Desert Medical Center
General Rules and Regulations
October 2020

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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 health plan 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.

1.11 INFLUENZA VACCINATION – As defined by Banner Policy, each Medical Staff member will submit to the Medical Staff Office a written statement that the member has received a current, CDC-approved influenza vaccination for the then-upcoming influenza season. The only exceptions shall be for religious or medical reasons as approved by the Banner Health Occupational Health Service.

g) A Medical Staff member with a religious objection or medical reason for not receiving an influenza vaccination shall submit the objection in writing to the Banner Health Occupational Health Service, which shall review and decide whether to approve the objection or reason.

h) A Medical Staff member without an approved medical reason or religious objection who fails to timely submit a written statement that he or she has received a current influenza vaccination shall have his or her privileges automatically suspended as defined by Banner Policy of the year in question. Such automatic suspension will not be related to the Medical Staff member's professional conduct or competence and therefore shall not be reported to the National Practitioner Data Bank or state licensure board.

i) Automatic suspension imposed under this Section shall terminate and the suspended privileges shall be restored upon the Medical Staff member's submission of a written statement of current influenza vaccination or at the end of the designated flu season privileges will be restored.

1.12 TREATING FAMILY - Unless specifically preauthorized, reviewed and deemed appropriate by the Chief of Staff**,** Chief Medical Officer**,** or designees, practitioners may not treat immediate family members at BDMC/CCMC or outpatient facilities on campus EXCEPT in an imminent life-threatening emergency AND when another QUALIFIED practitioner is not available timely. If a family member is under the care of a physician's associate or AHP, there is an understanding that minor/low acuity cross-covering care may be appropriate without the need for pre-authorization. This may require access to EMR and Order Entry. Any approved elective treatment is limited to the extent preauthorized. Immediate family member is defined as parents, children, siblings and spouse.

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 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.

2.3 REQUIRED PHYSICIAN VISITS.

A) After the initial visit by the Attending Physician (see 2.3) every patient must be seen daily by attending physician. When a patient is admitted primarily for surgery, the surgeon should see the patient as often as is clinically indicated until the surgical issues are sufficiently resolved. Each Consulting Physician(s) should see the patient as often as is clinically indicated until the condition for which the consultation was requested is sufficiently resolved. If the consulting physician is not seeing the patient daily, the physician must document expected rounding frequency and/or discontinuation of visits. 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.

2.4 ADMITTING MEDICAL STAFF MEMBERS. Only Active and Courtesy Staff members may admit patients.

3.0 CONSULTATION

3.1 CONSULTATIONS Medical practice includes proper and timely use of consultations; and effective communications among treating and consulting physicians.

3.2 ATTENDING PHYSICIAN CONSULTATION REQUEST

3.2.1 Define and document the following:

a) severity/priority of the consultation
b) detailed indication for the consultation must be entered via CPOE EMR
c) identification of individual consultant, group or service line
d) a method for contacting the attending physician with the findings/recommendation

3.2.2 Requests for emergent/urgent consultations (minutes to hours need) must be communicated directly to the consulting physician by the attending physician.

3.2.3 Routine consultations will be called by hospital staff at the time of the order. Each member of the medical staff is expected to work with his or her answering service to develop an appropriate triage protocol for those routine consultation requests that may come in during the hours the physician's office is closed.

3.2.4 The attending physician will coordinate recommendations between multiple consultants and communicate the collaborative care plan to the patient.

3.3 CONSULTANT

3.3.1 Immediately following consultation, the consultant (or designee) will document the critical findings, opinions and recommendations via a brief note, and direct communication, if appropriate followed by a full consult note. Include a contact number to facilitate further communication. The consultant will call the attending with findings and recommendations when indicated.

3.3.2 Document that consultant personally examined the patient and reviewed the medical record.

3.3.3 Complete the documentation within 24 hours of the consultation and, if the consultation pertains to the decision to operate, before the operation (except in a documented emergency).

3.3.4 Document when consultant has signed off on the care of the patient.

4.0 PHYSICIAN RESPONSIBILITIES FOR DISCHARGE AND TRANSPORT

4.1 DISCHARGE TO "HOME"

4.1.1 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.

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

4.2 TRANSPORT

4.2.1 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.

4.2.2 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, 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. Physician should respond by phone within fifteen (15) minutes. Timely admission orders must be given.

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. Physicians shall serve on the on-call roster based on need for coverage, unassigned and emergency patients as determined by the applicable department, the Medical Executive Committee, Administration and the EMTALA policy, as required. Refer to Medical Staff Emergency Department On-Call Policy and Procedure for approved call requirements.

6.2 EMERGENCY CALL ROSTER

6.2.1 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.

a) Medical Staff Services creates under the direction of the department chairman on-call lists consistent with both the EMTALA policy and Medical Staff Rules and Regulations.
b) The on-call list will include the names of the individual physicians who are on-call, not the name of groups. Accurate contact information must also be available.
c) Call rotation is from 7 a.m. to 7 a.m. for each day of call. A schedule of call rotation is available through the Banner Health Intranet titled Central Logic On-Call Schedule.

6.2.2 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 ED 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.

a) The Physician on-call has responsibility in arranging coverage, if unavailable. Coverage must be made as much in advance, as possible. Any physician who is unable to take call (e.g. vacation, family emergency) when assigned is responsible for finding qualified coverage by a physician on the Medical Staff with appropriate privileges to cover his/her assigned call. The physician must notify the Medical Staff Services Department or ED (after hours) of a change in coverage.
b) Physicians may serve on the on-call roster of another hospital simultaneously unless excluded by contract or other regulatory requirements. Physicians are required to notify the Medical Staff Office of their simultaneous obligations, at non-Banner facilities. (See Paragraph G of the Medical Staff EMTALA policy)

6.2.3 Exclusion. Medical Staff exemptions from service on the call schedule may be granted to physicians 60 years or older and to other physicians if the applicable department, Medical Executive Committee and Administration finds good cause for the exemption provided that the hospital has adequate on-call services if exemptions are permitted.

6.3 UNASSIGNED PATIENTS

6.3.1 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 patient) in accordance with these rules;
b) consult on unassigned patients with emergency medical conditions in the ED.

6.3.2 Responsibilities of the ED Physician

a) Refer non-trauma unassigned patients who have attained their 18th birthday to the Internal Medicine, Surgery, or Family Medicine physician on call, unless the family specifically requests a Pediatrician or the patient has a chronic illness that commenced during childhood and can be appropriately managed by a pediatrician. Refer non-trauma unassigned patients who have not attained their 18th birthday to the Pediatrician on call unless the patient requires obstetrical care or gynecologic treatment or services or is over the age of 14 and has been accepted by and can be treated appropriately by Internal Medicine, Surgery or Family Practice physician.
b) Refer trauma patients to Trauma Surgery. Trauma Surgeon will transfer patients under the age of 15 to Pediatric Trauma Surgeon within 24 hours of admission or when deemed necessary.
c) The admitting physician assumes care of the patient once the admit order is entered; however the ED physician will respond to an emergent change in the patient's condition.

6.4 ASSIGNED PATIENTS

6.4.1 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.

6.5 EMERGENCY CALL RESPONSE TIME. The on-call physician must respond in person, if requested to do so by the Emergency Department physician or, in the case of obstetrics, by the Obstetrical RN. An on-call physician may send a physician extender to the Emergency Department unless the Emergency Department physician disagrees.

6.5.1 STAT Call Response Time. Physicians should respond within 10-15 minutes to a STAT call from the ED.

6.5.2 Routine Response Time. Physicians should respond by phone or in person to ED calls within 30 minutes or sooner if required by the applicable department.

6.2.4 Physician Failure to Perform. Failure of the on-call physician to satisfy his/her on-call responsibilities or misuse of the on-call roster shall be investigated by the applicable Department Chairman, the President of the Medical Staff, and/or the Peer Review Committee of the appropriate department. Appropriate corrective action will be initiated when warranted.

6.6 TREATMENT OF ED/L&D PATIENTS

6.6.1 Medical Screening Examination

6.6.1.1 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.

6.6.1.2 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.

6.7 DEFINITIONS

6.7.1 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, for whom the determination of whether the patient is assigned would delay the medical screening exam or necessary stabilizing treatment.

6.7.2 An ASSIGNED PATIENT is a patient who:

a) has a current physician-patient relationship with a BDMC Medical Staff member ("attending physician"). The Medical Staff Departments may determine the parameters of a current physician/patient relationship.

6.7.3 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.

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 Appendix 7.5 and 7.6.

8.0 INFORMED CONSENT; MEDICAL DECISION-MAKING

8.1 PHYSICIAN RESPONSIBILITY.

8.1.1 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. The discussion must include, in a manner and in language the patient/surrogate can understand, the risks and benefits of, and alternatives to, the procedure. The discussion should be documented, either in the EMR or in the Medical Staff member's outpatient records.

8.1.2 Pre-Blood Administration. The medical staff member ordering blood or blood components is responsible for providing information about the risks and benefits to the patient or legal representative.

8.1.3 Pre-Sedation, Pre-Anesthesia. An anesthesiologist (or physician responsible for moderate or deep sedation) must advise the patient or his/her legally authorized representative of the anesthesia to be used. The discussion must include, in a manner and in language the patient/surrogate can understand, the risks and benefits of, and alternatives to, the procedure. The discussion should be documented, either in the EMR or in the Medical Staff member's outpatient record.

8.1.4 Physicians are also encouraged to disclose:

a) whether physicians other than the operating practitioner, including residents, will be performing important tasks related to the procedures and

b) 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.

8.2 DISCLOSURE OF SERIOUS EVENTS AND UNANTICIPATED OUTCOMES TO PATIENTS/FAMILIES. 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 should be performed in a collaborative manner with Banner Administration or designee, Risk Management and Quality Management. The discussion should be documented.

8.3 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 is known to have refused care or treatment.

8.4 MEDICAL DECISION-MAKING USING ADVANCE DIRECTIVES.
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) attempt to 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 of 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

9.1 GENERAL
9.1.1 A Medical Record is established and maintained for each patient who has been treated or evaluated at the Medical Center. The Medical Record, including electronic data, medical imaging, pathological specimens and slides, are the property of the Medical Center
9.1.2 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.

9.3 ELECTRONIC MEDICAL RECORD (EMR) – Banner Health is a "paper light" organization. As such, physicians need to adhere to record keeping practices that support the electronic environment. As much data as possible will be created electronically and paper-based documentation will be scanned. Records will be accessed by physicians and other users online and the records will not be printed for internal use. Selectively referred to herein as EMR.

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

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

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

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

9.5 ACCESS TO THE EMR - Access to patient information on the EMR will be made available to Medical Staff and Allied Staff members and their staff through Clinical Connectivity. All access to electronic records is tracked and unauthorized access to a patient's record is not tolerated.

9.6 EMR TRAINING - Practitioners who are appointed to the Medical Staff or Allied Health Staff November 11, 2010 pending Banner electronic medical record training (EMR) and who have not completed this training within six (6) months of appointment will be considered to have voluntarily resigned from the staff. Practitioners will be advised of the training requirement at or prior to appointment and reminded of the requirement five (5) months from the date of appointment. Exceptions will be made on a case by case basis to be determined by the facility CEO.

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

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

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

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

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

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

9.13 RESPONSIBILITY - The attending physician is responsible for each patient's medical record. The medical record must identify who is primarily responsible for the care of the patient. Transfers of primary responsibility of the patient are not effective until documented in the clinical information system by the transferring physician and accepted on the clinical information system by the accepting physician. All clinical entries in the patient's record must be accurately dated, timed and individually authenticated by the responsible physician; group signing of documentation is not permissible. Authentication means to establish authorship by written or electronic signature and shall consist of the practitioner's name and professional title indicating the professional credential. Electronic signature authentication of medical records is the standard practice.

9.14 COUNTER-AUTHENTICATION (Endorsement) - Physician Assistants- History and Physical Reports, Operative/Procedural Notes, Consultations and Discharge Summaries must be counter-authenticated timely by the physician. Each clinical event must be documented as soon as possible after its occurrence. Requirements for countersignature of Progress Notes will be established and monitored by the supervising physician.

9.14.1 Nurse Practitioners- History and Physical Reports, Operative/Procedural Notes, Consultations and Discharge Summaries must be counter-authenticated timely by the physician. Each clinical event must be documented as soon as possible after its occurrence. Requirements for countersignature of Progress Notes will be established and monitored by the supervising physician.

9.14.2 Medical Students-

9.14.2.1 1st & 2nd Year- Access to view the patient chart only. May not document in the medical record.

9.14.2.2 3rd & 4th Year- Any and All documentation and orders (if permitted) must be endorsed (countersigned, counter-authenticated) timely by the physician.

9.14.4 House Staff, Resident, and Fellows- Requirements for countersignatures will be established and monitored by specific training programs. Each clinical event must be documented as soon as possible after its occurrence. The Health Information Management Services Department does not monitor

countersignatures by House Staff, Resident or Fellows. Appropriate action will be taken by the specific training programs.

9.15 LEGIBILITY - All practitioner entries in the record must be legible, pertinent, complete and current.

9.16 MEDICAL RECORD DOCUMENTATION AND CONTENT – The medical record must identify the patient, support the diagnosis, justify the treatment, and document the course and results of treatment and facilitate continuity of care. The medical record is sufficiently detailed and organized to enable:

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

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

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

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

9.16.5 Accurate coding diagnosis in response to coding queries.

9.16.6 Copying and Pasting - Medical Staff members, Allied Health Professionals may not indiscriminately copy and paste documentation from other parts of the applicable patient's records. If copying a template, the practitioner shall make modifications appropriate for the patient. If copying a prior entry, the practitioner shall make appropriate modifications based upon the patient's current status and condition. The practitioner must reference the date of a prior note as appropriate. When copying patient data into the medical record from another provider, the practitioner must attribute the information to the person who performed the task unless it is readily apparent, based upon the nature of the information copied, that the data were entered by another provider. If referencing a form within the record, the form must be referenced with sufficient detail to identify the source. Example: "See chest X-Ray report of 1/1/2018."

9.17 HISTORY AND PHYSICAL EXAMINATION ("H&P") - A history and physical examination must be performed within 24 hours after admission or registration for inpatients or observation or prior to surgery or invasive procedure, or any procedure in which IV Moderate Sedation or anesthesia will be administered. The H&P shall be completed by a physician, or Allied Health Professional who is approved by the medical staff to perform admission history and physical examinations, and placed in the patient's medical record. The completed H&P must be on the medical record or the case will be cancelled unless the responsible physician documents in writing that such delay would constitute a hazard to the patient.

9.17.1 A legible office history and physical performed within 30 days (7 days for Nevada) prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services.

9.17.2 The Obstetrical H&P will consist of the prenatal record, if available, updated in the EMR by the responsible physician or Allied Health professional.

For patients admitted to a Rehabilitation Unit, the admitting rehabilitation physician must conduct an H&P that includes all required elements. A physician extender may complete the H&P but the rehabilitation physician must visit the patient and must assure that all required parts of the post-admission evaluation are completed within 24 hours of admission.

9.18 RESPONSIBILITY FOR H&P – The attending medical staff member is responsible for the H&P, unless

it was already performed by the admitting medical staff member. H&Ps performed prior to admission by a practitioner not on the medical staff are acceptable provided that they are updated timely by the responsible physician. An oral surgeon with appropriate privileges who admits a patient without medical conditions may perform the H&P, and assess the medical risks of the procedure to the patient. Dentists and podiatrists are responsible for the part of their patients' H&P that relates to dentistry or podiatry, and, if authorized by the medical staff, may be responsible for the complete H&P.

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

- 9.19.1 Medical history
- 9.19.2 Chief complaint
- 9.19.3 History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status
- 9.19.4 Relevant past medical, family and/or social history appropriate to the patient's age.
- 9.19.5 Review of body systems.
- 9.19.6 A list of current medications.
- 9.19.7 Any known allergies including past medication reactions and biological allergies
- 9.19.8 Existing co-morbid conditions
- 9.19.9 Physical examination: current physical assessment
- 9.19.10 Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
- 9.19.11 Initial plan: Statement of the course of action planned for the patient while in the Medical Center.

9.20 EMERGENCY DEPARTMENT REPORTS - A report is required for all Emergency Department visits.

The following documentation is required:

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

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

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

9.22 CONSULTATION REPORTS- A satisfactory consultation includes examination of the patient as well as the medical record and should be electronically recorded or dictated within 24 hours. When

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

9.23 PRE-OPERATIVE, INTRAOPERATIVE & POST ANESTHESIA/SEDATION RECORD FOR GENERAL, REGIONAL OR MONITORED ANESTHESIA

9.23.1 Pre-Operative anesthesia/sedation evaluation - A preanesthesia/sedation evaluation must be conducted and documented by an individual qualified to administer anesthesia or conscious sedation within 48 hours prior to the procedure.

A preanesthesia/sedation evaluation of the patient must include:

a) review of the medical history, including anesthesia, drug and allergy history;

b) review and examination of the patient;

c) notification of anesthesia risk (per ASA classification);

d) identification of potential anesthesia problems, particularly those that suggest
e) potential complications or contraindications;
f) additional pre-anesthesia as applicable;
g) and development of the plan for anesthesia care, including type of medications
h) for induction, maintenance, and post-operative care and discussion with the
i) patient of risks and benefits.

Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before pre-operative medication has been administered. Immediately prior to the induction of anesthesia while the patient is on the procedural table, the patient's vital signs, airway and response to pre-procedure medication must be assessed and the equipment checked.

9.23.2 The intraoperative anesthesia/sedation record will also include:

a) the name of the practitioner who administered anesthesia and the name of the supervising anesthesiologist or operating practitioner;
b) techniques used and patient position(s), including the insertion/use of any intravascular or airway devices;
c) name and amounts of IV fluids, including blood or blood products if applicable;
d) time-based documentation of vital signs as well as oxygenation and ventilation parameters;
e) any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

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

9.24 OPERATIVE AND PROCEDURE REPORTS – An operative or other high-risk procedure report is documented upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.

9.24.1 The exception to this requirement occurs when an operative or other high-risk procedure progress note is documented immediately after the procedure, in which case the full report can be documented within 24 hours of the procedure. If the practitioner performing the

operation or high risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be documented.

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

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

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

9.26 Prior to any operative/invasive procedures, the medical record must contain an informed consent. See Chapter 8.

9.27 Special Procedures. EEG's, EKG's, treadmill stress tests, echocardiograms, tissue, medical imaging and other special procedure reports will be interpreted and documented within 24 hours of notice. Notice will be a communication to the physician or agent to inform the provider of the test completion.

9.28 DISCHARGE DOCUMENTATION

A discharge summary must be documented at the time of discharge but no later than 24 hours thereafter by the responsible practitioner on all Inpatient and Observation hospitalizations 48 hours or greater in length. Normal newborns and normal vaginal deliveries do not require a discharge summary regardless of the length of stay. Any newborn patient admitted to the Special Care Unit or transported from the Newborn Nursery to a Level III Nursery will be required to have a dictated discharge summary. Exception is newborns admitted to the Special Care Nursery for observation of eight (8) hours or less.

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

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

Final Discharge Progress note should include:

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

9.30 DOCUMENTATION OF DEATH - A death summary is required for all deaths regardless of length of stay and must be documented at the time of death but no later than 24 hours thereafter by the responsible practitioner. In the case of the death of a pre-term newborn infant less than 3 hours after birth, a final discharge progress note will be documented by the physician who pronounced the death.

9.31 DOCUMENTATION FOR INPATIENT TRANSFERS TO ANOTHER FACILITY– The transferring physician must dictate or electronically create a transfer summary regardless of length of stay to include documentation that patient was advised of risks/benefits of transfer at the time of transfer but no later than 24 hours thereafter.

9.32 AMENDING MEDICAL RECORD ENTRIES

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

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

9.32.2 Paper-Based Documents - Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error by drawing a single line through the erroneous entry, but not obliterating it, and initialing and dating the error. Errors or omissions discovered at a later time shall be corrected by the individual with a new entry. The person making the change shall sign and note the date of the change and reason for the change. The new entry shall also state who was notified of the change and the date of such notification. The individual must notify the HIMS Department to permit a review of the erroneous documentation for recording in-error criteria within the EMR. Any physician who discovers a possible error made by another individual should immediately upon discovery notify the supervisor of that clinical or ancillary area.

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

9.33 COMPLETE MEDICAL RECORD. The Medical Record is not considered complete until all its essential elements are documented and authenticated, and all final diagnoses and any complications are recorded, consistent with these Rules.

9.34 TIMELY COMPLETION OF MEDICAL RECORD DOCUMENTS. All medical record documents shall be completed within time frames defined below:

Documentation Requirement	Timeframe	Exclusions
Emergency Room Report	Documented within 24 hours of discharge/disposition from the ED	

Admitting Progress Note	Documented within 24 hours of admission	
History & Physical	Documented within 24 hours of admission and before invasive procedure	
Consultation Reports	Documented within 24 hours of consultation	
Post op Progress Note	Documented immediately post-op when there is a delay in the availability of the full report	
Provider Coding Clarification	Documented within 24 hours of notice	
Operative Report	Documented immediately post-op and no later than 24 hours after the procedure.	
Special Procedures Report	Documented within 24 hours of notice	
Discharge Summary Report	Documented at the time of discharge but no later than 24 hours after discharge.	Not required on all admissions less than 48hrs, or for Normal vaginal deliveries and normal newborns
Discharge Progress Note	Documented at the time of discharge but no later than 24 hours after discharge all admissions less than 48hrs or for normal vaginal deliveries and normal newborns.	
Death Summary Death Pronouncement Note	Documented at the time of death/disposition but no later than 24 hours after death. Completed at the time the patient is pronounced with 24 hours.	
Transfer Summary	Documented at the time of transfer no later than 24 hours.	
Signatures	Authentication of transcribed or scanned reports and progress notes, within 7 days from the date of notice.	
Verbal Orders	Dated, time and authenticated within the timeframe specified by state regulation Arizona = 72 hours	

Psychiatric Evaluation	Documented within 24 hours of admission	

9.35 MEDICAL RECORD DEFICIENCIES – Physicians are advised of incomplete documentation via the physician inbox. The Health Information Management Services Department shall advise physicians, by fax, mail or electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has met or exceeded the timeframes in section 9.34. The notice will include a due date and a list of all incomplete and delinquent medical records.

If a vacation prevents the practitioner from completing his/her medical records the physician must notify the Health Information Services Department in advance of the vacation; otherwise the suspension/sanction will remain in effect until the documentation is completed.

If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the physician or the physician's office must notify the Health Information Management Services Department.

9.36 MEDICAL RECORD SUSPENSIONS/SANCTIONS - A medical record is considered eligible for suspension/sanction based on the timeframes in section 9.34.

If the delinquent records are not completed timely, providers will receive a notice and their admitting and surgical/procedure scheduling privileges will be temporarily suspended until all medical records are completed. A suspension/sanction list will be generated weekly and made available to the Executive Committee, Department Chairs, Administration, Medical Staff Services, Patient Registration, Patient Placement, Emergency Department, Cardiology, Inpatient and Outpatient Surgery areas.

9.37 CONTINUOUS TEMPORARY SUSPENSION - Each facility Medical Staff shall institute a process to address chronic medical record delinquency and temporary suspension of privileges or sanction.

9.38 For new facilities or facilities implementing new EMR Software, Medical Executive Committee may choose not to take action regarding delinquent medical records during the Medical Center's first 180 days of operation, or initial phase of implementation.

9.39 TEMPORARY MEDICAL RECORD SUSPENSION

9.39.1 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.

9.39.2 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.

9.39.3 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.

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

9.40 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.

9.41 CONFIDENTIALITY OF PATIENTS' MEDICAL RECORDS.

9.41.1 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)

9.41.2 Medical Staff Member Responsibility. Medical Staff Members must:

a. 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.
b. Otherwise obtain patient consent.
c. Protect access codes and computer passwords to protect confidential information.

9.41.3 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.

9.41.4 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 GENERAL INFORMATION

10.1.1 A physician order is required to admit a patient, place a patient in observation or extended recovery, and to transfer a patient to another physician. A physician or physician extender (provider) order is required to discharge or transfer a patient for all tests, services, therapy and procedures. Exceptions may be made through a Medical Staff approved Standing Order or Protocol.

10.1.2 All orders will be entered and authenticated within the prescribed time frames.

10.1.3 Whenever possible, orders will be entered directly into the electronic medical record (EMR.) When the EMR is unavailable, orders should be documented on Banner Health Order form(s).

10.1.4 If physicians or providers do not have the ability to access the EMR to input orders themselves, or if a delay in accepting the order could adversely affect patient care, telephone/verbal orders may be accepted by appropriate facility personnel. (Faxed orders are acceptable provided that they are signed (timed exceptions exist for certain outpatient diagnostic orders.)

10.1.5 All orders should be reviewed and continued or discontinued when a patient is transferred from one level of care to another (e.g., from the Emergency Department to an inpatient unit, to or from intensive care units, and/or pre and post-surgery). An order entered into Cerner will be continued until such time as the order is discontinued or modified.

10.1.6 Orders as originally written cannot be changed or added to at some future time. When it is necessary to change an order, it must be rewritten with the current date.

10.1.7 Nurses have the responsibility of questioning any order that they feel might harm the patient.

10.1.8 Orders which are not legible will be clarified with the responsible physician or provider before they are carried out.

10.2 VERBAL AND TELEPHONE ORDERS

10.2.1 Verbal (face to face) orders are discouraged except in the case of emergency. 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.

10.2.2 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.

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

10.2.4 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 pertaining to their specialty. All telephone orders will be written by the person receiving the order or entered into the EMR then the entire order must be read back to verify accuracy and signed by the receiving individual. Telephone orders will be authenticated by the responsible physician or provider.

10.2.5 In areas other than nursing units, certain telephone orders may be taken by the personnel in each department most qualified to accept them. The director of the department will be responsible for the acceptance of such orders, and for the designation, if necessary, of personnel with the appropriate skills to accept telephone orders. All such orders will be strictly limited to the area of expertise of the department. Bed placement, registration staff and unit secretaries may accept admission orders from physicians only related to the type of bed needed (telemetry vs ICU, etc.) and specifying the reason for the admission.

10.3 MEDICATION ORDERS: PHYSICIAN RESPONSIBILITIES

10.3.1 Required Contents Regarding Medication:

10.3.1.1 Rule: Medication Orders must include:

a. Exact dosage, frequency, form, route, and duration if applicable.

10.3.1.2 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). Where a Discern Advisor has been triggered, orders must be reviewed to avoid duplication.

10.3.1.3 Range Orders:

a. Routine range orders are discouraged but permitted if indicated.

b. If Physician uses a range order, it must specify indication and appropriate dose range and frequency suitable for the specific medication.

10.4 HOME MEDICATIONS:

a. A specific order is required for medications brought into the hospital by a patient.
b. Follow facility policies regarding Home Medications.

10.4.1 Notation, Abbreviations:

10.4.1.1 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. 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).

10.4.2 Prescriber Identification:

10.4.2.1 Prescriber's name/signature must be legible and the name should be either printed or stamped in addition to the signature.

10.5 ORDERS FOR OUTPATIENT TESTS/PROCEDURES

10.5.1 Orders for Outpatient tests/procedures may be accepted from physicians licensed either in Arizona or in another state and from PA's and NP's licensed in Arizona.

10.5.2 Orders are valid for the length of the ordered therapy or one year, whichever is shorter. A signed order must be received prior to performing outpatient procedures/tests.

10.5.3 A statement of the reason for the test and/or diagnosis must be indicated on the order and it must also be signed, timed and dated by a physician. Orders to "rule out [X]" are not sufficient.

10.5.4 The following facsimiles or original orders are accepted:

a. Outpatient scheduling form
b. Prescription forms
c. Referral forms (can be payor specific)
d. Notation in patient's history and physical
e. Provider order sheet
f. Provider office letterhead (stationary)

10.6 STANDING ORDERS

The Medical Executive Committee may adopt standing orders and protocols, which are implemented unless expressly overridden by the physician.

10.7 PHARMACY ORDERS

10.7.1 The Pharmacy and Therapeutics Committee is responsible for determining which medications and medication categories are required to be automatically stopped unless the prescriber specifies otherwise;
10.7.2 Pharmacy Services will automatically review medication orders for duration of therapy.
10.7.3 Prescribers will be contacted regarding the need to discontinue or reorder medications based on clinical assessment and laboratory findings, unless the medication order indicates the exact number of doses to be administered or an exact period of time for the medication.

10.8 RESTRAINTS

10.8.1 Restraints require a physician or nurse practitioner order. PRN orders are not acceptable
10.8.2 Restraints" include medications and physical means of restricting freedom of movement or normal access to one's body.
10.8.3 An order is required before initiating each episode of restraint and/or seclusion and must be renewed within specific time and may not exceed 24 hours.

10.9 ORDERS FOR SURGERY

10.9.1 Physicians must provide the patient/surrogate with information about the risks, benefits and alternatives of the procedure so that informed consent can be obtained from the patient/surrogate. A physician order is needed to obtain a hospital consent for surgery. The order will state the specific procedure to be performed. The procedure listed on a signed fax pre-operative order form can serve as the surgical consent order. The surgeon is responsible for signing, dating and timing the orders and verifying that the correct surgical procedure has been indicated.

10.9.2 Anesthesia medication orders given by the anesthesiologist performing the case will take precedence over pre-anesthesia medication orders.

10.9.3 Orders entered into Cerner will continue after surgery. Orders handwritten prior to surgery that are to be resumed after surgery must be ordered electronically after surgery.

10.9.4 No "On Call" orders for preoperative medications will be accepted on regularly scheduled cases. The only exceptions to this are for cases that are scheduled to follow which are patients of the same surgeon, etc., or when the surgeon wishes to hold medication until the patient leaves for surgery.

10.10 ORDERS FOR BLOOD PRODUCTS

10.10.1 Physicians must provide the patient/surrogate with information about the risks, benefits and alternative of blood/blood products so that informed consent can be obtained.

10.11 AUTHORITY TO ORDER CONSULTATION

10.11.1 Attending Physician. The attending physician is primarily responsible for calling for a physician consultation. Unless otherwise directed by the attending, consultants may also order physician consultations, however discussion and communication with the attending on the need for and choice of consultant is recommended when possible.

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

10.11.3 Not Authorized to Order Consultation**:**

a. Nursing Personnel are not authorized to order a physician Consult. After appropriate discussion with the Attending Physician, nursing personnel with responsibility for a patient who believe that the Attending Physician is not seeking appropriate physician consultation must follow the chain of command policy to address the concern.

b. Allied Health Professionals are not authorized to order a physician consult. After appropriate discussion with the Attending Physician, Allied Health Professionals with responsibility for a patient who believe that the Attending Physician is not seeking appropriate physician consultation must contact their sponsoring physician who will contact the department chairman as appropriate.

10.12 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:

10.12.1 appropriate procedure or therapy.
10.12.2 possible treatment/operative risks.
10.12.3 diagnosis
10.12.4 psychiatric and behavioral issues

10.13 PROCEDURE FOR ORDERING CONSULTATIONS

10.13.1 Physician orders for a consult should be entered into the EMR and state:

1) The name of the consultant/consultant's group
2) The purpose of the consult;
3) The urgency of the consultation ;
4) Contact information for physician ordering consult;
5) If not ordered by the Attending, the Attending should be notified when possible.

10.13.2 Physician should also communicate directly with Consultant. If the Unit staff is unable to arrange the consultation, the Physician must contact the consultant directly to request the Consultation.

10.14 NO CODE ORDERS/ALLOW NATURAL DEATH (AND)

10.14.1 No code/AND orders are entered in the electronic medical record and authenticated by the responsible physician. A properly documented no code/AND order will include the medical reasons for the order and the discussion with the patient's family or with the patient. This should be documented in the progress note.

10.14.2 Telephone no code/AND orders are discouraged. However, if no code/AND orders must be placed by telephone, the house staff/resident or RN taking the order will have a witness on the telephone to verify and document the no code/AND status. Physicians will authenticate the no code/AND telephone order upon their next visit and document the reasons (as in paragraph A above) even though the patient may have already expired.

10.14.3 No code/AND orders written by residents are authenticated by the responsible physician upon his/her next visit.

10.14.4 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

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

11.0 SURGERY and OTHER PROCEDURES USING ANESTHESIA OR MODERATE AND DEEP SEDATION

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

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

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

11.1 SCHEDULING: PHYSICIAN RESPONSIBILITIES

11.1.1 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.

11.1.2 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.

11.2 PRE-PROCEDURE: PHYSICIAN RESPONSIBILITIES

11.2.1 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.

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

11.2.3 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 and Chapter 9 of the Rules and Regulations.

11.2.4 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.

11.3 INTRA-PROCEDURE MONITORING

11.3.1 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.

11.3.2 For Anesthesia patients: The anesthesiologist is responsible for monitoring patients in accordance with departmental policies and Chapter 9 of the Rules and Regulations.

11.4 POST-PROCEDURE PHYSICIAN RESPONSIBILITIES.

11.4.1 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.

11.4.2 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.

11.4.3 Documentation.

a. Comprehensive Post-Operative Progress Report. Documentation requirements are laid out in Chapter 9 of these Rules and Regulations.
b. Post-Operative Orders. The surgeon is responsible for documenting post-operative orders.

11.5 VISITORS AND OTHER UNCREDENTIALED INDIVIDUALS.

11.5.1 In the OR non-credentialed 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.

11.5.2 The presence and permissible activities of non-credentialed individuals in L&D is governed by the policies of the Department of Obstetrics.

11.6 SURGICAL ASSISTANTS

11.6.1 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.

11.7 DEFINITIONS:

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

11.7.2 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 patient 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.

12.0 PATHOLOGY

12.1 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.

12.1.1 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

12.1.2 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.

12.2 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.

12.3 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.

12.3.1 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.

12.3.2 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

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

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

12.5 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.

13.0 DYING AND DEATH

13.1 IN-HOSPITAL DEATH

13.1.1 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.

13.1.2 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.

13.2 ANATOMICAL DONATIONS

13.2.1 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 an 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.

13.2.2 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.

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

13.3 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)

13.3.1 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.

13.3.2 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.

13.3.3 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.

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

14.0 MEDICAL & CLINICAL EDUCATION

MEDICAL STUDENTS:

Medical Students: Medical Students are divided into two categories: First and Second Year Medical Students (1st and 2nd Year) Third and Fourth Year Medical Students (3rd and 4th Year).

First and Second Year Medical Students

Prerequisites. First and Second Year Medical Students will be allowed a clinical rotation under the direct supervision and in presence of supervising physician provided the following have been satisfactorily completed:

A "Statement of Physician" form; student must obtain the signature of the BDMC/CCMC Medical Staff.

- Registration by the Medical Student in Medical Staff Services that includes a copy of the Medical Student's student ID, time frame of rotation and name of Medical School.
- Student Guideline form
- Verification of satisfaction of health requirements by their educational Institution Annual TB screen. Skin test for a negative result. If history of positive result, submission of proof of a previous chest x-ray showing no evidence of pulmonary tuberculosis, plus completion of a questionnaire indicating asymptomatic for TB. If symptomatic per the questionnaire, submissions of proof of a new chest x-ray showing no evidence of pulmonary tuberculosis. Two measles, mumps, rubella vaccinations, or one positive titer, evidence of adequate Varicella titer, Hepatitis A and B series or signature by the individual on a waiver declining such.

Supervision, Scope of Permissible Activities. First and Second Year Medical Students:

- Must at all times be under the direct supervision and in the presence of the Supervising Physician.
- May not dictate H&P's, operative reports/discharge summaries, nor document progress notes or otherwise write in the medical record.
- May not write or give verbal orders.
- May participate in physical exam, critical data analysis and disposition, history taking and have access to medical records (under the direct supervision and in presence of supervising physician).
- May observe in surgery with appropriate consent from the patient and surgeon of record.

Third and Fourth Year Medical Students

Prerequisites: Third and Fourth Year Medical Students will be allowed a clinical rotation provided the following have been satisfactorily completed:

- Clinical Education Agreement approved by the BDMC/CCMC Medical Executive Committee and executed by Banner Health and the Student's medical school program.

- A letter of good standing from the Student's educational institution as evidence of sufficient training for the clinical in which they will participate.
- A "Statement of Supervising Physician" form; Student must obtain the signature of the BDMC/CCMC Supervising Physician. In addition, Student will complete a facility evaluation.
- Verification of satisfaction of health requirements by their educational institution Annual TB screen. Skin test for a negative result. If history of positive result, submission of proof of a previous chest x-ray showing no evidence of pulmonary tuberculosis, plus completion of a questionnaire indicating asymptomatic for TB. If symptomatic per the questionnaire, submissions of proof of a new chest x-ray showing no evidence of pulmonary tuberculosis. Two measles, mumps, rubella vaccinations, or one positive titer, evidence of adequate Varicella titer, Hepatitis A and B series or signature by the individual on a waiver declining such.
- The insured must provide proof of professional liability insurance policy for $1 million per occurrence and $3 million in aggregate.

Supervision, Scope of Permissible Activities. Third and Fourth Year Medical Student:

- MAY Participate in care and management of the patient, including invasive and non-invasive procedures, under the auspices/direct supervision of the supervising physician at all times.
- MAY assist in procedures with assigned supervising physician and with patient consent.
- Must be able to PROVIDE EVIDENCE OF education of aseptic technique prior to assisting in surgery.
- MAY Document in the medical record the following: discharge summaries, orders, H&P's, brief operative notes and progress note if the supervising physician is present and immediately reviews and countersigns the entry. Orders, particularly, are not legal, and must be immediately countersigned so as to prevent delay/confusion in their implementation.

NURSE PRACTITIONER STUDENTS

Prerequisites: Nurse Practitioner Students will be allowed a clinical rotation provided the following have been satisfactorily completed:

- The Banner Student Center of Excellence will review clinical goals and objectives for nurse practitioner students.
- The NP student applications will be processed and tracked by the Student Coordinator, copies will be forwarded to Medical Staff Services. The Student Coordinator will coordinate the gathering of documentation as required by the affiliation Clinical Education Rotation Agreement prior to starting the clinical experience and provide orientation to Banner Health policies, programs, and channels of communications.
- Qualification and responsibilities of the Preceptor. The NP student preceptor is a member in good standing of the Medical Staff (physician) of BDMC/CCMC in which the student will train. The preceptor must have unsupervised clinical privileges in the functions and procedures he or she will be supervising. The preceptor shall complete and sign the Preceptor Participation Acknowledgement prior to the start of the preceptorship and provide a copy to the hospital's Student Coordinator.

PODIATRIC STUDENTS

Prerequisites: Podiatric Students will be allowed a clinical rotation provided the following have been satisfactorily completed:

- Clinical Education Agreement approved by the BDMC/CCMC Medical Executive Committee and executed by Banner Health and the Student's medical school program.
- A letter of good standing from the Student's educational institution as evidence of sufficient training for the clinical in which they will participate.
- A "Statement of Supervising Physician" form; Student must obtain the signature of the BDMC/CCMC Supervising Physician. In addition, Student will complete a facility evaluation.
- Verification of satisfaction of health requirements by their educational institution Annual TB screen. Skin test for a negative result. If history of positive result, submission of proof of a previous chest x-ray showing no evidence of pulmonary tuberculosis, plus completion of a questionnaire indicating asymptomatic for TB. If symptomatic per the questionnaire, submissions of proof of a new chest x-ray showing no evidence of pulmonary tuberculosis, two measles, mumps, rubella vaccinations, or one positive titer, evidence of adequate Varicella titer, Hepatitis A and B series or signature by the individual on a waiver declining such.
- The insured must provide proof of professional liability insurance policy for $1 million per occurrence and $3 million in aggregate.

Supervision, Scope of Permissible Activities. Podiatric Student may:

- Participate in care and management of the patient, including invasive and non-invasive procedures, under the auspices/direct supervision of the supervising physician at all times.
- Assist in procedures with assigned supervising physician and with patient consent.
- Must be able to document education of aseptic technique prior to assisting in surgery.
- Document in the medical record the following: discharge summaries, orders, H&P's, brief Operative notes and progress note if the supervising physician is present and immediately reviews and countersigns the entry. Orders, particularly, are not legal, and must be immediately countersigned so as to prevent delay/confusion in their implementation.

PHYSICIAN ASSISTANT STUDENTS

Prerequisites: Physician Assistant Students will be allowed a clinical rotation provided the following have been satisfactorily completed:

- Clinical Education Agreement approved by the BDMC/CCMC Medical Executive Committee and executed by Banner Health and the Student's medical school program.
- A letter of good standing from the Student's educational institution stating the student has demonstrated sufficient training and competency to participate in the care and management of the patients including invasive and non-invasive procedures.
- A "Statement of Supervising Physician" form; Student must obtain the signature of the BDMC/CCMC Supervising Physician. In addition, Student will complete a facility evaluation.
- Verification of satisfaction of health requirements by their educational institution Annual TB screen. Skin test for a negative result. If history of positive result, submission of proof of a previous chest x-ray showing no evidence of pulmonary tuberculosis, plus completion of a questionnaire indicating asymptomatic for TB. If symptomatic per the questionnaire, submissions of proof of a new chest x-ray showing no evidence of pulmonary tuberculosis, two measles, mumps, rubella vaccinations, or one positive titer, evidence of adequate Varicella titer, Hepatitis A and B series or signature by the individual on a waiver declining such.
- The insured must provide proof of professional liability insurance policy for $1 million per occurrence and $3 million in aggregate.

Supervision, Scope of Permissible Activities. Under the direct supervision of the supervising physician, at all times, the Physician Assistant Student activities are limited to:

- Rounding with the supervising physician in the care and management of the patient, including invasive and non-invasive procedures.
- May assist with invasive and noninvasive procedures only when performing clinical rotation training.
- Document in the medical record the following: discharge summaries, H&P's, brief operative notes and progress notes only if the supervising physician is present and immediately reviews and countersigns the entry.
- With patient consent, and with the supervising physician in the room, may assist in surgery if completing a family practice, obstetrics and gynecology or surgical rotation.
- Must be able to document education of aseptic technique prior to assisting in surgery.
- May not write orders.
- May not dictate.
- May not independently perform procedures without direct supervision.

SUPERVISING PHYSICIAN. Regardless of Student classification, the Supervising Physician is directly responsible for:

- Proper performance and completion of the History and Physical, progress notes, discharge summary, operative reports and daily visits.
- Obtaining and documenting the patient's prior consent for medical student rounds.
- Abiding by the Rules and Policies of the BDMC/CCMC Medical Staff.
- Completing the Student's Evaluation.

DEFINITIONS: For this Article, the following definitions shall apply:

- "Clinical": A BDMC/CCMC rotation for Medical Students participation by a medical student in BDMC/CCMC rotation to include interaction with or observation of staff, physicians and/or patients.
- "Program": Allopathic or Osteopathic Clinical Educational program which requires medical students to participate in a clinical exchange for credit from an educational institution or accrediting body.
- "Direct Supervision": The student is under the direct supervision/auspices of the supervising physician (specifically instructed or directly observed).
- "Supervising Physician": A BDMC/CCMC Medical Staff member who is responsible for supervising the medical student's patient care activities in accordance with the program and the relevant department's Policies and Procedures.
- Is currently authorized by BDMC/CCMC Medical Staff to supervise and/or provide resources for medical students during clinical, and has an agreement with the Student's rotation program to teach in the rotation and abide by the rotation program policies and procedures, and signs the Medical Student's Statement of Supervision.

II. RESIDENTS/FELLOWS

Supervision of Interns, Residents and Fellows

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

Interns, Residents and Fellows from Banner—University of Arizona Phoenix or Tucson Programs will be allowed to rotate to BDMC on approval of a Program Letter of Agreement by the appropriate Department Committee and Medical Executive Committee.

Interns, Residents and Fellows shall function within BDMC under the direction of a supervising physician with appropriate clinical privileges. The supervisor(s) and graduate education program director make d ecisions about each participant's progressive involvement and independence in specific patient care activities. The Supervising Physician, who is a member in good standing of the BDMC Medical Staff, shall communicate information to the graduate medical education (GME) training program and Board about the quality of care, treatment, and services and educational needs of the participants he/she supervises.

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

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 BDMC, 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.

Orders and Operative Reports

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

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