PAGE HOSPITAL

2015

MEDICAL STAFF RULES & REGULATIONS

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PAGE HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS

I. MEETINGS

1. The meetings of the Medical Staff shall be held as provided in Article Eleven B(1)(c) of the Bylaws.

2. The Medical Staff discussions held at meetings as provided for under #1 of this Section I. shall constitute a thorough review and analysis of the clinical work done in the hospital, including consideration of deaths, unimproved cases, infectious complications, error in diagnosis and results of treatment from among significant cases in the hospital at the time of the meeting and significant cases discharged since the last meeting, and analysis of clinical reports and reports of committees of the Medical Staff.

II. ADMISSION POLICIES

1. A general consent form signed by the patient or his/her legally authorized representative must be obtained at the time of admission on every patient admitted to the hospital. The attending physician shall be notified when such consent has not been obtained or the patient has refused such consent. When so notified it shall, except in emergency situations, be the practitioner's obligation to obtain a proper consent before the patient is admitted and treated in the hospital. In the case of a medical emergency, the physician must document the emergent situation.

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

3. Patients shall be attended by their own physicians. Patients applying for admission who have no attending physician shall be assigned to a member of the Active Staff. Patients will be attended by members of the Medical Staff

regardless of race, creed, sex, national origin, religion or source of payment for care.

4. Each patient will be seen by the attending physician or his designee within 12 hours after admission. Intensive care patients admitted to the intensive level of care will be seen within four (4) hours of admission. All patients admitted to the hospital will be seen at least once daily after the initial assessment. A complete history and physical examination shall in all cases, be dictated (with a note in the chart to that effect) or hand written within 24 hours after admission of the patient (except for swing bed patients). Legible copies of history and physical examinations performed no more than 30 days prior to admission or within 24 hours after admission may be used in the medical record.

5. The hospital shall admit patients suffering from all types of diseases, except those whose illness requires special facilities not readily available, as determined by the hospital CEO and Chief of Service concerned.

6. Admission laboratory testing will be done only upon specific order of the physician.

7. Verbal orders should be used infrequently and must be authenticated by the appropriate practitioner within 48 hours. Verbal orders must be accepted only by a registered nurse. Licensed respiratory care practitioners, pharmacists, physical therapists and radiology technologists shall be allowed to accept verbal orders, provided the orders are directly related to the specialized discipline. Orders dictated over the telephone shall be signed by the person to who dictated with the name of the practitioner per his or her own name.

8. A patient admitted for dental care or by a podiatrist consistent with specific delineated privileges is a dual responsibility involving the dentist or podiatrist and physician member of the medical staff as provided in Article Four, Sections E and F of the Bylaws.

III. DISCHARGE POLICIES

1. Patients shall be discharged only on written order of the attending physician. At the time of discharge the attending physician shall see that the record is complete, state his final diagnosis and sign the record.

   The following shall be noted on the “Discharge Summary”:
   A. Reason for hospitalization (chief complaint).
   B. Final diagnosis.
   C. Brief history and physical.
   D. List of procedures performed with significant findings.
   E. Hospital course.

F. Condition on discharge and instructions to the patient and/or family; including diet, activity, physical limitations, medications and follow-up care.

2. If at any time a patient is, in the CEO's judgment, unsuitable for treatment, or if the conduct of the patient is such that their presence is undesirable, the CEO may order immediate removal or discharge after reporting the facts of the case promptly to the attending physician or surgeon, and if necessary to the Chief of Staff.

IV. MEDICAL RECORD POLICIES

1. General Rules

A. 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.

B. 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.

2. Purpose of the Medical Record

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

B. 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,

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

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

E. 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.

3. Electronic Medical Record (EMR)

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

4. Use of the EMR

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

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

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

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

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.

6. EMR Training

Practitioners who are appointed to the Medical Staff or Allied Health Staff 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.

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.

8. Confidentiality of Patients' Medical Records

The medical records are confidential and protected by federal and state law. Medical record access to confidential materials by authorized individuals is only permissible when access is sought for patient care, payment, peer review, risk management, approved research, or other appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are

maintained or stored and applies equally to information stored in hard copy form or electronically stored. In addition, Banner Health safeguards patients' records against unauthorized disclosure and/or use, loss, defacement, and tampering. Unauthorized access or disclosure of confidential patient information or tampering, loss or defacement of medical records constitutes grounds for disciplinary action.

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.

10. Passwords

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

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.

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.

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.

14. Counter-authentication (Endorsement)

A. 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.

B. 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.

C. Medical Students

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

2) 3rd & 4th Year- Any and All documentation and orders (if permitted) must be endorsed (countersigned, counter-authenticated) timely by the physician.

D. 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.

15. Legibility

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

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:

A. 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.

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

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

D. Retrieval of pertinent information required for utilization review and/or quality assurance activities.
E. Accurate coding diagnosis in response to coding queries.

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 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.

A legible office history and physical performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. If approved by the Medical Staff, the Emergency Room Report, or Consultation report may be used as the H&P as long as all the elements in section 4.19 are included and the document is filed as a History and Physical on the EMR. 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.

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

18. Responsibility for H&P

The attending medical staff member is responsible for the H&P, unless it was already performed by the responsible 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 attending 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, in addition to the medical history & physical.

19. Contents of H&P

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

A. Medical history
B. Chief complaint
C. History of the current illness, including, when appropriate, assessment of

emotional, behavioral and social status

D. Relevant past medical, family and/or social history appropriate to the patient's age.
E. Review of body systems.
F. A list of current medications and dosages.
G. Any known allergies including past medication reactions and biological allergies
H. Existing co-morbid conditions
I. Physical examination: current physical assessment
J. Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
K. Initial plan: Statement of the course of action planned for the patient while in the Medical Center.

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.

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.

A. Admitting Note

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

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).

23. Intra-operative and Post Anesthesia/Sedation Record for General, Regional or Monitored Anesthesia

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

24. Pre-operative Anesthesia/Sedation Evaluation

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

25. The Post-anesthesia Evaluation

The post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia or moderate sedation 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.

26. 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.

A. 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 a time frame defined by the hospital.

B. 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 a time frame defined by the hospital.

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

D. The operative or other high-risk procedure report includes the following information:
   1) The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
   2) The name of the procedure performed
   3) A description of the procedure
   4) Findings of the procedure
   5) Any estimated blood loss
   6) Any specimen(s) removed
   7) The postoperative diagnosis

27. 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.

28. Prior to any operative/invasive procedures, the medical record must contain an informed consent. See Section IX (2).

29. 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.

30. 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.

A. Discharge Summary

The discharge summary shall include:

1) Reason for hospitalization
2) Concise summary of diagnoses including any complications or co-morbidity factors
3) Hospital course, including significant findings
4) Procedures performed and treatment rendered
5) Patient's condition on discharge (describing limitations)
6) Patients/Family instructions for continued care and/or follow-up
7) Patient's condition on discharge (describing limitations)
8) Patients/Family instructions for continued care and/or follow-up

B. Final Discharge Progress Note

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

1) Final diagnosis(es)
2) Condition of patient
3) Discharge instructions
4) Follow-up care required

31. 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.

32. Documentation for Inpatient Transfers to Another Facility

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

33. Amending Medical Record Entries

A. 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.

B. 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.

34. 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. No medical record shall be considered complete without fulfilling the documentation requirements except on order of the Medical Executive Committee.

35. 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 within 24 hours after death Completed at the time the patient is pronounced within 24 hours	
Home Health (Face to Face Discharge Documentation)	Completed within 30 days of discharge	
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 = 48 hours	
Psychiatric Evaluation	Documented within 24 hours of admission	

36. Medical Record Deficiencies

Physicians are advised of incomplete documentation via the physician inbox. The Health Information Management Services Department shall advise physicians, by fax, mail or electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has met or exceeded the timeframes in section 4.35. 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.

37. Medical Record Suspensions/Sanctions
A medical record is considered eligible for suspension/sanction based on the timeframes in section 4.35.

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 monthly and made available to the Executive Committee, , Administration, Medical Staff Services, Patient Registration, Patient Placement, Emergency Department, Inpatient and Outpatient Surgery areas.

38. Continuous Temporary Suspension
Each facility Medical Staff shall institute a process to address chronic medical record delinquency and temporary suspension of privileges or sanction.

39. New EMR Implementation
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.

40. Copying and Pasting

Medical Staff Members and Allied Health Professionals may not indiscriminately copy and paste documentation for 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 practitioners shall make appropriate modifications based upon the patient's current status and condition. The practitioner must reference the date of a prior note as appropriate. When copying patient data into the medical record from another provider, the practitioner must attribute the information to the person who performed the task unless it is readily apparent, based upon the nature of the information copied, that the data was entered by another provider. If referencing a form within the record, the form must be referenced with sufficient detail to identify the source. Example, "for review of systems, see form dated 6/1/10."

V. LAB

1. Laboratory services shall be provided in the hospital to insure as complete a service as possible. Examinations which cannot be made in the hospital shall be referred to an outside approved laboratory. Lab reports from a certified outside lab will be considered acceptable for charting as long as the reports contain adequate patient identification and other appropriate documentation.

2. All newborns shall have a Metabolic Screening Test done as required/recommended by the Arizona Department of Health Services.

VI. RADIOLOGY POLCIES

1. Teleradiology services are provided by the hospital. Practitioners providing interpretive services are credentialed and privileged through the Medical Staff mechanisms as set forth in the Page Hospital Medical Staff Bylaws. These practitioners are assigned to the Telemedicine Staff category and are not members of the Medical Staff.

VII. CONSULTATION POLICIES

1. Consultation with another member of the Medical Staff is recommended in critically ill cases when the patient is not responding to treatment, where diagnosis is obscure, pre-surgically on all major cases in which the patient is not a good surgical risk, and in all first Caesarean cases. Other recommendations for consultation may be developed from time to time in service policies. The consultant shall make and sign a record of the findings and recommendations in

every such case. Consultations are to be encouraged and are an indication of the interest the physician has in giving and assuring good medical care.

It is recognized that the attending physician has the freedom of choice in selecting the consultant but also the responsibility of notifying the patient of the need for consultation.

2. Consultation is encouraged for all seriously ill patients whose medical problem is not within the realm of the attending physician. If appropriate consultation is not sought by the attending physician, the appropriate Chief of Service should contact the attending physician with the recommendation for consultation in the care of his/her patient. If the attending physician refuses to seek appropriate consultation, the Chief of Service or Chief of Staff may request such consultation.

VIII. ALLIED HEALTH PROFESSIONALS

1. Physician Assistants, Nurse Practitioners, Certified Registered Nurse Anesthetists, and Optometrist.
The hospital and Medical Staff recognize Physician Assistants, Nurse Practitioners, and CRNAs as health care professionals whose performance of approved activities, under the supervision of a member of the Medical Staff, can be beneficial to health care in the hospital. Optometrists are members of the Allied Health Professional staff and do not require a sponsoring/supervising physician as they can practice independently. Physician Assistants and Nurse Practitioners, CRNAs, and Optometrist are not members of the medical staff; their activities in the hospital being governed solely by these Rules and Regulations, the scope of practice approved by the Joint Board or State Board of Nursing and by limitations or restrictions imposed by the hospital.

Subject to Arizona Statutes, Rules and Regulations of the State Board of Medical Examiners and the Arizona State Board of Nursing, Physician Assistants, Nurse Practitioners, CRNAs or Optometrists may collaborate with physicians in the care of patients within the hospital, subject to the conditions, limitations and guidelines stated in these Rules and Regulations. Physician Assistants must be registered with the Joint Board of Medical Examiners and Osteopathic Examiners in Medicine and Surgery.

Nurse Practitioners must be Registered Nurses who have completed an accredited program and have been certified by the Arizona State Board of Nursing, where certification is available, to function in the extended role and to practice in the area of specialty for which they are qualified.

CRNAs must be Registered Nurses who have completed an educational program accredited by the American Association of Nurse Anesthetists' Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor and

that has the objective of preparing a nurse to practice nurse anesthesia, and certified by the American Association of Nurse Anesthetists' Council on Certification of Nurse Anesthetists to function in the extended role and to practice in the area of specialty for which they are qualified.

Optometrist must be licensed in the state of Arizona to practice as an optometrist and have successfully completed an OD degree at an optometry school accredited by the ACOE (Accreditation Council on Optometric Education) or the American Optometric Association (AIOA), OR current Board Certification in Optometry to function in the extended role and to practice in the area of specialty for which they are qualified.

2. Procedure for Application:

A. Medical Staff member who is the employer, sponsor and/or supervisor of a Physician Assistant shall submit the completed application to the hospital Medical Staff Services/Administration office. After collecting the references and other materials deemed pertinent, the application and all supporting materials shall be transmitted to the Credentials Committee for evaluation of the applicant's credentials. If acceptable, it shall be transmitted to the Executive Committee for approval. The application shall include the Physician Assistant's dossier listing:

1) Information on character, background, education and experience, giving three references.
2) Delineation of the supervision to be provided by the physician employer, sponsor and/or supervisor.
3) Arizona Joint Board of Medical Examiner's Registration Number
4) Scope of practice checklist.

B. Medical Staff member who is the employer, sponsor and/or supervisor of a Nurse Practitioner or CRNA shall submit the completed application to the hospital Medical Staff Services/Administration office. After collecting the references and other materials deemed pertinent, the application and all supporting materials shall be transmitted to the Credentials Committee for evaluation of the applicant's Credentials. If acceptable, it shall be transmitted to the Executive Committee for approval. The application shall include the Nurse Practitioner's or CRNAs dossier listing:

1) Information on character, background, education and experience, giving three references.
2) Delineation of the supervision to be provided by the physician employer, sponsor and/or supervisor.
3) State Board of Nursing certification, when applicable.
4) Scope of practice checklist.

A statement must be filed with the hospital Administration and Nursing Service detailing the "job description" of each Physician Assistant and Nurse Practitioner,

as approved by the Joint Board of Medical Examiners and Osteopathic Examiners in Medicine and Surgery and the State Board of Nursing. The Physician Assistant, Nurse Practitioner or CRNA and his sponsoring physician will be responsible for completing a job description and a checklist, co-signed by the sponsoring physician, stating all proposed activities for the Physician Assistant, Nurse Practitioner or CRNA within the hospital.

3. Collaborative Agreement

Physician Assistant, Nurse Practitioner, CRNA must practice in collaboration with, and under the direction and supervision of, a member of the Medical Staff who has agreed in writing to be, and shall be responsible at all times for the actions of the Physician Assistant, Nurse Practitioner, CRNA in the hospital.

A. A physician who sponsors a Physician Assistant, Nurse Practitioner or CRNA, remains responsible for the acts of the Physician Assistant, Nurse Practitioner, or CRNA, however, an agent may be designated, who must also be a physician, to supervise such Physician Assistant, Nurse Practitioner, or CRNA,. The agent must be a peer licentiate or a member of the supervising physician's group, partnership, corporation or clinic. Regarding the Physician Assistant, the Joint Board must be notified in writing of such agents. The Hospital shall also require written notification of this requirement which may be satisfied in the Physician Assistant's, Nurse Practitioner's, or CRNA's application.

4. Physicians employed by the hospital must have Executive Committee approval before hiring a Physician Assistant or Nurse Practitioner.

A. Physician's Assistants, Nurse Practitioners, CRNAs, and Optometrists must inform themselves concerning all applicable hospital and Medical Staff policies and procedures, and must carry out their activities according to such policies and procedures.

B. <u>Duties/Limitations</u>

Physician Assistants, Nurse Practitioners or CRNAs may make appropriate notations on records and progress notes and may write orders under the supervision of their physicians. Physician Assistants and Nurse Practitioners may perform the following functions under the delegation of the supervising physician:

1) Obtain patient histories
2) Perform physical examinations (including medical screening exam)
3) Formulate a diagnostic impression
4) Develop and implement a treatment plan
5) Assist in surgery
6) Perform minor surgery
7) Make appropriate referrals
8) Perform other non-surgical health care tasks

9) Order and perform diagnostic and therapeutic procedures
10) Monitor the effectiveness of therapeutic interventions
11) Offer counseling and education to meet patient needs
12) Prescribe Prescription-Only medications

C. CRNAs may perform the following functions:
1) Conduct a pre-anesthetic assessment of the patient, and record pre, intra and postoperative anesthesia information;
2) Select and administer peri-anesthesia medication;
3) Interview, assess and examine the patient to determine the selection of anesthetic agent and technique, for the particular patient and the contemplated surgical procedure;
4) Request, review and evaluate pertinent laboratory and x-ray studies;
5) Insert intravenous catheters, central venous access and arterial line access;
6) Administer general anesthesia and adjuvant drugs;
7) Administer regional anesthesia techniques
Subarachnoid, epidural, caudal, upper extremity, lower extremity, diagnostic and therapeutic nerve blocks, local infiltration, topical, periocular block, transtracheal, intracapsular, intercostal;
8) Manage the anesthesia process to include induction, maintenance and post-anesthetic care:
9) Utilize all current techniques in monitoring;
10) Recognize abnormal patient responses to anesthesia or to any adjunctive medication or other form of therapy, and take corrective action including consultation with the anesthesiologist;
11) Identify and manage emergency situations including assessment of adequacy of recovery of antagonism of muscle relaxants, and implement appropriate management techniques;
12) Manage fluid, blood and electrolyte loss and replacement with an anesthesia care plan;
13) Endotracheal intubation and extubation;
14) Manage pain relief;
15) Provide professional observation and resuscitation care and request consultation whenever appropriate during the perioperative period;
16) Follow up post-anesthesia and evaluate patients from perspective of the anesthesia service;
17) Participate in cardiopulmonary resuscitation;
18) Document all aspects of care provided by the CRNA;
19) Maintain knowledge of current techniques appropriate to the conduct of anesthesia and implement these techniques within established protocols;
20) Maintain anesthesia at require levels;

21) Support life functions during the period in which anesthesia is administered, including induction and intubation procedure;
22) Recognize and take appropriate corrective action (including the requested consultation when necessary) for abnormal patient response to anesthesia or to any adjunctive medication or other forms of therapy.

D. Optometrists

Optometrists may perform the following functions:

1) Order clinical tests that are appropriate to diagnose, treat or manage conditions of the human eye and its adnexa and that are limited to those CLIA-waived clinical tests approved pursuant
2) Provide consults as requested for urgent and emergent management of nonsurgical eye conditions
3) Amblyopia
4) Binocular dysfunction
5) Corneal epithelial debridement
6) General refractive errors

E. Physician Assistants may, with Joint Board on the Regulation of Physician Assistants approval, delegation by their supervising physician and their own DEA number prescribe and administer Schedule II, III, IV and V controlled substances. Schedule II and III controlled substances may be prescribed for a period not to exceed 72 hours and any other controlled substances without Joint Board approval if medically indicated in an emergency dealing with potential loss of life or limb or major acute traumatic pain. Physician Assistants may dispense, prescribe or refill prescriptions of drugs for a period not exceeding one year.

F. Nurse Practitioners may, with Arizona State Board of Nursing approval, delegation by their supervising physician and their own DEA number, prescribe, dispense and administer medications within their sphere of practice.

7. Performance Review

The Hospital, Medical Staff shall periodically (at least bi-annually), review the performance of any Physician Assistant, Nurse Practitioner, CRNA, or Optometrist and may, at any time, with or without notice, prohibit, suspend, restrict or impose limitations upon the approved activities of a Physician Assistant, Nurse Practitioner, CRNA, or Optometrist. The employing, sponsoring and/or supervising physician shall be promptly advised of any such action.

8. Hearing Procedure

If a Physician Assistant, Nurse Practitioner, CRNA, or Optometrist is the subject of action pursuant to this rule, the sponsoring physician may, within 5 days of the receipt of notice of such action, request a hearing before the appropriate hospital committee. The sponsoring physician shall be given at least 5 days' notice of the time and place of the hearing. The hearing shall be conducted informally, as a professional discussion, without participation of legal counsel or application of technical rules of any sort. The decision of the committee shall be final as to all substantive matters. The sponsoring physician may appeal the committee's decision to the Executive Committee of the Medical Staff only with respect to the fairness of the hearing. Such an appeal shall require a written request to the Executive Committee within 5 days after the decision of the hearing committee.

Any questions concerning the activities of Physician
Assistants should be referred to the appropriate Chief of Service of the physician employer, sponsor and/or supervisor. Any questions concerning the activities of Nurse Practitioners or CRNAs should be referred to the appropriate Chief of Service of the physician employer, sponsor and/or supervisor and also to Nursing Administration. Any questions concerning the activities of Optometrist should be referred to the appropriate Chief of Service.

IX. SURGICAL POLICIES

1. Except in extreme emergencies, the pre-operative diagnosis and indicated diagnostic tests must be recorded on the patient's medical record prior to any surgical procedure. When history and physical examinations are not recorded or stated in writing to have been dictated before the time stated for any surgical procedure, the operation shall be cancelled. If such a delay would constitute a hazard to the patient, the attending surgeon must so state in writing. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery. Legible copies of history and physical examinations performed no more than 30 days prior to admission may be used. The history and physical examination must be updated within 24 hours after admission or before surgery; whichever comes first.

2. A surgical procedure shall be performed only upon consent of the patient or his legal representative, except in emergencies. Consent forms should be in writing and properly signed and witnessed. Signed consent forms will be made a part of the patient's permanent medical record.

3. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be written (or dictated) immediately following surgery for outpatients as well as inpatients, and the report shall be promptly signed by the surgeon and made a part of the patient's current medical record. All tissues removed at operation shall be sent to the pathologist, who shall make such examination as may be considered necessary to arrive at a pathological diagnosis, and shall sign the report.

4. Acceptable indications for abortion and female sterilization are specified in the OB Policy Manual.

5. In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed. Specific procedures requiring surgical assistants are delineated in the Surgery Policy Manual. Other recommendations for surgical assistants may be developed from time to time in service policies. A qualified assistant is defined as a physician or physician assistant designated by the Executive Committee to assist. "Qualified", in this instance, means physicians or physician assistants acknowledged by the Executive Committee as having sufficient training to properly and adequately assist.

X. PHARMACY POLICIES

1. All medications administered to inpatients must be obtained from the Hospital pharmacy, except as noted in #2 of this Section IX. Drugs ordered by trade name may not necessarily be filled by that name, unless the physician states "do not substitute" on the order. Under no circumstances will the pharmacist make therapeutic substitutions, unless therapeutic interchange (substitute) is approved by the Pharmacy and Therapeutics Committee.

2. All medications shall be administered only on the order of a Medical Staff member. Medications may be brought into the hospital by a patient. All medications brought into the hospital by a patient must be identified prior to administration. The medication must be identified by either a pharmacist or physician.

3. If a medication may be administered by more than one route, the route must be specified.

4. The hospital Pharmacy maintains an open formulary as authorized by the Pharmacy and Therapeutics Committee.

5. Automatic Stop Orders for Drugs
   An automatic 7 day stop order is in force for the following drugs, provided the physician has been personally notified of the discontinuation:
   A. Antibiotics
   B. Narcotics: Codeine, oxycodone, meperidine, morphine, etc.
   C. Sedatives

   Anti-neoplastics are ordered by specific dose(s).

   Medications ordered "held" will be discontinued unless specific parameters for reinstitution are documented.

   All medications are discontinued immediately before surgery and will not be reinstituted unless reordered.

6. Medication Administration
   Medications and contrast media shall be administered by, or under the supervision of, appropriately licensed personnel in accordance with laws and governmental rules and regulations governing such acts and in accordance with approved Medical Staff rules and regulations. Administration of medications shall be only in response to a bonafide order, by an individual as set forth above. The following categories of

personnel may administer medications at Page Hospital under the order of a qualified and licensed medical practitioner:

Physician
Physician Assistant
Certified Registered Nurse Anesthetist
Nurse Practitioner
Registered Nurse, RN
Licensed Practical Nurse, LPN: No IV medications
Respiratory Care Practitioner:
Medications related to Respiratory Therapy only
Physical Therapist: Topical medications only
Registered Pharmacist, RPh
Radiology Technologist:
Per policy, medications related to Radiology only

XI. EMERGENCY POLICIES

1. The term “emergency medical condition” according to federal law means:
   A. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
      1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
      2) Serious impairment to bodily functions; or
      3) Serious dysfunction of any bodily organ or part; or
   B. With respect to a pregnant woman having contractions:
      1) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
      2) That transfer may pose a threat to the health or safety of the woman or the unborn child.

2. A nurse shall triage (preliminary exam to determine order of being seen) all patients presenting to the emergency department. All patients seeking care shall undergo a medical screening exam. A medical screening exam can be done only by the ED provider (Physician, Physician Assistant, Nurse Practitioner).

XII. GENERAL POLICIES

1. Each member of the Medical Staff not a resident in the city or immediate vicinity shall name a member of the Medical Staff who is a resident in the city, who may be called to attend patients in an emergency. Any member

of the Medical Staff leaving the city must make satisfactory arrangements for care of his hospital patients while absent. In case of failure to name such associate, the CEO of the hospital shall have the authority to name any member of the staff should he/she consider it necessary.

2. Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without written consent of a relative or legally authorized agent. All autopsies shall be performed by the pathologist or by a physician delegated this responsibility. Medical examiner requirements (A.R.S. 11-593A) shall take precedence over family and/or physician prerogatives.

3. All members of the Medical Staff (residing in the city or immediate vicinity) shall participate in disaster situations per the hospital Disaster Plan.

4. If a clinical employee has any reason to doubt or question the care provided to any patient, and no action has been taken by the attending physician or the Chief of Service, the nurse or clinical employee shall call this to the attention of the supervisor who, in turn, shall refer the matter to the Chief Nursing Officer or Administrator on Call. If warranted, the Chief Nursing Officer or Administrator on Call shall bring the matter to the attention of the Chief of Staff and CEO.

5. In the event of a hospital death, the deceased shall be pronounced dead by the attending provider or by a staff provider designated by him, within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff.