BANNER GATEWAY MEDICAL CENTER
MEDICAL STAFF RULES AND REGULATION

ARTICLE I. GENERAL

1.1 The Active Medical Staff shall consist of physicians who are involved in the care of twenty (20) or more patients at the Medical Center during each calendar year. Any Medical Staff Member who has not been involved in the care of twenty (20) or more patients at the Medical Center may submit documentation of other activities demonstrating substantial involvement in the affairs of the Medical Staff and/or the Medical Center to request Active Medical Staff membership. The Medical Executive Committee, or its designee, shall in its discretion determine if such other activities are sufficient to satisfy the requirements necessary to achieve or maintain Active Medical Staff membership. Each Medical Staff Member must meet the above criteria during the previous calendar year to achieve and maintain Active Medical Staff membership. Continuation of membership on the Active Medical Staff may be forfeited by any member who fails to comply with these Bylaws, Rules and Regulations or any other departmental requirements.

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

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

1.4 Physicians who have substantiated health reasons for being excused from call rotation may be excused by the Department Chairman and CEO.

1.5 All research being conducted at, sponsored by, or otherwise affiliated with BGMC facilities and Medical Staff must be in compliance with current Banner Health policies

1.6 Physicians on the Medical Staff who wish to resign as members of the Medical Staff may do so by sending or delivering a written notice to that effect to the Medical Staff Services office of the Medical Center. Such notice should set forth the date and time the physician desires to have his or her resignation become effective. Notwithstanding the foregoing, no physician's voluntary resignation from the Medical Staff shall be effective until such time as: 1) the physician has dictated, completed and signed all medical records for which the physician is responsible; and 2) the physician has completed any call rotation period which was scheduled to commence within two (2) weeks following the Medical Staff Services Office's receipt of the physician's written request to resign from the Medical Staff.

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

1.8 Consent: The patient, or in special circumstances, someone acting for the patient, gives consent. Spouses and other family members do not have the right to consent or refuse consent for most patients. For unemancipated minors and wards, parents or guardians generally have the right to consent. (See Banner Gateway Medical Center policies on consent for further information.) Consent forms should be in writing and properly signed and witnessed. It is acceptable practice for someone other than a physician to obtain and witness a patient's signature on a consent form. However, it is essential that the physician provide the medical explanation including the risk, benefits, and potential complications associated with procedures leading to the patient's consent for surgeries or other significant procedures. Signed consent forms will be made a part of the patient's permanent medical record.

1.9 Physicians with patients in the hospital must be readily accessible by pager or cell phone.

ARTICLE II. ADMISSION POLICIES

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

2.2 Patients will not be discriminated against on the basis of race, creed, sex, national origin, or religion.

2.3 Patients who present to the Emergency Department and who have no attending physician with appropriate privileges at the Medical Center shall be treated and admission arranged for by the doctor on duty in the Emergency Department at the time and assigned to members of the Medical Staff on call or their designee in the service to which the illness of the patient indicates assignment.

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

2.5 Except in an emergency, no patient shall be admitted to the Medical Center until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible. (For the purpose of these Rules and Regulations, the term "emergency" may be applied to any patient whose condition is such that any delay occasioned by compliance with any of these Rules and Regulations might prejudice the physical welfare of the patient.) Physicians shall be held responsible for giving such information as may be necessary to assure the protection of other patients and Medical Center personnel from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self-harm.

2.6 Patients must be seen by the patient's attending physicians or their physician designees:

a. Patients admitted to Critical Care status—within 6 hours;
b. Patients admitted to Telemetry status—within 16 hours;
c. All others—within 24 hours.

Patients must be seen sooner if their condition warrants physician intervention. Patients must be seen daily thereafter by the physician, or more often if the patient's condition

warrants. (Exceptions may be granted for obstetrical patients.) The appropriate department chairman is to be notified if a patient is not visited by the attending physician or his/her physician designee within the designated time following admission and daily thereafter.

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

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

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

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

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

ARTICLE III. CONSULTATIONS

3.1 Consultation is *encouraged* for all seriously ill patients or for those whose medical problem is not within the scope of the attending physician. Except in an emergency, consultations with another qualified physician should be obtained for cases on all services in which, according to the judgment of the physician: 1) the patient is not a good medical or surgical risk, 2) the diagnosis is obscure, 3) there is doubt as to the best therapeutic measures to be utilized. Each department may establish its own consultation requirements subject to approval by the Medical Executive Committee.

3.2 If appropriate consultation is not sought by the attending physician, the Chairman of the appropriate department should be contacted. Where the chair concurs that consult is warranted, he/she shall contact the attending physician with the recommendation for consultation in the care of his/her patient. If the attending physician refuses to seek appropriate consultation, the Chairman of the appropriate department may request such consultation.

3.3 Direct physician to physician communication when requesting a consultation from a colleague is optimal for enhancing efficiency, quality and safety of patient care. Except where patient care situations dictate otherwise, direct physician to physician communication is required for all urgent or emergent consultations. Urgent/emergent consultations are those situations where the referring physician believes the patient needs to be seen by the consultant as soon as possible for an imminently serious or potentially life-threatening situation. This applies to all patient care areas. For routine consultations, the decision to speak directly with the consultant physician will be left to the discretion of the referring physician. The specific reason for the consultation should be included with the written or verbal order for the consultation. The attending physician is responsible for requesting the consultation with a physician order. All consultations shall be requested by specifying the individual physician.

3.4 A satisfactory consultation includes examination of the patient as well as the health record. When operative procedures are involved, the consultation shall be recorded prior to the operation (except in an emergency).The consultant shall make and authenticate a record of his/her findings and recommendations in every case.

3.5 Consultation must be rendered on a timely basis. Consultants are expected to see patient within 24 hours for situations that are not considered imminently serious or potentially life-threatening. Every effort should be made to coordinate orders between

multiple consultants and the attending physician. The attending physician will coordinate orders unless he/she specifies differently.

3.6 When a patient attempts suicide while in the Medical Center, there must be an evaluation by a psychiatrist, psychologist, or trained behavioral health professional who is a member of the Medical Staff or Allied Health Staff of Banner Gateway Medical Center.

ARTICLE IV. MEDICAL RECORD POLICIES

A. General

a. A Medical Record is established and maintained for each patient.

4.1 Purpose of the Medical Record - An adequate health record is compiled and maintained for each patient who has been treated or evaluated at the Medical Center. The purposes of the medical record are:

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

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

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

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

4.1.5 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, education, and research.

4.2 Electronic Medical Record (also referred to as clinical information system). Banner Gateway is a "paper light" organization. As such, physicians need to adhere to record keeping practices that support the electronic environment. As much data as possible will be created electronically and paper-based records will be minimized as much as possible. Records will be accessed by physicians and other users online and the records will not be printed for internal use. Access to patient information that is not routinely distributed will be made available to physicians and their staff through direct online access with Clinical Connectivity. All access to electronic records will be tracked and no unauthorized access to a patient's record will be tolerated.

4.3 Access. Medical record access to confidential materials by members of the Medical and other staffs of the Medical Center, Medical Center employees, and others is only permissible when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, approved research, or some other appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored.

4.4 Retention. Current and historical medical records are maintained via Cerner Millennium. The electronic medical record is maintained in accordance with state and federal laws and regulatory guidelines. Refer to Banner Retention Policy.

4.5 Confidentiality of Patients' Medical Records - Patients' medical records are the property of the Medical Center. Because they are confidential, the Medical Center releases the information contained in them only on proper written authorization of the patient or as otherwise authorized by law and Banner policies. In addition, the Medical Center

safeguards patients' records against unauthorized disclosure and/or use, loss, defacement, and tampering. The Health Information Management Department keeps a log of all requests submitted for access to medical record information.

4.5.1 Extremely Sensitive Patient Information – The laws requires additional protection for certain information in the Medical Record (e.g., certain drug and alcohol treatment, psychiatric, communicable disease and HIV-related information). Medical Center 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.

4.5.2 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.

4.6 Electronic Signature - Electronic signature authentication of medical records will be the standard practice. In order to maintain the integrity of the medical record as a legal document and assure that electronic signatures and/or computer generated signature codes are secure from unauthorized persons, all members of the medical staff must have on file a signed statement that s/he is the only individual using and in possession of the confidential password. Each transcribed report will be individually authenticated by the responsible physician. Refer to HIMS Electronic Signature policy.

4.7 Mode of Entry – All documents created after the patient is admitted shall be created utilizing Banner Health systems, either through on-line entry or dictation to allow for patient information to be exchanged and shared electronically among caregivers. The Medical Center will accept prenatal information and History & Physicals from a physician office or from a previous admission provided that they meet the time requirements and contain the data elements specified in the Medical Staff Rules and Regulations. All other reports (Operative Reports, Consultations, Discharge Summaries, and Progress Notes) will be completed utilizing Banner approved formats.

4.8 Information from Outside Sources - Health record information obtained on request from an outside source is placed in the health record and is available to the professional staff concerned with the care and treatment of the patient. This information will contain the source name facility/address. Results of examination (Laboratory and X-Ray) performed prior to admission of the patient to the Medical Center and that are required for or directly related to the admission are properly a part of the patient's Medical Center record and should be recorded by the attending physician in his progress notes.

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

4.10 Ownership and Removal of Medical Records - All original patient medical records including x-ray films, pathological specimens and slides, are the property of the Medical Center and may be removed only in accordance with state and federal law, a court order, or subpoena, the permission of the Medical Center's Chief Executive Officer, or in accordance with Medical Center's policies. Unauthorized removal of an original medical record or any portion thereof from the Medical Center constitutes grounds for disciplinary action.

B. Medical Record Documentation and Content

Content of the Medical Record – The medical record must identify the patient, support the diagnosis, justify the treatment, document the course and results of treatment and

facilitate continuity of care. Refer to HIMS policy Content of the Medical Record. The health record is sufficiently detailed and organized to enable:

- •The responsible practitioner to provide continuing care, determine later what the patient's condition was at a specified time, and review diagnostic/therapeutic procedures performed and the patient's response to treatment.
- •A consultant to render an opinion after an examination of the patient and review of the health record.
- •Another practitioner to assume care of the patient at any time.
- •Retrieval of pertinent information required for utilization review and/or quality assurance activities.

4.11 Responsibility - The attending physician is responsible for each patient's medical record. The medical record must identify who is primarily responsible for the care of the patient. Transfers of primary responsibility of the patient are not effective until documented in the clinical information system by the transferring physician and accepted on the clinical information system by the accepting physician.

4.12 Authentication - All clinical entries in the patient's record must be accurately dated, timed and individually authenticated. Authentication means to establish authorship by written or electronic signature and shall consist of the practitioner's name and professional title indicating the professional credential.

4.13 Legibility - All practitioner entries in the record must be legible, pertinent, complete and current. Legibility issues will be forwarded to the Professional Review Committee.

4.14 Authority to Document - No persons other than the following shall be authorized to enter, change or authenticate material in the medical record:

- Medical Staff
- Nursing Staff
- Allied Health Staff
- Dieticians
- Physical Therapists
- Occupational Therapists
- Speech Pathologists
- Recreational Therapists
- Addiction Therapists
- Mental Health Counselors
- Chaplains
- External Case Managers
- Medical Imaging Techs
- Laboratory Techs
- Pharmacists
- Social Services
- Case Workers
- Psych Techs
- Case Mgrs (Int. UM Reviewers)
- Medical/PA/Nursing Students
- Physicists
- Respiratory Therapists
- Residents/Fellows

4.15 Counter-authentication - All entries, History and Physical Reports, Procedural Notes, and Discharge Summaries made by Physician Assistants and/or Nurse Practitioners must be counter-authenticated timely by the attending physician. Each clinical event must be documented as soon as possible after its occurrence.

4.16 History and Physical Examination ("H&P") - H&Ps must be recorded within 24 hours of admission and present on the chart before any inpatient or outpatient elective invasive procedure being performed, regardless of location, otherwise the procedure will be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

4.17 **Invasive Procedures include (but not limited to)**

- Main OR procedures
- Ambulatory surgeries
- Cardiac catheterizations

- C-section deliveries/tubal ligations
- Endoscopies
- Interventional Cardiac Procedures – Percutaneous Transluminal Coronary Angioplasty (PTCA), Rotational Atherectomy, Mechanical Thrombolysis, Permanent Pacemakers
- Interventional Radiology Procedures: Percutaneous Transluminal Angioplasty (PTA), Nephrostomy Tube Insertion, Transjugular Intrahepatic Portosystemic Shunt (TIPS), CT Guided Biopsies, Thoracentesis, Paracentesis, Epidural Blocks, Nerve Root Blocks, Facet Infections, Angiograms
- Venograms
- Transesophageal Echocardiogram (TEE)
- Cardioversions
- Bone Marrow Studies
- Lumbar Puncture

4.18 Legible copies of H&Ps performed up to thirty days before admission may be used in the medical record. All history and physical reports completed prior to the patient's admission must be updated within 24 hours of the patient's admission and prior to surgery unless the attending surgeon states in writing that such a delay would constitute a hazard to the patient.

4.18.1 Responsibility for H&P - The attending medical staff member is responsible for the H&P, unless it was already performed by the admitting medical staff member. Dentists and podiatrists are responsible for the part of their patients' H&P that relates to dentistry or podiatry.

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

4.18.2.1 Medical history:
4.18.2.2 Chief complaint
4.18.2.3 History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status.
4.18.2.4 Relevant past medical, family and/or social history appropriate to the patient's age.
4.18.2.5 Review of body systems.
4.18.2.6 A list of current medications and dosages.
4.18.2.7 Any known allergies including past medication reactions and biological allergies
4.18.2.8 Existing co-morbid conditions
4.18.2.9 Physical examination: current physical assessment
4.18.2.10 Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
4.18.2.11 Initial plan: statement of the course of action planned for the patient while in the Medical Center.

4.18.3 For other outpatient (ambulatory) surgical patients, as necessary for treatment

4.18.3.1 Indications/symptoms for the procedure.
4.18.3.2 A list of current medications and dosages.
4.18.3.3 Any known allergies including past medication reactions

4.18.3.4 Existing co-morbid conditions
4.18.3.5 Assessment of mental status
4.18.3.6 Exam specific to the procedure performed.

4.18.4. IV moderate sedation - For patients receiving IV moderate sedation, all of the above elements, plus the following:

4.18.4.1 Examination of the heart and lungs by ausculation.
4.18.4.2 American Society of Anesthesia (ASA) status
4.18.4.3 Documentation that patient is appropriate candidate for IV moderate sedation.

4.19 Emergency Department Reports - A report is required for all Emergency Department visits. The following elements should be included:

4.19.1 Time and means of arrival

4.19.2 Pertinent history of the illness or injury and physical findings including the patient's vital signs and emergency care given to the patient prior to arrival

4.19.3 Clinical observations, including results of treatment

4.19.4 Diagnostic impressions

4.19.5 Condition of the patient on discharge or transfer

4.19.6 Whether the patient left against medical advice

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

4.20 Progress Notes - Progress notes are to be recorded with a frequency that reflects appropriate attending involvement but at least every day. Exception may be given to an obstetrical patient that has a discharge order written from the day before. Progress notes should describe not only the patient's condition, but also include response to therapy.

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

4.22 Pre-Operative Anesthesia Evaluation - The anesthesiologist must perform and document in the record within 48 hours prior to the procedure a pre-anesthesia evaluation of the patient, including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, American Society of Anesthesiologists patient status classification, and orders for pre-op medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before the pre-operative medication has been administered.

4.23 Post-Anesthesia Assessment - The anesthesiologist must perform and document at least one description of the presence and/or absence of anesthesia-related complications, cardiopulmonary status, level of consciousness, follow-up care and/or observations.

4.24 Operative and Procedure Reports - Operative and procedure reports must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary performing practitioner and any assistants. The full report must be dictated or

electronically created immediately, as well as the recording of a post-operative note to be made available in the record after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend the patient. Procedures requiring dictated or electronically created operative reports are identified in section **4.18**

Criteria for Post-Operative Note

- Post-operative diagnosis
- Surgeon
- Assistant surgeon (if applicable)
- Technical procedures used
- Findings
- Specimens removed
- Estimated blood loss

4.25 Discharge Documentation - At the time of discharge, but no later than 24 hours, thereafter the attending physician is responsible for dictating or electronically creating a discharge summary.

4.25.1 A discharge summary must be dictated or electronically created on all inpatient hospitalizations with a length of stay of 48 hours or greater. The discharge summary shall include:

4.25.1.1 Reason for hospitalization
4.25.1.2 Concise summary of diagnoses including any complications or co-morbidity factors
4.25.1.3 Hospital course, including significant findings
4.25.1.4 Procedures performed and treatment rendered
4.25.1.5 Patient's condition on discharge (describing limitations)
4.25.1.6 Patients/Family instructions for continued care and/or follow-up

4.25.2 A final discharge progress note may be substituted for the discharge summary for patients with a length of stay of 2 days or less as well as for normal newborns and obstetrical cases. The note shall include:

4.25.2.1 Final diagnosis(es)
4.25.2.2 Condition of patient
4.25.2.3 Discharge instructions
4.25.2.4 Follow-up care required

4.25.3 For Deaths - A death summary is required for all deaths regardless of length of stay and must be dictated or electronically created within 24 hours of death by the attending physician.

4.25.4 For Transfers – The transferring physician must dictate or electronically create a transfer summary at the time of transfer regardless of length of stay to include documentation that patient was advised of risks/benefits.

C. Amending Medical Record Entries

4.26 Electronic Documents (Structured, Text and Images)

4.26.1 Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the

error or omission through the clinical information system. The clinical information system will track all changes made to entries.

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

4.26.3 If information is found to be recorded on the wrong patient, regardless of the status of the entry, the clinical information system will not allow deletion of any entries. The entry recorded in error must be uncharted by the author, placing the entry in an "in error" status and re-entering the information on the correct patient.

4.27 Paper-Based Documents

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

4.27.2 Errors or omissions discovered at a later time shall be corrected by the individual by entering a separate new entry in the current portion of the record. The original entry shall be lined out, or if a scanned in document refered to, not obliterated. The person making the change shall sign and note the date of the change and reason for the change. The new entry shall also state who was notified of the change and the date of such notification.

4.27.3 Any physician who discovers a possible error made by another individual shall immediately upon discovery notify the supervisor of that clinical or ancillary area. If none of these individuals are available, the physician will notify the house supervisor.

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

4.27.5 After a record has been identified as complete, no deletions or amendments may be made; however, the attending physician may make a suitably-dated addendum as a progress note identifying the erroneous information elsewhere in the record and stating the correct information with the date of the new entry. If individuals other than the attending physician discover information in a record which has been filed as complete and which they believe to be erroneous, they shall bring this information to the attention of the attending physician.

D. Timely Completion of Medical Records

4.28 All medical records shall be completed within time frames defined below:

4.28.1 Emergency Room Report – within 12 hours of disposition of the patient
4.28.2 H&P – within 24 hrs of admission & before invasive procedure
4.28.3 Consultation Reports – within 24 hours of consultation
4.28.4 Operative Note - immediately post-op
4.28.5 Operative Report – within 24 hours
4.28.6 Discharge Summary – within 24 hours of discharge
4.28.7 Discharge Note - within 24 hours of discharge
4.28.8 Death Summary - within 24 hours of death
4.28.9 Transfer Summary - at the time of transfer
4.28.10Authentications – within 28 days of discharge

4.29 The Medical Record is not considered complete until all its essential elements are inputted and authenticated, and all final diagnoses and any complications are recorded, consistent with these Rules. A medical record is considered delinquent if not complete 28 days post discharge of patient. No medical record shall be considered complete without fulfilling the documentation requirements except on order of the Medical Executive Committee.

E. Medical Record Deficiencies

4.30 Notices of deficiencies for History & Physical and Discharge Summary will be created automatically by the clinical information system at the time of admission and discharge of the patient, respectively. The notices for the deficiencies will be communicated to the responsible physician.

4.31 All deficiencies will be assigned to the responsible physician regardless of the age or status of the deficiency. The Health Information Management Services Department shall advise physicians, by fax or system e-mail address (based on practitioner preference) of incomplete medical records. Warning and Suspension Notices will be sent each Wednesday and will include a list of all incomplete and delinquent medical records based on the timelines identified below:

Documentation Requirement	Completion Requirement	Temporary Suspension Eligibility
Emergency Room Report Dictation	12 hours	72 hours
History & Physical Report Dictation	24 hours	72 hours
Consultation Report	24 hours	72 hours
Operative Report	24 hours	72 hours
Discharge Summary	24 hours	72 hours
Authentications	28 days	28 days

4.32 No additional notification beyond the information routinely posted to the Inbox will occur if records are completed according to the completion requirements. If there are extenuating circumstances (defined as illness or vacation) that prevent the practitioner from completing their medical records, the doctor or the doctor's office shall so notify the HIMS Department. If there are none of these extenuating circumstances and the record has not been completed. Physicians with records pending completion will receive a reminder notice from HIMS.

F. Medical Record Suspensions

4.33 If the delinquent records are not completed by the suspension timeframe, physicians will receive a Notice of Suspension indicating that their admitting, surgical and/or consultative privileges will be temporarily suspended until all medical records are completed per HIMS Medical Record Completion Policy. A suspension list will be generated and distributed by the Health Information Management Services Department. The Suspension List is distributed to the Executive Committee, Department Chairs, Administration, Patient Registration, Emergency Department, Cardiology, Inpatient and Outpatient Surgery areas and all Medical Center Units.

4.34 Upon temporary suspension, the delinquent member shall have no admitting, surgical and/or consultative privileges, other than patients in labor or patients

needing emergent care, until delinquent records have been completed. A member whose privileges have been suspended under this Section shall be allowed to continue the medical and surgical care only of patients who were in the Medical Center under their care prior to imposition of the temporary suspension of privileges, or for those patients who are pre-scheduled for surgery/procedures. Specifically, a suspended physician shall not: schedule new admissions, schedule admissions under an associates/covering physician's name, perform consultations, schedule inpatient or outpatient surgeries or other procedures, assist in surgery, administer anesthesia, round on patients of associates/covering physician's patients, or participate in Emergency Department Call. It is the responsibility of the physician to arrange coverage for Emergency Department call for which that physician is scheduled.

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

4.36 The HIMS Committee will prepare and submit for each Medical Executive Committee meeting a list of physicians whose privileges have been suspended and those who have been restored.

G. Automatic Termination of Privileges for Delinquent Medical Records

4.37 Temporary suspension shall become automatic permanent suspension following 60 cumulative days of temporary suspension within a calendar year. At that time, the practitioner's privileges will automatically move to permanent suspension for failure to complete medical records. Affected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if all delinquent records have been completed. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff. In order to reinstate their staff privileges following such action, the physician will be required to re-apply for medical staff membership, including the reapplication fee.

4.38 Neither temporary nor permanent suspension of privileges or revocation of membership and privileges under this Section entitles a staff member to rights pursuant to the Fair Hearing Plan. Physicians may submit evidence demonstrating why the suspension/revocation is unwarranted to the Medical Executive Committee pursuant to Article 6.6 of the Bylaws.

4.39 Medical Executive Committee may choose to monitor but not take action regarding delinquent medical records during the Medical Center's first 180 days of operation.

ARTICLE V. PHYSICIAN ORDERS

5.1 Physician Orders – Banner Gateway seeks to facilitate timely and accurate execution of physicians' orders to deliver quality patient care, and to provide guidelines within which its medical staff, nursing service, and employees can best accomplish this objective. Orders for treatment shall be routinely entered electronically into the clinical information system and shall be dated, timed and authenticated. If the clinical information system is unavailable for any reason and orders are written on paper, each entry must be dated, timed and signed. It is the responsibility of the physician who is transferring the patient to a new level of care to review all active orders for clinical accuracy and appropriateness. New orders must be generated by physicians after a surgical procedure.

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

5.1.2 Physician orders are required for all tests, services and procedures.

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

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

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

5.1.6 Patients shall be discharged only on the order of the attending, consulting or covering physician.

5.1.7 Inpatient orders may be generated only by physicians with medical staff privileges or by Allied Health Staff (NP's, PA's) according to their scope of practice.

5.2 Orders for Surgery

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

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

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

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

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

5.3 Orders for Inpatient Medical Imaging Tests/Procedures

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

5.3.2 A statement of the reason for the test and/or diagnosis must be indicated on the order and it must also be signed, timed and dated by a physician.

5.4 Orders for Outpatient Tests

5.4.1 Orders for outpatient services are acceptable within their scope of practice from Medical Staff members, non-staff physicians, out of state physicians and those licensed within Arizona with prescriptive authority (PA's, NP's).

5.4.2 A signed order must be received prior to performing outpatient procedures/tests.

5.4.3 A statement of the reason for the test and/or diagnosis must be indicated on the order and it must also be authenticated and dated by a physician.

5.4.4 The following facsimiles or original orders are accepted:

5.4.4.1 Outpatient scheduling form

5.4.4.2 Prescription forms

5.4.4.3 Referral forms (can be payor specific)

5.4.4.4 Notation in patient's history and physical

5.4.4.5 Physician order sheet

5.4.4.6 Physician office letterhead (stationery)

5.5 Verbal and Telephone Orders

5.5.1 Verbal (face to face) orders are not acceptable except in the case of an emergent situation. Verbal orders will be accepted only by a registered nurse (RN) or licensed practical nurse (LPN). Licensed Respiratory Care Practitioners (RCP) and registered pharmacists can accept verbal orders provided the orders are directly related to their specialized discipline. The physician will authenticate these orders within 48 hours.

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

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

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

5.5.5 In areas other than nursing units, certain telephone orders may be taken by the personnel in each department most qualified to accept them as long as the order is directly related to their specialized discipline. All such orders will be strictly limited to the area of expertise of the department.

5.6 No Code Orders

5.6.1 No code orders are entered in the patient's health record and authenticated, timed and dated by the responsible physician. A properly documented no code order will include the physician's medical reasons for the order and his/her discussion with the patient's family, or with the patient. This should be documented in the progress note.

5.6.2 Telephone no code orders are discouraged. However, if no code orders must be placed by telephone, the RN taking the order will have a witness on the telephone to verify and document the no code status. Physicians will sign the no code telephone order upon their next visit and document the reasons even though the patient may have already expired.

ARTICLE VI. GENERAL PHARMACY POLICIES

6.3 General Information

All medication administered to patients at Banner Gateway Medical Center will be supplied by the Department of Pharmacy Services unless otherwise defined by policy or by pharmacy approval. The Department of Pharmacy Services maintains a formulary as authorized by the Pharmacy & Therapeutics Committee. The formulary is an established compendium of approved medications available at Banner Gateway for diagnostic, prophylactic, therapeutic or empiric treatment of patients. The pharmacy is not required to stock more than one brand of an individual medication unless directed differently by the Pharmacy & Therapeutics Committee. Medications ordered by trade name may not necessarily be filled by that name unless the physician states "do not substitute" within the order. The pharmacy will be permitted to make therapeutic substitutions of medications only within clearly defined parameters established by the Pharmacy & Therapeutics Committee and approved by the Executive Committee. In general, medication samples should not be used for patients of the Medical Center.

6.4 Medications

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

a) These medications will be kept at the nursing unit. Medications may be kept at the patient's bedside for self-administration only upon specific written orders of the physician.
b) Medications brought in by the patient that cannot be identified will not be administered to the patient by Medical Center Medical Center personnel nor should they be taken by the patient.
c) Outpatient prescriptions, with the few exceptions defined in pharmacy policy, will not be filled at Banner Gateway Medical Center. If a medication is to be sent home with a patient, a prescription must be written.
d) All medications taken out of the Medical Center by a patient on a pass must be properly labeled.

6.5 Medication Orders

a) All medication orders must be complete, including medication name, dose, route, frequency. Medications ordered by "PRN" must specify frequency and indication.
b) Only standard abbreviations according to Banner Health's policy "Medical Record Abbreviations and Symbols", on the Medical Center's approved list can be used. Medication dosages should be expressed in the metric system and a leading zero must always precede a decimal expression of less than one (i.e., 0.1 mg not .1 mg). A terminal or trailing zero is never to be used after a decimal (e.g., 1 mg never 1.0 mg).
c) There will be no automatic stop order except for those medications defined by the Pharmacy and Therapeutics Committee or the medication order indicates the exact number of doses to be administered or an exact period of time for the medication is specified.
d) All medication orders must be reviewed when a patient is transferred from one medical service to another, for example, to or from Intensive Care Units.
e) All medication orders entered prior to invasive surgery are automatically cancelled. Specific post-op orders must be entered, dated, timed and authenticated by a physician.

6.6 Pharmacy Review

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

6.7 Pharmacy Dosing and Changes

If the pharmacist is requested by the prescriber to dose the medication, or take any changes in the original medication orders, the pharmacist involved is responsible for entering the revised order into the patient's medical record.

6.8 No "Per Protocol"

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

6.9 Authorization to Order Medications

Practitioners licensed by the State of Arizona to prescribe medications may enter orders for medications, if they satisfy the requirements for privileges on the Medical Staff of Banner Gateway Medical Center consistent with their scope of practice. Allied Health Professionals as defined in the Bylaws may write orders under the policies outlined in the AHP Rules and Regulations. Registered pharmacists are permitted to order medications under physician ordered pharmacotherapy consults.

6.10 Authorization to Administer Medications

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

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

8. Physical Therapist (topical medications only. Medications related to physical therapy treatments only)
9. Students under direct supervision of a preceptor from number 1 through 8 above.

6.11 Reporting Adverse Drug Events

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

ARTICLE VII. GENERAL SURGICAL POLICIES

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

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

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

7.4 Operative notes shall be entered into the medical record immediately after surgery. Operative reports shall be dictated or electronically created within 24 hours after surgery.

7.5 All orders for patient care will be cancelled at the time of surgery and it will be the responsibility of the physicians to enter new orders for continuation of the patient's care.

7.6 Tissues and foreign bodies removed during a surgical procedure shall be sent to the Medical Center pathologist for evaluation according to policy. Such specimens shall be properly labeled, packaged in preservative as designated, and identified as to patient and source in the operation room at the time of removal. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. Receipt by the laboratory of surgically removed specimens for examination shall be documented, and identity of the specimens and patients shall be assured throughout the processing and storage.

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

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

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

7.8 **OPERATIVE AND HIGH RISK INVASIVE PROCEDURE SITE IDENTIFICATION**

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

ARTICLE VIII. RESTRAINTS

8.1 RESTRAINTS

a) MED/SURG RESTRAINT – As per Medical Center policy, restraints needed to maintain a patient's safety and integrity of medical therapy require a physician order for initiation with renewal every twenty-four (24) hours. This category applies to soft restraints for intubated patients and to prevent NG or IV removal as well as cognitively impaired patients at risk for falling or other accidental injury. This category also applies to the use of all 4 bed rails.
Summary of physician actions:
    i. First 12 hours after application: give an order (verbal) or enter order, to restrain the patient.
    ii. Within 24 hours: document need for restraint and authenticate (if verbal) previous order.
    iii. Every 24 hours: enter a new order for restraints if need continues.

b) BEHAVIORAL RESTRAINT – Restraints needed to control violent or aggressive behavior require a physician order with renewal every 4 hours even though the patient is a medical (not behavioral health) patient. This category would apply to all types of patients in all units who need to be forcibly put in restraints because of immediate, perilous danger of physical injury to self or others, or destruction of property when less restrictive

measures are not adequate. CMS and JCAHO require that such patients undergo a bedside assessment by a physician or nurse practitioner WITHIN one (1) hour of restraint application. If the attending physician is unable to do this, he/she must arrange for a proxy to see the patient. Bedside assessment is necessary every eight (8) hours if patient behavior remains violent or aggressive. Orders for restraining violent/aggressive patients are renewed every 4 hours.

- 1st hour: **SEE** the patient and document need for restraints and authenticate order.
- 2nd hour: **FOR PATIENTS 17 AND UNDER –** if patient needs continued behavioral restraint, give verbal order or enter order for restraints.
- 4th hour: if patient needs continued behavioral restraint, give verbal order or enter order for restraints.
- 8th hour: **SEE** the patient if violent/aggressive behavior remains that places patient and staff at risk.

ARTICLE IX. ADVANCE DIRECTIVES AND END OF LIFE

9.1 HEALTH CARE DIRECTIVES

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

9.2 WITHDRAWAL OF LIFE SUPPORT

A. Withdrawal of life support should occur in conjunction with best efforts to ascertain the wishes of the patient given the circumstances of his/her illness. If the patient is unable to speak on his/her own behalf, decisions should be made with appropriate family members or defined surrogate (e.g. designated medical power of attorney). Discussions with patient, family members or surrogate decision maker should be documented in the medical record.

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

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

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

9.3 AUTOPSIES

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

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

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

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

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

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

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

9.3.5.1. The case meets the criteria of a Medical Examiner's case.

9.3.5.2. The case was waived by the Medical Examiner's office, but appears to have criminal implications.

9.3.5.3. The Consent for Autopsy appears to be invalid, incomplete, or questionable.

9.3.5.4. The pathologist believes that the case represents a risk to him/her or Medical Center personnel that the facility is not equipped to handle (e.g. Cruetzfeidt-Jacob Disease).

9.3.5.5. Autopsy fails to meet quality assurance or education criteria.

9.3.5.6. The pathologist determines that the autopsy does not meet the criteria as stated in the policy and procedure of the facility.

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

9.3.7 Families requesting an autopsy when the attending physician or pathologist will not authorize the autopsy may contact an independent pathologist to perform the post mortem exam. A list of outside pathologists will be provided. The Medical Center will not be responsible for any arrangements nor charges associated with independent autopsies.

9.3.8 The pathologist discusses the case with the attending physician and invites the attending physician to be present.

ARTICLE X – ALLIED HEALTH PROFESSIONALS

ARTICLE XI. INTERN, RESIDENT AND FELLOW ROTATIONS

11.1 Supervision of Interns, Residents and Fellows

Professional Graduate Medical Education Programs wishing to rotate Interns, Residents or Fellows through Banner Gateway Medical Center will require approval by the appropriate Department Committee, the Medical Executive Committee and Medical Center CEO. This approval will be based upon information provided by the GME training program. Once approved, the professional liability coverage and competencies of each resident or fellow will be confirmed. Successful completion of Banner's electronic medical record/computer assisted order entry training (CPOE training) is required before start of the assigned rotation.

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

Interns, Residents and Fellows are not members of the Medical Staff and are not entitled to any of the rights set forth in the Medical Staff Bylaws. By way of example, they may not admit patients, hold elected office or vote. They are not required to pay staff dues, however, they may attend meetings or serve on committees if invited by the organized medical staff.

11.2 Documentation By Interns, Residents And Fellows

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

11.3 Orders And Operative Reports

Interns, Residents and Fellows approved for rotation through Banner Gateway, who are appropriately registered with the Arizona Medical Board and who are participants

in an accredited training program, may enter patient care orders as determined by the supervising physician.

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

Adopted and recommended to the Banner Health Board of Directors by the
Banner Gateway Medical Executive Committee on

Approved and adopted by resolution of the Banner Health Board of Directors on