify the Member's office.)
- 2) The purpose of the consult;
- 3) The urgency of the consultation ;
- 4) If not ordered by the Attending, that the Attending has been notified.

3.3.2 Physician should also communicate directly with Consultant.

3.4 CONSULTATION REPORT SHALL:

3.4.1 Report the consultant's findings, opinions and recommendations,

- 3.4.2 Document that consultant personally examined the patient and reviewed the medical record;
 - 3.4.3 Be documented within 24 hours of the consultation and, if the consultation pertains to the decision to operate, before the operation (except in a documented emergency).
- 3.5 REFERRALS. It is important for every specialist to whom a patient is referred to communicate in a timely fashion with the referring physician about the examination or procedure and about recommendations for further treatment. If the referring physician wishes the specialist to take any specific action, he/she should discuss that with the patient and communicate the request on the referral. The specialist must document any deviation from an express request and so notify the referring physician.

4.0 PHYSICIAN RESPONSIBILITIES FOR TRANSFER, DISCHARGE AND TRANSPORT

4.1 Transfer from Hospital to Another Facility

- 4.1.1 Treating Physician Responsibilities. The attending physician:
- a. Must document an order for any transfer or discharge that satisfies 9.1.3.
 - b. Must discuss with the patient the risks and benefits of the transfer.
 - c. Must ensure that the patient is assessed for stability and clinical needs prior to transfer.

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

4.2 Transfers within the Hospital

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

4.2.2 From Level of Care to Another. Patient transfers from one level of care to another require an order by the treating physician and the reentry of medication orders by the Medical Staff member responsible for the patient in the receiving unit.

Exception:

Surgeons' orders documented immediately post-surgery in the OR or PACU.

4.3 Discharge to "Home"

- 4.3.1. Treating Physician Responsibilities. The treating physician [or authorized designee]:
- a. Must document an order for discharge of a patient from the Hospital prior to discharge, and include detailed follow-up and care instructions.
 - b. Must sign the discharge summary that includes a description of the patient's medical condition and the medical services provided.

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

4.4 Transport

- 4.4.1 Treatment Physician Responsibilities. The treating physician:
- a. Must document an order for the medical service necessitating the transport.
 - b. Must explain the risks and benefits of the transport, if the other facility is not in close proximity and does not routinely provide the requested services to BDMC inpatients and if the consent is not documented in the conditions of admission.
 - c. Should ensure that the patient is assessed for stability and clinical needs prior and subsequent to transport in the case of transport to another facility.

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

5.0 CRITICAL CARE SERVICE

- 5.1 DEFINITION. The Critical Care Service (CCS) includes the Intensive Care, Neonatal Intensive Care, Pediatric Intensive Care, Cardiovascular Intensive Care, Cardiac and Pulmonary Telemetry Care Units and Critically Ill Patients in the Surgical Transition Intensive Care Unit.
- 5.2 CRITICAL CARE PATIENTS: Admission and Discharge. The patient's attending physician (or a consultant who has assumed responsibility in accordance with these Rules) determines whether a patient should be admitted to, or discharged from, the CCS in accordance with criteria approved by the Medical Staff, and posted in the units.
- 5.2.1. All Medical Staff Members with hospital admitting privileges may admit to the CCS, as approved by their respective department.
- 5.2.2. For continuity of care, the physician admitting to the CCS must be able to care for the patient throughout the entire hospitalization, including after transfer out of the CCS to the floor.
- 5.2.3. Patient who meet the CCS Discharge Criteria will be transferred out of the CCS only on physician order with the concurrence of the Attending Physician. The Chair of CCS Committee or Pediatrics Department (as appropriate) makes preliminary triage rankings as dictated by demand.
- 5.3 ROUNDS. CCS patients must be seen within 12 hours of admission and re-evaluated at least daily thereafter by the attending physician. In addition, surgeons must see their post-op ICU patient daily.
- 5.4 PRIMARY PATIENT RESPONSIBILITY. Unless primary responsibility is properly transferred (Rule 9.1.3), the physician admitting the patient to a CCS Unit is responsible for the patient's care and for coordinating the care provided by other physicians to the patient.
- 5.5 REQUIRED CONSULTATION. Consultation by a nephrologist will be required for dialysis.

6.0 EMERGENCY ROOM

6.1 MEDICAL STAFF MEMBER EMERGENCY CALL RESPONSIBILITIES

6.1.1.Unassigned Patients

6.1.1.1 Responsibilities of On-Call Physician. The on-call physician must (within the scope of his/her privileges):

- (a) accept unassigned patients with an emergency medical condition requiring admission when referred by the ED Physician (or by OB-triage nurse, if an Ob) in accordance with these rules;
- (b) consult on unassigned patients with emergency medical conditions in the ED; and
- (c) provide in-office follow-up care to resolve emergency medical conditions of unassigned patients treated in the ED, when contacted by the ED Physician at the time treatment.

6.1.1.2 Responsibilities of the ED Physician: The Ed Physician shall:

- a) Determine which clinical departments' and/or sections' professional medical services are required to treat the unassigned patient, as a patient's condition may require more than one medical specialist to complete the medical screening exam and to stabilize an emergency medical condition. The ED physician shall determine which specialist shall come to the ED, admit, assume primary responsibility and/or consult. The ED Physician's determination shall be made in accordance with these Rules and approved departmental policies, consistent with the provisional diagnosis. Upon discussion with the on-call physician and prior to if the provisional diagnosis changes or the needs of the patient dictate, subsequent on-call referrals shall be the responsibility of the ED Physician. (See 6.3.2)
- b) Refer Unassigned patients with multiple systems injuries requiring admission to the General Surgeon on call.
- c) Refer Unassigned patients who have attained their 18th birthday to the Internal Medicine, Surgery, or Family Practice physician on call, unless the family specifically requests a Pediatrician. A pediatric patient is defined as a patient who has not yet attained his/her 18th birthday. Unassigned patient who have not attained their 18th birthday will be referred to the Pediatrics Department physician on call, unless
 1. the patient or family specifically requests a different specialty or
 2. the patient requires obstetrical care.

6.1.1.3 When an on-call physician signs out to a substitute on-call physician, the substitute assumes all of the scheduled physician's treatment responsibilities. (See 6.1.2)

6.1.1.4 An on-call physician who accepts call pursuant to these Rules shall be indemnified by BDMC against liability arising out of treating the ED patient in accordance with the BH Indemnification Policy.

6.1.1.5 An on-call physician who accepts call for a BDMC-contracted plan patient whose physician is unavailable will be indemnified and paid his/her usual and customary fee by BDMC.

6.1.2 Assigned Patients

6.1.2.1 Responsibilities of Physician: Medical Staff members must respond to BDMC emergency call to treat emergency patients with whom they have a current physician-patient relationship, within the scope of their privileges and/or license, consistent with these Rules and the Medical Staff Bylaws. Response includes making arrangements for appropriate coverage by a BDMC Medical Staff member with appropriate privileges. Arrangements for coverage must cover all patients, regardless of health care plan or third party payor, and may require more than one physician to provide required coverage.

6.1.2.2 Responsibilities of the ED Physician: The ED Physician will notify the member's substitute about the patient according to the Member's treatment protocol card in the ED/L&D, unless the substitute physician has notified the ED charge nurse or OB-triage that he/she is covering.

6.2 EMERGENCY CALL RESPONSE TIME

6.2.1. STAT Call Response Time. Physicians should respond within 20 minutes to a STAT call from the ED.

6.2.2. ROUTINE Response Time. Physicians should respond by phone or in person to ED calls. If the physician does not respond within fifteen minutes of the call, a second call is made.

6.2.3 Unavailability. Upon determining that a physician is unavailable, the ED Physician shall find alternative medical treatment for the patient (The Department Chair will assist in finding an alternate physician at the request of the ED Physician), and complete the Hospital transmittal form, giving the basis for the determination. (Unavailability shall be based on the severity of the patient's condition.)

6.2.4 Physician Failure to Perform. Any failure of a physician to be available and to respond to call as required by Sections 6.1 and 6.2 will be referred to the next regularly scheduled meeting of the physician's department (section) committee for review.

6.3 TREATMENT OF ED/L&D PATIENTS

6.3.1 Medical Screening Examination

6.3.1.1 In the ED: After a triage nurse determines the order in which a patient will be seen, a physician (or an authorized physician extender under the direct supervision of a physician) screens each ED patient to determine whether the patient has an emergency medical condition.

6.3.1.2 In L&D: OB triage nurses conduct medical screening examinations limited to determining active labor and rupture of membranes; triage nurses transfer pregnant patients potentially having other EMC's to the ED upon consultation with an appropriate OB/Gyn.

6.4 ADMITTING AN ED PATIENT

6.4.1 Unless the on-call physician personally examined the patient in the ED, the ED Physician must specify who has primary responsibility for an admitted patient who is still in the ED while awaiting a bed. If not specified, the patient remains the responsibility of the Ed Physician.

6.4.2 The attending physician and the ED Physician must specify who has primary responsibility for an admitted patient who is still in the ED while awaiting a bed. If not specified, the patient remains the responsibility of the ED Physician.

6.4.3 Subsequent Referrals. Once a patient is accepted and admitted, the attending physician arranges all subsequent, required medical/surgical referrals. If requested, Department chairs shall assist attending physician in finding a subspecialty referral for admitted patients.

6.5 TRANSFER TO ANOTHER FACILITY

6.5.1 A patient may be transferred to another facility if:

- a) the patient is “stable for transfer” (see 6.5.2); or
- b) the patient requests the transfer in writing after being informed of the hospital’s obligations to treat and of the risks of the transfer.

In either case, the transfer must be “appropriate” and the hospital must

- provide medical treatment and transportation personnel and equipment to minimize risk to the patient;
- transfer to the receiving facility all available medical records relating to the patient’s condition;
- assure that the receiving facility has capacity to accept the patient; and the transferring physician must have obtained agreement from a physician at the receiving facility to accept the transfer and to provide appropriate medical treatment.

6.5.2 Unstable Patient:

- a) An Unstable Patient may be transferred if the attending certifies his/her reasonable belief that the medical benefits reasonably expected from the transfer outweigh the increased risks to the patient and documents a summary of the risks and benefits upon which the certification is based.

6.5.3 A patient may be deemed transferable by either (a) the ED Physician or (b) the attending or on-call physician. Disagreements about transferability shall be resolved by the ED Physician, unless the attending or on-call physician has personally evaluated the patient.

6.5.4 It may be necessary for a physician to determine what equipment and personnel should reasonably accompany the patient to effectuate a safe transfer.

6.6 DISCHARGE

6.6.1 No patient determined to have an emergency medical condition may be discharged whose EMC has not been resolved, unless;

- a) the patient has been determined to be “Stable for discharge” and has been provided a written plan for appropriate follow-up care to resolve the EMC; or
- b) the patient requests discharge after being informed of the Hospital’s obligations to treat and of the risks of discharge (The Hospital will take all reasonable steps to secure the patient’s written informed refusal.)

6.6.2 “Stable for discharge” means that, although the EMC is not resolved, within reasonable medical probability, the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an

outpatient or later as an inpatient, provided the patient is given a written plan for appropriate follow-up care with the discharge instructions.

- 6.6.3 Either the ED physician or the attending (on-call) physician may determine that a patient with an EMC is “stable for discharge.” Disagreements are resolved by the ED physician, unless the attending or on-call physician has personally evaluated for patient.
- 6.6.4 If appropriate follow-up care for a no-physician patient whose EMC has not been resolved requires a physician’s care, the ED physician shall, prior to ordering the patient’s discharge, consult with the on-call physician regarding the patient, notify the physician’s office by fax of the referral and include the physician’s name in the written follow-up plan.
- 6.6.5 Patients determined not to have an EMC may also be discharged with a written follow-up plan.

6.7 EMERGENCY CALL ROSTER

- 6.7.1 Responsibility. Medical Staff Services establishes and maintains the Emergency Call Roster based on the list of eligible physicians provided by each department pursuant to its policies and procedures.
- 6.7.2 Revision. The Emergency Call Roster shall be revised semi-annually and posted 30 days before it becomes effective.
- 6.7.3 Cover/Backup. A covering on-call physician for the scheduled on-call physician must have appropriate privileges at BDMC. The on-call physician must identify to the ER charge nurse, OB-triage or Medical Staff Services the name of his/her cover, if the cover is not the person covering his/her practice.
- 6.7.4 Exclusion. Those 60 and over may request exclusion from the Emergency Call Roster. The request must be in writing to the physician’s department no sooner than 3 months before the 60th birthday. The department may deny the request.

6.8 DEFINITIONS

- 6.8.1 An UNASSIGNED PATIENT is a patient with an emergency medical condition:
 - a) who has no current physician-patient relationship with a BDMC Medical Staff member (“attending physician”); or
 - b) who would be an assigned patient but for the physician’s unavailability, as determined by the ER physician (In the ED) or the OB chair (in L&D), or
 - c) for whom the determination of whether the patient is assigned would delay the medical screening exam or necessary stabilizing treatment.
- 6.8.2 An ASSIGNED PATIENT is a patient who:
 - a) has a current physician-patient relationship with a BDMC Medical Staff member (“attending physician”)
- 6.8.3 An ON-CALL PHYSICIAN is the physician scheduled on the Emergency Call Roster to take responsibility for emergency call for unassigned patients at a specified time, and includes his/her substitute, backup or cover. “On-Call Physician,” “Substitute,” “Backup,” and “Cover” are limited to physicians as defined in the Bylaws and Rule 1.6.
- 6.8.4 Emergency Medical Condition (“emc”), according to federal law, means:

- a) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to any bodily function; or (3) serious dysfunction of any bodily organ or part; or
- b) with respect to a pregnant woman having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery; or (2) that transfer may pose a threat to the health or safety to the woman or the unborn child.

7.0 INFECTION CONTROL

- 7.1 STANDARD PRECAUTIONS. Standard precautions are required for all patients and shall be appropriate to the type and extent of potential exposure to blood and other body substances. Depending on the procedure the following should be worn:
- a) Gloves
 - b) Gown/plastic apron (when blood splattering or soiling from other body substances is likely)
 - c) Protective eyewear (when aerosolization or splattering are likely, e.g., in certain dental and surgical procedures, wound irrigation, suctioning procedures and bronchoscopy)
 - d) Mask (when sustained direct face-to-face contact with a productively coughing patient is anticipated, or with procedures where aerosolization or splattering may occur)
- 7.2 ACCIDENTAL EXPOSURE TO BLOOD FLUIDS. Testing the source of the exposure is done only with the specific written informed consent. (See Rule 8.0 and Appendix 7.2)
- 7.3 ISOLATION.
- a) Patients known to be HIV-positive shall not solely on that basis be subject to special isolation.
 - b) Isolation techniques used by the Hospital are described in the Infection Control Manual (found in each clinical department) under Isolation/Precautions, by mode of transmission, e.g., airborne, droplet, contact.
- 7.4 REPORTING DIAGNOSIS OF A COMMUNICABLE DISEASE. Medical Staff members who diagnose a communicable disease must report to the County Health Department as described in Appendix 7.4.
- 7.5 WARNING A THIRD PARTY AT RISK OF EXPOSURE TO HIV. A Medical Staff member may warn a contact of a patient of a risk of HIV infection only in the manner described in Appendix 7.5.
- 7.6 COMMUNICATING WHETHER OR NOT A PATIENT IS HIV-POSITIVE. Medical Staff members may not communicate whether or not a patient is HIV-positive, regardless of the source of the information, or whether or not a patient has been tested for HIV. Exceptions are listed in Appendices 7.5 and 7.6.

8.0 INFORMED CONSENT; TREATMENT REFUSAL; MEDICAL DECISION-MAKING

8.1 SCOPE OF GENERAL CONSENT EXECUTED UPON ADMISSION. On admission, the Hospital seeks a patient's general consent for treatment, which allows physicians to order routine diagnostic tests for a patient.

8.2 CIRCUMSTANCES REQUIRING ADDITIONAL, SPECIFIC WRITTEN INFORMED CONSENT.

8.2.1 Additional, specific written informed consent is necessary for any diagnostic or treatment procedure that is not routine for the specific diagnosis.

8.2.2 The patient must be informed about proposed procedures, tests, or therapies and sign the consent for the specific procedure, and the use of blood and blood products and sedation and anesthesia following appropriate patient counseling and education. For guidance, physicians can use the Hospital's printed consent forms which comply with any special legal requirements.

8.2.3 The process of "informed" consent requires that the patient understand all material consequences of both positive and negative results or outcomes as well as alternative treatments and the prognosis with and without treatment. All procedures listed as a surgical procedure in billing coding systems used by CMS or the Hospital requires specific written informed consent. Specific written informed consent will also be obtained for new surgical-procedures for which a surgical procedure code has not been established.

8.2.4. HIV-Related Testing. Appendix 8.2 states current law for testing patients for HIV and should be referred to before ordering an HIV-related test. The Hospital will make available written consent requirements.

8.3 PHYSICIAN RESPONSIBILITY.

8.3.1 Pre-Procedure. The Medical Staff member performing the surgical or invasive procedures is responsible for obtaining informed consent from the patient or his/her legally authorized representative.

8.3.2. The process of informed consent requires that the patient understand all material consequences of both positive and negative results or outcomes as well as treatments and the prognosis with and without treatment. The communication process for informed concern requires that information be discussed in a manner and language understood by the patient. The Medical Staff member must document the discussion with the patient of:

- (i) the nature of the condition for which the procedure is to be performed and the alternative, including not undergoing the procedure; and
- (ii) reasonably foreseeable risks and benefits from the procedure.

8.3.3 Physicians are also encouraged to disclose:

(i) whether physicians other than the operating practitioner, including residents, will be performing important tasks related to the procedures. Resident involvement will be based on their skill set and under the supervision of the responsible practitioner and

(ii) whether qualified medical practitioners who are not physicians will perform important parts of the procedures or administration or anesthesia per their scope of practice and as granted by the Hospital.

8.3.4 Pre-Sedation, Pre-Anesthesia. An anesthesiologist (or physician responsible for moderate or deep sedation) must advise the patient of the anesthesia to be used and document the discussion leading to informed consent to anesthesia (or moderate or deep sedation). Once the patient has been informed, another member of the team may document the consent.

- 8.4 Disclosure of Unanticipated Outcomes to Patients/Families.
(a) Medical Staff members should disclose serious events and unanticipated outcomes affecting a patient's future medical care and decision-making to patients/families. This discussion may be performed in a collaborative manner with Banner Administration. The discussion should be documented.
(b) The Hospital will consult with the treating physician before disclosing unanticipated outcomes and events.
- 8.5 CIRCUMSTANCES NOT REQUIRING WRITTEN INFORMED CONSENT. Written informed consent is not required if the patient needs immediate medical attention and an attempt to secure express consent would delay treatment and increase the risk to the patient's life or health. However, the law does not imply consent where a competent patient or legally authorized representative has refused care or treatment.
- 8.6 HEALTH CARE DECISION-MAKING CAPACITY.
- 8.6.1 ADULTS. An adult patient (over 18) with decision-making capacity generally has the right to accept or refuse medical and surgical treatment. A legally authorized representative can consent on behalf of an incapacitated individual.
- 8.6.2. MINORS. Persons under the age of 18 generally lack capacity to consent.
Exceptions:
A. Emancipated minors, (Veterans; married (or previously married minors; or minors living away from home and completely self-supporting, unless under court-ordered custody); and homeless minors living apart from parents/guardians may consent to medical, surgical and hospital care. The bases for a determination that a minor is emancipated should be documented in the record.
B. Any mature minor may consent to HIV testing.
C. Any minor may consent to treatment for a STD or for use of a dangerous drug or narcotic, or to examination, diagnosis and care in connection with sexual assault.
- 8.7 REFUSAL TO CONSENT TO MEDICAL TREATMENT
- 8.7.1 Rule. A competent patient or a patient's legally authorized representative generally has the right to refuse unwanted medical treatment. The physician should explain and document the nature of the treatment, the reason it is urged and the probable medical consequences of refusal. The physician should also document the patient's response. When possible, a witness should confirm the patient's response in the record. [BH]
- 8.7.2 Exceptions. Arizona law prohibits the denial of medical care or treatment to an infant less than one year of age, if in the physician's reasonable medical judgment the care or treatment:
A. Is necessary to save the infant's life, AND
B. Will be effective in doing more than prolonging temporarily the act of dying, AND
C. Creates no risks to the infant's life or health that outweigh its potential benefit.
- 8.7.3. REPORTS. A physician who reasonably believes that:
A. Medical care or treatment has been denied to an infant in violation of the laws summarized in 8.7.2 must report that reasonable belief to Child Protective Services.

- B. Someone has denied nourishment to an infant with the intent to cause or allow the infant's death, must report that reasonable belief to Child Protective Services.
- C. Someone acting on behalf of a vulnerable or incapacitated adult has refused medical care for that adult when the refusal amounts to abuse or neglect must report that reasonable belief to Adult Protective Services.

8.7.4. CONSULTATION. A physician is encouraged to consult with the Bioethics Committee whenever he/she:

- A. Believes that the refusal of medical care by a patient's legally authorized representative is not in the patient's best interest;
- B. Believes that the refusal by a pregnant woman threatens the life or safety of a viable fetus; or
- C. Believes that the refusal by the sole parent of a minor child risks abandoning the minor child; or
- D. Is uncertain of his or her obligations under 8.7.1, 8.7.2, 8.7.3 or 14.4.

8.7.5. RISK MANAGEMENT. Risk Management is on call 24 hours a day and can assist in resolving urgent refusal-to-consent situations.

8.8. MEDICAL DECISION-MAKING USING ADVANCE DIRECTIVES.

8.8.1 POLICY. At the time of inpatient admission, BDMC Informs patients of the right to accept or refuse medical and surgical treatment and to formulate advance directives; and documents whether the patient has executed an advance directive. BDMC attempts to obtain it for the record.

8.8.2 DEFINITIONS. An "Advance Directive" is a written document by a competent adult that is either (or both) a "Health Care Power of Attorney" that appoints an agent (surrogate) to make health care decisions or a "Living Will" that directs particular future health care decisions, once the patient becomes unable to make or communicate health care decisions. In the absence of an agent or a guardian appointed by a Court to make health care decision, BDMC will locate and contact a "Statutory Surrogate" in the following order of priority:

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

None of these surrogates may decide to withdraw food or fluid.

8.8.3 ATTENDING PHYSICIAN RESPONSIBILITIES WITH RESPECT TO MEDICAL DECISIONS BASED ON ADVANCE DIRECTIVES.

- A) Before implementing a decision of a surrogate or Advance Directive, the physician must document the basis of the determination that the patient is unable to make or communicate medical decisions. (If unsure, obtain second, documented opinion.)
- B) Consult with the patient's surrogate about the patient's health status and care to the same extent as with the patient.
- C) Become familiar with the patient's treatment preferences, as expressed in the Advance Directive, and comply with the decisions expressed in the directive or by the surrogate.

- A physician may not comply with a surrogate's decision that the physician knows conflicts with the patient's health care directive. If a surrogate's decision is inconsistent with the patient's wishes as stated in the Advance Directive, physician may consult with the Bioethics Committee; if Committee is unavailable, physician may consult with Risk Management.
- D) If unable to comply with decisions expressed in an Advanced Directive or by a surrogate because the decisions violate the conscience, (inform the surrogate and) promptly transfer the patient's care to a physician who will comply with the decisions.
- E) If BDMC is unable to locate a willing surrogate within a reasonable time, the attending physician may make health care treatment decisions (other than withdrawal of food and fluid) after obtaining recommendations of the Bioethics Committee or if that is impossible, after consulting with a second physician who concurs with the attending physician's decision.

9.0 MEDICAL RECORDS/DISCLOSURE OF PATIENT INFORMATION

This Chapter is divided into three sections:

- 9.1 General
- 9.2 Purpose of the Medical Record
- 9.3 Authentication
- 9.4 Deadlines
- 9.5 Temporary Medical Record Suspension
- 9.6 Termination of Medical Staff Membership
- 9.7 Confidentiality of the Medical Record

9.1 GENERAL

9.1.1 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.

9.1.2 4.1.2 For purposes of this Medical Records section, practitioner includes physicians, dentists, podiatrists, advanced practice nurses, physician assistants, and other credentialed practitioners to give orders, provide consultations and/or perform surgical procedures.

9.2 PURPOSE OF THE MEDICAL RECORD. The purposes of the medical record are:

- 9.2.1 To serve as a detailed data base for planning patient care by all involved practitioners, nurses and ancillary personnel.
- 9.2.2 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,
- 9.2.3 To allow a determination as to what the patient's condition was at a specific time,
- 9.2.4 To permit review of the diagnostic and therapeutic procedures performed and the patient's response to treatment,
- 9.2.5 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.

9.2.1 History and Physical Examination ("H&P").

a) H&P Deadlines

1) H&Ps must be performed and documented (or updated, if performed within 30 days prior to admission) within 24 hours after admission and before any elective inpatient or outpatient invasive procedure, including elective C-Section and tubal ligation. This Rule applies throughout the Hospital (OR, endoscopy, cath lab, radiology, etc). Exception: Emergencies documented by the attending physician. Elective procedures will be cancelled in the absence of documentation of the H&P.

2) Updating requires physician to indicate that the information has been reviewed and updated and to sign and date the entry with the current date.

3) "Documented" means handwritten, direct data entry, or voice.

- b) Contents of H&P. The H&P must include the following documentation:
- 1) For all Inpatients and for those Outpatients having procedures requiring general, spinal or epidural anesthesia: The H&P must document:
 - A. Medical History:
 - Chief complaint
 - History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status.
 - Relevant past medical, family and/or social history appropriate to the patient's age.
 - Review of body systems.
 - A list of current medications and dosages.
 - Any known allergies including past medication reactions and biological allergies.
 - Existing co-morbid conditions.
 - B. Physical Examination: Current physical assessment must be appropriate for the chief complaint and provisional diagnosis and the procedure to be performed.
 - C. Provisional Diagnosis: Statement of the conclusions or impressions drawn from (A) and (B) (two preceding paragraphs).
 - D. Initial Plan: Statement of the course of action planned for the patient while in the hospital.
 - E. Obstetrical Patients: Every obstetrical patient must have a prenatal H&P.
 - F. Psychiatric Patient: H&P must include a mental status exam and a comprehensive neurological exam.
 - 2) For other Outpatient (ambulatory) patients; the H&P must document, as necessary for treatment:
 - A. Indications/symptoms for the procedure.
 - B. A list of current medications and dosages.
 - C. Any known allergies including past medication reactions
 - D. Existing co-morbid conditions.
 - E. Assessment of mental status.
 - F. Exam specific to the procedure performed.
 Plus the following for Outpatients receiving IV moderate sedation:
 - G. Examination of the Heart and Lungs by auscultation.
 - H. ASA status
 - I. Documentation that patient is appropriate candidate for IV moderate sedation.
- c) Responsibility for H&P. The attending Medical Staff member is responsible for the H&P. If performed by an allied health professional authorized to practice at BDMC, the H&P must be countersigned by the supervising medical staff member. Dentists and podiatrists are responsible for the part of their patients' H&P that relates to dentistry or podiatry.

9.2.2 Informed Consent. The medical record shall contain informed consents in accordance with Rule 8.

9.2.3 Progress Notes. The treating physician must document a progress note each day and as necessary. (See 2.4) Each note should describe the patient's status and reflect any change in the patient's condition and the results of treatment.

- a) Unconscious Patients. Progress note must document neurological status of unconscious patient.
- b) Brain Death.
 - 1) Only a physician knowledgeable of contemporary brain death criteria may certify brain death. The physician shall document in the progress notes the clinical criteria used to determine brain death.
 - 2) Supportive therapy is to be discontinued after documentation in the medical record of discussion between the physician and patient's surrogate.

9.2.4 Orders. Communication, implementation and documentation of orders must comply with Rules Chapter 10.0 ("Orders").

9.2.5 Reports – Reports That are Required to be Included in the Record Include:

- a) Post-Operative Reports. Immediately after an invasive procedure, the physician who performed the procedure must comply with the documentation requirements stated in 12.4.3.
- b) Final Laboratory Report. The final laboratory report is filed in the patient's Medical Record within 24 hours of completion.
- c) Medical Imaging Report. The Medical Imaging report with the radiologist's authentication must be incorporated the patient's Medical Record within 24 hours of completion.
- d) Special Procedure Report. EEGs, EKGs, treadmill stress tests, echocardiograms, and other special procedures, must be interpreted, documented within 24 hours of notice. "Notice" means communication to the physician (agent) to inform the physician of the test's completion.
- e) Anesthesia Record.
 - 1. The original anesthesia record must at all times remain with the patient's record; be authenticated immediately after the procedure; and document the following:
 - a) Pre-anesthesia evaluation performed within 48 hours of the procedure and including notation of anesthesia risk; anesthesia, allergy and drug history; potential anesthesia problems; and patient's condition before induction of anesthesia;
 - b) Intraoperative activities, including record of all pertinent events during the induction of, maintenance of and emergence from anesthesia, including name, dosage route, time and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood components; oxygen flow rate; continuous recordings of patient blood pressure, heart and respiration rate; complications or problems, including time, description of symptoms, vital signs, treatments and response to treatment; and
 - c) Post-anesthesia assessment, including at least one description of presence- absence of anesthesia-related complications; cardiopulmonary status, level of consciousness, follow-up care and/or observations. In the inpatient setting, a post-anesthesia evaluation must

be completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery.

2. Any further anesthesia reports must be documented in accordance with Rule 12.4.3 (Post-Procedure Documentation).

f) Autopsy Protocol. When an autopsy is performed in the Hospital, a summary of the gross findings shall be documented within three days, and the final protocol authenticated by the pathologist must be incorporated into the Medical Record within 60 days.

9.2.6 Consultations. Consultations must be documented as Described in Rules Chapter 3.

9.2.7 Discharge Documentation

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

B) Other Documentation Required for Discharge:

1) Discharge Summary: The Attending physician is responsible for ensuring the completion (within 21 days of discharge) of a discharge summary for all patients that recapitulates:

- a. the reason for hospitalization,
- b. all relevant diagnoses,
- c. significant findings,
- d. procedures performed,
- e. care, treatment and services provided,
- f. the patient's condition and final diagnosis (outcome of the Hospitalization) at discharge, and
- g. any specific instructions given to the patient and/or family, including physical activity, medication, diet and follow-up care.

2. Exceptions.

a. Discharge Note. A physician may substitute a final discharge progress note for inpatients with "minor" problems or interventions (requiring less than 48 hour-admissions, unless otherwise defined by Department). A Discharge Note must include diagnosis, disposition and condition of patient and instructions (e.g., medication, diet, follow-up care) given to the patient and/or family. It must be written within 21 days of discharge.

b. Death Summary. A death summary is required for all deaths and must be documented within 21 days of discharge

c. Transfer Summary. The transferring physician must dictate a transfer summary at the time of transfer to a different level of care within Banner. A progress note may be used for transfers when care givers remain the same.

9.3 Authentication. Medical Staff members must authenticate certain entries and co-sign certain others.

- a) Authentication. "Authentication" verifies authorship and the substance of the entry.
- b) Co-Signing. Co-signing indicates supervision or co-management rather than authorship. A Medical Staff member must co-sign the entry of another practitioner, if the entry pertains to medical services, and the originator of the entry is on the member's "team" and is not licensed or privileged to practice medicine independently but who is:
 - 1) Either under the Medical Staff member's supervision or
 - 2) Is licensed to practice pursuant to duly approved protocols that describe the nature and scope of the practitioner's practice and require the member to co-manage or be consulted under the circumstances.
 - 3) Orders generated by Allied Health Professionals (PA's, NP's, CRNA's) whose scope and credentialing expressly authorize, do not require co-signature by sponsoring physician.
- c) Permissible Signatures. Entries must be authenticated by the responsible Medical Staff member.
 - 1) Electronic Signatures. Electronic signatures must be used for all dictated computer entries. Physicians must have a signed statement on file in the Medical Records Department stating that he/she alone will use the Personal User ID for the computer.
 - 2) Written Signatures. The Medical Records Department keeps an example of each practitioner's written signature and initials on file.

9.4 Deadlines.

- 1) Admitting Note (2.3: Within 24 hrs of admission)
- 2) H&P (2.1: Within 24 hrs of admission & before invasive procedure)
- 3) Operative Note (9.2.5: Documented immediately post-op)
- 4) Operative Report (9.2.5: Documented immediately post-op)
- 5) Special Procedure Reports (Rule 9.2.5: Interpreted, documented & signed within 48 hrs of notice)
- 6) Discharge Summary (9.2.7.: Within 21 days of discharge)
- 7) Discharge Progress Note (9.2.7: Within 21 days of discharge)
- 8) Death Summary (9.2.7: Within 21 days of discharge)
- 9) Transfer Summary (9.2.7: At the time of transfer)
- 10) Consultation Report (3.4: Within 24 hrs of consultation & before invasive procedure)
- 11) Authentication of Verbal Orders (10.2: within 48 hours)
- 12) Signatures – Within 30 days of discharge

9.5 Temporary Medical Record Suspension

9.5.1 Definitions. Medical Records Suspension means loss of all Hospital privileges, including the ability to schedule procedures, admit, attend, consult, or fill shifts (for example, members of the Emergency Medicine Department, Hospitalists) until all charts are completed.

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

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

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

9.5.2 Responsibilities of suspended physician: The suspended physician must provide cover by another physician with appropriate privileges to assume his/her patient care duties, including ER call. A suspended physician may not admit a patient under another physician's name and then assume the patient's care.

9.5.3 Causes, Implementation, Enforcement. Once HIMS has determined that a member has failed to complete required contents (9.2) for which the member is responsible (anytime within 30 days of patient discharge), HIMS will notify the member of the delinquency and that Medical Records Suspension will be imposed if the records are not completed within a specified time. Once HIMS has suspended the member, HIMS will notify all appropriate clinical and Hospital departments of the suspension and ensure enforcement.

9.5.4 Resumption of Privileges. Medical Records Suspension is lifted once all records have been completed.

9.6 Termination of Medical Staff Membership. Termination of all practice privileges will occur, in accordance with Medical Staff Bylaws, if a Medical Staff member remains on continuous Medical Records Suspension for 60 days. The HIMS Director will direct the member, by certified letter, to complete all incomplete records within five working days. If the records remain incomplete, the HIMS Director will consult review the outstanding delinquencies with the suspended member's Department Chair. The terminated member will be reported to the Arizona Medical Board.

9.7 CONFIDENTIALITY OF PATIENTS' MEDICAL RECORDS.

9.7.1 General. Patients' medical records are the property of the Hospital. Because they are confidential, the Hospital releases the information contained in them only on proper written authorization of the patient. In addition, the Hospital safeguards patients' records (whether hard copy, microfilm or computerized) against unauthorized disclosure and/or use, loss, defacement, and tampering. The Medical Records Department keeps a log of all requests for and of specified persons gaining physical access to patients' Medical Records. (Appendix 9.3.1)

9.7.2 Medical Staff Member Responsibility. Medical Staff Members must:

1. Use and Disclose patient health information only as necessary for treatment, payment or health care operations and authorized research. Health care operations include activities such as peer review, quality assessment and performance improvement.
2. Otherwise obtain patient consent.
3. Protect access codes and computer passwords to protect confidential information.

9.7.3 Extremely Sensitive Patient Information. Certain information in the Medical Record (e.g., drug and alcohol treatment, psychiatric, communicable disease and HIV-related information) require additional protection, because of potential criminal and civil penalties associated with their improper disclosure. Hospital procedures prevent such sensitive information from being released on a general consent. Note: "HIV-related" and "communicable disease related" information means positive and negative information.

9.7.4 Faxing Medical Records. Before transmission, the fax number and the name of the recipient are verified. The cover sheet warns about the confidential nature of the fax.

After transmission, proper receipt is verified by phone. The Medical Record documents:
fax date, phone number, persons sending and receiving.

10.0 ORDERS

10.1 Definitions, Priorities

- 10.1.1 “Standing Order” means a clinical department-approved protocol for therapeutic and diagnostic orders (See 10.5)
- a. An individual physician’s order takes precedence over a standing order.
 - b. Standing orders do not require authentication.
- 10.1.2 “Pre-Printed Order” means a Hospital-approved form for specific type order that provides the ordering practitioner with options. Medical staff members should write orders on pre-printed forms when available.
- 10.1.3 “Preference Card” means an individual medical staff member’s written preferred treatment protocols for a specified diagnosis.

10.2 Orders may be generated only by members of the Medical Staff with Medical Staff privileges or by Allied Health Staff (PA’s, NP’s, CRNA’s) according to their scope of practice.

10.3 **BDMC Privileges Required.** Orders for medications, diagnostic procedures and treatments require appropriate **BDMC** clinical privileges or formal **BDMC** authorization.

- 10.3.1 Exception: Non-Member Physician Orders for Non-Invasive OP Diagnostic and Therapeutic Procedures. Hospital Administration will:
- a. Verify prior to implementation that an order for any outpatient diagnostic and therapeutic procedure is issued by a physician (I) with a currently valid license, (II) who has not been excluded by any State or Federal program, and that the order is within the practitioner’s scope of practice under the law of the State in which the practitioner is licensed.
 - b. Propose a process (approved by the Medical Staff) to ensure that test results and any recommended follow-up actions are provided to the ordering physician and/or the patient.

10.4 Orders of a Non-Physician: Required Signatures. Orders by non-physicians must be cosigned or authenticated consistent with Rule 9.2.8.

10.4.1 Allied Professionals whose scope and credentialing expressly authorize orders may write orders; such orders must be co-signed by the supervising medical staff member.

10.4.2 Orders of Advance Practice nurses in the NICU are governed by NICU Policies.

10.5 VERBAL ORDERS. Verbal orders should be used infrequently. All verbal orders must be authenticated within 48 hours.

10.5.1 Only registered nurses may accept and transcribe telephone orders in nursing units. Other qualified practitioners may accept and transcribe telephone orders in other units, if specifically authorized in medical department policies and procedures. Telephone orders must be given by a physician.

10.5.2 Hospital policies specify which health care practitioners may contact physicians for clarification of orders.

10.6 MEDICATION ORDERS:PHYSICIAN RESPONSIBILITIES

10.6.1 Required Contents Regarding Medication:

- 10.6.1.1 Rule: Medication Orders must include:
- a. Medication Name (including special nomenclature for sustained-release or delayed action dosage forms, e.g. “CD”, “XR”, etc.)
 - b. Exact metric weight or concentration of dosage, where applicable (not “1 amp”)
 - c. Dosage form (if available in a form other than an oral solid),
 - d. Route of administration
 - e. Frequency.
- 10.6.1.2 PRN Orders: A PRN schedule for a medication will not be assumed unless written as “PRN”. All PRN orders must include a frequency and indication (e.g.; every 4 hours PRN pain).
- 10.6.1.3 Range Orders:
- a. Range orders permit varying dose or dosing interval over a prescribed range depending on the situation or patient status. Range orders typically involved but are not limited to analgesics, anti-emetics, anti-diarrheas, anti-spasmodic, anxiolytics, antihistamines, anti-tussives, decongestants, and muscle relaxants.
 - b. Physician order must specify indication and appropriate dose range and frequency suitable for the specific medication.
- 10.6.1.4 Outpatient: Outpatient prescription orders should include a brief note or purpose (e.g., nausea), unless considered inappropriate by the prescriber.

10.6.2 Required Contents Regarding Patients: The Prescriber:

- 10.6.2.1 Should include the age and/or weight (in kilograms) whenever used to calculate dosage. (For all pediatric and neonate patients, patient weight will be provided)
- 10.6.2.2 Must verify the patient’s allergy status prior to ordering medications.

10.6.3 Notation, Abbreviations:

- 10.6.3.1 All prescription orders must be legible.
- 10.6.3.2 No abbreviations or "slang" terms are to be used for medication names. Abbreviations on the **DO NOT USE ABBREVIATIONS AND SYMBOLS** list **MUST NOT BE USED**.
- 10.6.3.3 All prescription orders should be written in the metric system, except for therapies such as insulin, vitamins and heparin that use standard units. The word "Units" should always be spelled out. The abbreviations "ML:" should be used in place of "CC".
- 10.6.3.4 A zero should always precede a decimal expressing less than one (e.g., 0.1 mg NOT .1 mg). A terminal zero must not be used after a decimal. (e.g., 1 mg NEVER 1.0 mg).

10.6.4 Prescriber Identification:

- 10.6.4.1 Prescriber's name/signature must be legible and the name should be either printed or stamped in addition to the signature.
- 10.6.4.2 The prescriber should include a contact telephone, pager number or other contact information to facilitate ready communication with pharmacist/nurse when questions arise about the prescription.

10.7 Standing Orders

- 10.7.1 Use. To ensure uniformity of care for patients in particular situations, physician orders may be standardized for specific procedures, diagnostic workups or therapies. Once approved, they are implemented unless expressly overridden by the physician and require no authentication.
- 10.7.2 Adoption. Individual Departments may adopt standing orders, which should be included in their policies and procedures. Standing orders must be approved by the Executive Committee and should be reviewed annually for pertinence.

10.8 Authorization to Administer Medication. Ordered medications and diagnostic contrast media may be administered only by the following categories of personnel:

- a) physician
- b) registered nurse and licensed practical nurse
- c) respiratory care practitioner I,II, III, IV
- d) radiology technician
- e) physical therapist (topicals only)

10.9 AUTOMATIC STOP ORDERS

- 10.9.1 FOR LABS: All daily lab orders shall be discontinued automatically after three (3) days, unless:
 - a) the order specifies an exact period of time,
 - b) the attending physician reorders the daily lab, or
 - c) the physician has not been notified before the discontinuance.

10.9.2 FOR DRUGS

- a) Unless ordered for a specific length of time, an automatic seven (7) day stop order is in force for the following drugs, provided the physician has been personally notified of the discontinuation 48 and 24 hours before discontinuation:
 - 1) antibiotics
 - 2) controlled substances: narcotics, stimulants, tranquilizers and sedative hypnotics
 - 3) anti-coagulants
 - 4) oral anti-neoplastics (injectable anti-neoplastics are ordered by specific dose(s))
- b) Medications ordered "held" will be discontinued unless specific parameters for reinstatement are documented.
- c) All medications are discontinued immediately before surgery and will not be reinstated unless reordered.

10.10 RESTRAINTS

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

10.10.2 Restraints to provide or facilitate acute medical and surgical care (versus to manage behavioral symptoms) and not "undertaken because of an unanticipated outburst of severely aggressive or destructive behavior an imminent danger to the patient and others" requires a prior physician order but may be initiated in an emergency by an RN without an order, if the RN consults with the patient's treating physician as soon as possible.

that poses
physician order
if the RN
possible.

10.10.3 Restraints for Violent or Self-Destructive Behavior and/or Seclusion:
Restraints may be applied as needed to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient or others.

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 specifically trained RN or PA must perform face-to-face assessment within one (1) hour of initiation of the restraint and/or seclusion, even if the restraining and/or seclusion ends within one (1) hour of initiation and again prior to writing renewal order. The assessment must be conducted to evaluate the patient's immediate situation, reaction to the intervention, medical and behavioral condition, and the need to continue or terminate restraint and/or seclusion.

a. Physician and/or NP Actions:

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

3. Every 24 hours and before writing new order, assess the patient.

11.0 PHARMACEUTICAL

11.1 All medications administered to patients must be obtained from the Hospital pharmacy, when the pharmacy is unable to supply the medication. If the Pharmacy cannot supply the medication, individual orders for each medication need to be initiated including the name, strength, dose, route and schedule for each medication brought from home. Statements such as "Patient may take own medications," are not allowed. Drugs ordered by trade name may not necessarily be filled by that name unless the physician states "do not substitute" on the order. The Pharmacist will only be allowed to make therapeutic substitutions based on the formulary as determined by the P&T Committee following comment and input by each of the clinical departments and approved by the Executive Committee.

11.1.1 In the ED, the patient's home medications will be handled on a case by case bases upon physician order, including name, strength, dose, route and schedule.

11.2 FORMULARY.

11.2.1 The Hospital pharmacy maintains an open formulary except when drugs have been specifically designated as non-formulary by the Pharmacy and Therapeutics Committee.

11.2.2 The Hospital pharmacy maintains a current formulary of parenteral antibiotics that includes at least one representative drug of all major, parenteral antibiotic classes (i.e., family and generation).

- a) Antibiotic formulary information is coordinated with the Hospital's microbiology laboratory.
- b) Areas taken into consideration during the antibiotic formulary review include: review of adverse effects and QA data collected, available medical literature and pharmacological data, cost-acquisition data and antibiotic sensitivity data.
- c) Once the antibiotic formulary is delineated, the information may then be transferred to the Hospital pharmacy, microbiology laboratory and the Medical Staff.
- d) The annual review process does not hinder the Pharmacy and Therapeutics Committee from considering interim additions or substitutions of antibiotics on the basis of critically relevant information generated for in-Hospital review or from the medical literature.

11.2.3 Medical Staff members wishing to add medications to the formulary must attend the Pharmacy and Therapeutics Committee meeting and provide evidence based literature to support the medication.

12.0 SURGERY and Other Procedures Using Anesthesia or Moderate and Deep Sedation

12.0.1 This Chapter governs responsibilities of physicians performing invasive procedures anywhere in the Hospital including the O.R.

12.0.2 Surgical procedures permitted to be performed outside the O.R. must be approved by the Executive Committee and the relevant department.

12.0.3 "Surgeon" in this chapter means the physician responsible for performing the invasive procedure.

12.1 Scheduling: Physician Responsibilities.

12.1.1 Elective Cases.

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

12.1.2 Emergency Cases.

- a) Only the responsible physician or his/her office may schedule emergency cases.
- b) Emergency cases take precedence over other procedures and are to be performed as soon as an OR is available.
 1. Emergency cases are accommodated either by "bumping" a scheduled case or by opening an additional O.R.
 2. Disputes as to priority or emergency will be resolved by the chairman of the OR Committee (or the appropriate department chairman, if the OR chairman is involved in the case).
- c) The surgeon should personally request the physician whose case is to be bumped to permit the change.

12.2 Pre-Procedure Physician Responsibilities.

12.2.1 Consents. Physicians must obtain informed consent for the procedure, sedation or anesthesia, and blood or blood products in accordance with 8.2 and 8.3.

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

12.2.3 Assessments.

- A. **Pre-Operative Diagnosis.** Prior to surgical procedures, the physician performing the procedure is responsible for:
 1. Documenting the preoperative diagnosis in the medical record and
 2. Reviewing any relevant results of lab studies, imaging and other diagnostic tests and H&P in the medical record.
- B. **Pre-Sedation Assessment.** The physician with sedation privileges who orders moderate or deep sedation is responsible for:

1. Ensuring appropriate patient assessment immediately prior to sedation,
2. Co-signing an assessment performed by another,
3. Being present in the room during initiation of moderate or deep sedation administration.

C. Pre-Anesthesia Assessments must be in accordance with Anesthesiology Department policies.

12.2.4 Wrong-Site Surgery. Prior to Operative and high-risk invasive procedures, surgeons should:

- a. Document the Site of the procedure in (a) orders and (b) H&P.
- b. Mark the site together with the patient, in cases involving right/left distinction, multiple structures (e.g., fingers, toes) or levels (e.g., spine).
- c. Agree verbally with the anesthesiologist and preoperative nurse in the correct site.

12.3 Intra-Procedure Monitoring:

12.3.1 For sedated patients (who have been administered moderate or deep sedation):

- a. As required by law and/or accreditation standards, the Hospital will provide personnel skilled in airway management (ACLS- and/or PALS-trained) to monitor the patient and not engage in tasks that could interfere with continuous monitoring; and to be immediately available in emergencies.
- b. The physician with sedation privileges who orders moderate or deep sedation must remain in the building during the procedure.

12.3.2 For Anesthesia patients: The anesthesiologist is responsible for monitoring patients in accordance with departmental policies.

12.4 POST-PROCEDURE PHYSICIAN RESPONSIBILITIES.

12.4.1 Monitoring.

- a. Sedated Patients. As required by law and/or accreditation standards, the Hospital will ensure the sedated patient is monitored by qualified staff, present in the room, until required values are achieved and documented.
- b. Anesthesia Patients. The Anesthesiologist will monitor patient according to departmental policies and procedures.

12.4.2 Surgical Tissue and Foreign Bodies. Operatively removed tissue and foreign bodies must be sent to the Pathology Department with pertinent clinical information. See Rule 13.0 for exceptions.

12.4.3 Documentation.

- a. Comprehensive Post-Operative Progress Report.
Immediately after an invasive diagnostic or therapeutic procedure, the physician who performed the procedures must:
 1. Document a brief post-operative note indicating the procedure's completion, by either completing the Hospital's Immediate Post-Operative Surgical Progress Note Form or in a note that includes the required components, and
 2. Document a detailed post-operative report, giving the pre-operative diagnosis, the title of procedure performed, and the names of any assistants; and describing all operative procedures, surgical

- techniques, findings and specimens, tissue removed or altered, and foreign objects removed.
- b. Post Operative Orders. The surgeon is responsible for documenting post-operative orders.

12.5 VISITORS AND OTHER UNCREDENTIALLED INDIVIDUALS.

12.5.1 In the OR uncredentialed persons must sign in and are limited to:

- a. Licensed physicians, dentists and paramedical personnel; and bona fide medical and nursing students, premedical students in a medical career program who are sponsored by a staff member, and participants in other formal programs approved by the Administration and the Medical Staff, subject to patient consent and prior approval of the Operating physician and anesthesiologist.
- b. Industry representatives during procedures involving technology for which the expertise of the representative during the procedure is in the best interest of the patient, subject to patient consent and prior approval of the Operating physician and a Hospital representative.

12.5.2 The presence and permissible activities of uncredentialed individuals in L&D is governed by the policies of the Department of Obstetrics.

12.6 SURGICAL ASSISTANTS.

12.6.1 Qualifications of the Surgical Assistant. The qualifications of the assistant are at the discretion of the operating surgeon, taking into consideration the surgeon's opinion of the best interests of the patient, the wishes of the patient and the opinion of the referring physician.

12.7 DEFINITIONS:

12.7.1 "Sedated Patient" has been administered moderate or deep sedation.

12.7.2 The continuum of consciousness from the undrugged state to deep anesthesia falls roughly into four states:

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

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

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

D. Anesthesia - Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful

stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

13.0 PATHOLOGY

13.1 All tissues removed by biopsy or at operation anywhere in the Hospital shall be sent to the Department of Pathology, accompanied by pertinent clinical information. A professional interpretation is included automatically for special orders listed in appendix 13.1.

13.1.1 There shall be an exception for specimens that by their nature or condition do not permit meaningful examination or where medical issues concerning the quality of patient care or legal requirements do not apply. These include but are not limited to:

- a) Cataracts
- b) Orthopedic appliances
- c) Foreign bodies
- d) Portion of ribs removed to enhance operative exposure
- e) Therapeutic radioactive sources
- f) Traumatically impaired members that have been amputated
- g) Foreskin from infants and children
- h) Placentas including those following c-section
- i) Teeth
- j) Toenails and calculi (those calculi requiring chemical analysis should be sent directly to the chemistry section of the laboratory)
- k) Thrombi
- l) Skin and subcutaneous tissue from cosmetic surgery
- m) Varicose veins
- n) Hernia sac

13.1.2 Other specimens may be included; however, judicious exemption from gross or microscopic examination will require consultation with the pathologist. A written report of each examination shall be entered in the patient's chart.

13.2 CYTOLOGY. All samples for cytological diagnosis, whether exfoliated or aspirated, and all serous fluids obtained anywhere in the Hospital, shall be sent to a member of the Department of Pathology for examination. A report of each examination shall be entered in the patient's chart.

13.3 AUTOPSY. Autopsies are encouraged and will be performed by a Pathologist. Physician request for autopsy must be documented in the chart. The physician is responsible for securing a valid consent. Guidelines for obtaining proper authorization are found in the BDMC laboratory manual and are based on Arizona statutes. When an autopsy is performed in the Hospital, a summary of the gross findings shall be completed within three (3) days, and the final protocol signed by the pathologist must be added to the Medical Record within 60 days.

13.3.1 Autopsies Performed by Pathology Department. Indications for autopsies include but are not limited to:

- a) Unanticipated death
- b) Death occurring while patient is being treated under an experimental regimen
- c) Death occurring within 48 hours after surgery or an invasive diagnostic procedure
- d) Death incident of pregnancy or within 7 days following delivery.
- e) Death where the cause is sufficiently obscure to delay completion of the death certificate
- f) Death in infants/children with congenital malformations.

13.3.2 Autopsies Not Performed by Pathology Department. The pathologist is not responsible for post-mortem examinations [1] on patients who die at home, in transit to the Hospital, in the Emergency Room prior to admission or [2] if the case must be referred to the Medical Examiner. Deaths referred to the Medical Examiner's Office include:

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

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

13.4 A member of the Department of Pathology is available for consultation on diagnostic problems in clinical pathology at all times.

13.5 ANCILLARY LABORATORY TESTING (BEDSIDE TESTING). The direction, authority, jurisdiction and responsibility of point of care testing and ancillary-testing programs as defined in the BDMC (DBA) LSA CLIA license, shall be under the direction of the Pathology Department.

14.0 DYING AND DEATH

14.1 In-Hospital Death.

14.1.1. Notification of next of kin. The attending physician is responsible for notifying the family of a patient's death. Social Services will assist in identifying and contacting the next of kin.

14.1.2. Death Certificate, Cause of Death. Except when the decedent's body has been referred to the County Medical Examiner (see Rule 13.3.2), the attending physician who, for purposes of this Rule, is any Physician (including in the ER and CCU) who actively treated or cared for the patient or who was in charge (in the Hospital) of the Patient's care for the illness or condition that resulted in death, shall complete and sign the medical certification of a cause of death within 72 hours of the death. The attending physician must write "pending further examination" when unable to certify cause of death due to pathology report delay.

14.2 Anatomical Donations.

14.2.1 Consent. When a death occurs at the Hospital, a Hospital employee, trained by the Donor Network of Arizona ("representative") will:

- a) Consult with the attending physician about the decedent's medical conditions and any known refusal to make a donation; and
- b) If the donor is deemed acceptable by the Donor Network of Arizona, and if the decedent has not executed any document consenting to or refusing to make a donation, obtain informed consent from the legally authorized person.

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

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

14.3 Autopsy. The Medical Staff encourages its members to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest that are not referred to the County Medical Examiner. (See 13.3.2)

14.3.1 Consent

- a) Persons Authorized to Consent. Legal authority to consent to autopsy lies with the person statutorily responsible for burying the body, who is, in descending order:
 - spouse;
 - if minor, parents;
 - adult children

Thereafter any person willing to assume responsibility for burying the body may do so and may consent to the autopsy, including: guardian; next of kin; friend; fraternal, charitable or religious organization. (The "surrogate" decision-maker (see 8.6) is not authorized to consent to post-medical-treatment decisions.)

- b) Responsibility for Obtaining Consent. The Hospital is responsible for reasonable attempts to identify and contact, and the attending physician is responsible for discussing and requesting autopsy from, the person authorized to give consent.

14.3.2. Documentation. Documented witnessed consent on the Hospital's autopsy permit is required before the autopsy may be performed. The consent may be by phone, if heard contemporaneously by two Hospital employees and recorded.

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

14.3.4. Pathology Department. The final decision to perform an autopsy rests with the Pathology Department based on autopsy criteria (rule 12.3), legality and safety.

14.4. Do Not Resuscitate; Withdrawal/Withholding of Life Support. Rules 8.6 (Refusal to Consent) and 8.7 (Advance Directives) also apply to do-no-resuscitate and withholding and withdrawal of life support.

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

14.4.2. Definitions:

- a) "Do not resuscitate (DNR)" and "No code" and "No cardiopulmonary resuscitation (CPR)" all mean:
 - No basic CPR (no mechanical chest compression, no mouth-to-mouth or bag valve ventilation); and
 - No endotracheal intubation; and
 - No defibrillation; and
 - No resuscitative cardiovascular chemical agents.
- b) "Orders" in Rule 15.4 refer to orders for DNR and withholding or withdrawal of life support.
- c) "Life sustaining treatment" is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, antibiotics and artificial nutrition and hydration.

14.4.3. Orders:

- a) Prior Discussion. The attending physician must discuss the implications of the orders with the patient (surrogate) before issuing the order. (For pediatric patients, see Pediatric policies and procedures) Exception to prior discussion for DNR: when the attending physician determines that CPR cannot be expected either to restore cardiac or respiratory function) and time is inadequate to consult with patient (surrogate).
- b) Written Orders. Order must be unambiguous; DNR order must also be entered on the checklist.
- c) Verbal Orders. Verbal order must be witnessed by two RNs who hear the order at the same time; and be authenticated within 24 hours.
- d) Limited Resuscitation: The specific resuscitative measures to be withheld should be documented in the medical record if they differ from the definition of DNR. "Slow" responses are not acceptable.

- e) Effect of Order: Neither DNR nor withholding-withdrawal orders affect the other medical or nursing care treatment or care orders, including medications, IV fluids, etc.
- f) Review of Order: The attending physician must review:
 - All DNR and withholding/withdrawal orders in light of the patient's condition whenever the patient's status changes substantially but at least every 72 hours.
 - All DNR orders with the patient (surrogate) before surgery. The medical record and checklist should indicate whether the DNR order is to be suspended, and if so, for what period peri-operatively and post-anesthesia.
- g) Rescission: Patients (surrogates) may rescind DNR, withholding and withdrawal orders at any time.
- h) Potential Organ Donor: If DNR is ordered and death is imminent, the Hospital will call the Donor Network of Arizona, which will determine suitability and conduct necessary discussions with the patient/surrogate.

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

- a) Condition: the patients complete medical condition and prognosis, basis for the DNR or withholding-withdrawal order.
- b) Discussion: summary of discussion between the physician and patient (surrogate) prior to writing order (See 15.4.3(a)).
- c) Capacity: basis for physician's determination that patient has medical-decision-making capacity when patient requests order. If attending physician questions the patient's capacity, a second medical opinion should be sought and documented.
- d) Consultation: if attending physician is surrogate by default, that the attending physician has sought consultation as required under Rule 8.7.3 (e).

14.4.5. Resolution of Disputes/Conflicts: Refer to Rules 8.6.4 and 8.7.3(c).

APPENDIX¹

1.10 Form Letter to Appeal Concurrent Coverage Denials:

Date:

Time:

BY TELECOPIER #: _____

Plan Name

Plan Address

Re: Denial of Continued Hospitalization of

____ [Patient's Name] _____

Dear -----,

I was informed today at ___pm/am that you have denied coverage for continued hospitalization of the above-referenced patient as of [date/time].

I am writing this letter to inform you that, in my professional judgment, the patient's condition requires further medical care in an acute care setting, and should therefore be covered under your policy.

The following description of the patient's condition and attachments support my conclusion about the medical necessity of continued coverage for hospitalization:

Yours truly,

Attachments

cc: Hospital Administrator
Medical Staff President

¹Because this Appendix states information that is subject to change, it will be updated as needed on approval of the Executive Committee.

6.2.2 BDMC-Contracted Health Plans:

See attached list.

7.2 Accidental Exposure to Blood Fluids.

- a) Treatment. Immediately wash cuts or wounds with soap and water; may follow with Betadine solution or Chlorhexidine. Immediately rinse exposed mucous membrane (e.g., nose or mouth) with water or saline. Eyes should be rinsed with water or saline only. Other cleaning agents may damage these tissues and result in infection.
- b) For Employed Physicians Who May Wish to be Covered by Workers' Compensation. Immediately complete an Employee Industrial Incident Report, available in the Employee Health Office. The completed form should be returned no later than 10 days after the exposure to the Medical Staff member's employer; and within 10 days of the exposure, obtain a confidential test for HIV. If the test results are negative, to present a prima facie case that an HIV infection was caused by the reported exposure, the Medical Staff member must test positive for HIV within 18 months of the reported exposure.

7.4 BOMEX-Published List of Reportable Communicable Diseases] See attached list.

7.5 Warning a Third Party at Risk of Exposure to HIV. A physician should attempt to obtain the patient's consent to warn an identifiable third party at risk of exposure to HIV. If the patient refuses to consent, the physician may warn a third party at risk without exposing him or herself to liability by reporting to the Department of Health Services ONLY: (1) the name and address of the patient's contact (but not the patient's name) and (2) the name and address of the person reporting, ONLY IF the physician:

- a) knows that the patient has contracted or tests positive for HIV;
- b) reasonably believes that an identifiable third party is at risk of HIV infection from a significant exposure;
- c) knows that the patient has not notified or referred for testing, or will not notify or refer for testing, the patient's contact;
- d) has asked the patient to consent to "release this information" voluntarily, and the patient has refused; and
- e) makes the disclosure to the Department of Health Services "in good faith and without malice."

7.6 Permissible Disclosures of a Patient's HIV-Status Without a Specific Informed Written Consent May Be Made To:

- a) the patient (or if the patient lacks capacity to consent, to the person authorized to consent to health care for the patient);
- b) another health care provider in the Hospital, if that person's knowledge of the information is necessary to provide appropriate care or treatment to the patient or the patient's child;
- c) a Hospital employee who is authorized to access the patient's medical records to obtain the information and the employee provides health care to the patient or maintains or processes medical records for billing or reimbursement;
- d) the Administrator or another Medical Staff member in relation to the procurement, processing, distribution or use of a human body or human body part for medical education, research, therapy or transplantation;
- e) the Administrator or committee engaged in the review of professional practices, provided such information does not directly identify the protected person; and
- f) others as may be expressly permitted or mandated by law.

8.2 Patient Consent for Performance of HIV-Related Test.

It is a misdemeanor to perform an HIV-related test without first obtaining the specific written informed consent of the subject of the test. If the patient lacks capacity to consent, the specific written informed consent must be obtained from a person legally authorized to consent to health care for that patient.

Exceptions. Specific written informed consent is not required, in the following limited circumstances:

8.2.1 Emergency, if

- a) HIV-related testing is necessary for the diagnosis and treatment of an emergency condition, AND
- b) the patient lacks capacity to consent, AND
- c) no person authorized to consent to health care for that person can be identified on a timely basis, AND
- d) the attending physician documents the existence of an emergency medical condition, the necessity of the HIV-related testing to diagnose and treat the emergency condition and the patient's lack of capacity.

8.2.2 Diagnosis and Treatment, if

- a) HIV-related testing is directly related to and necessary for the diagnosis and treatment of the patient's medical condition, AND

- b) the patient lacks capacity to consent, AND
- c) no person authorized to consent to health care for that person can be identified on a timely basis, AND
- d) the attending physician and a consulting physician certify in writing that the HIV-related testing is directly related to and necessary for the diagnosis and treatment of the patient's medical condition.

8.2.3 Research, Autopsy, Transplants, if the testing is performed

- a) for research, provided the identity of the test subject is not and may not be known by the researcher; and
- b) on a deceased person to determine the cause of death or for epidemiologic or public health purposes; and
- c) in relation to the procuring, processing, distributing or use of a human body or a human body part for use in medical research or therapy or for transplantation to other persons.

9.2.7 Automatic Signature For a report to be deemed to be signed automatically, physicians participating in the Automatic Signature Program must complete the dictated report within the following time frames:

History and Physical.....within 24 hours of admission.
 Emergency Room Report.....within 24 hours of emergency service.
 Operative Reportwithin 24 hours of surgery.
 Cardiac/Vascular Catheterwithin 48 hours of procedure.
 Discharge Summary within 7 days after discharge.
 Consultation Report.....no time limit.

9.3.1 Access to and Use of Patients' Medical Records. The Hospital permits the following persons, among others, to examine medical records: patients, patients' and Hospital attorneys, insurance representatives, financial auditors. (MR-005) In addition, the Hospital permits authorized representatives of "external review organizations" that perform medical record reviews to review patients' medical records. Patient Services Department keeps an up-to-date list of each authorized representative of an agency on file. On each visit, the reviewer must log in and out of the Patient Services Department, identify in advance which patients will be reviewed and wear a badge; the reviewer may not remove or photocopy the medical record, but may request copies from the Medical Records Department. (MR-011)

13.1 Pathology. A professional interpretation is to be included automatically with orders for the following studies: (Added 6/5/97)

83020 Hemoglobin electrophoresis

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