Banner Thunderbird®
Medical Center

MEDICAL STAFF RULES AND REGULATIONS

July 12, 2018

BANNER THUNDERBIRD MEDICAL CENTER
Glendale, Arizona

MEDICAL STAFF RULES AND REGULATIONS

ARTICLE 1: GENERAL

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

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

Physicians who are fifty-five (55) years or older, or who have served twenty (20) years on the Medical Staff of Banner Thunderbird Medical Center may elect to be excused from serving on the ER call rotation. Physicians who have substantiated health reasons for being excused from call rotation may be excused by the Department Chairman or the Professional Health Committee.

1.3 **Research:** All research being conducted, sponsored by, or otherwise affiliated with BTMC facilities and Medical Staff must be in compliance with current Banner Health policies.

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

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

1.6 **Consent**: The patient, or in special circumstances, someone acting for the patient, gives consent. Spouses and other family members do not have the right to consent or refuse consent for most patients. For unemancipated minors and wards, parents or guardians generally have the right to consent. (See Banner Health policies on consent for further information.) Consent forms should be in writing and properly signed and witnessed. It is acceptable practice for someone other than a physician to obtain and witness a patient's signature on a consent form. However, it is essential that the physician provide the medical explanation including the risk, benefits, and potential complications associated with procedures leading to the patient's consent for surgeries or other significant procedures. A physician may delegate his/her responsibility to obtain Informed Consent to his/her Physician Assistant or Nurse Practitioner. Signed consent forms will be made a part of the patient's permanent medical record. A copy of consent forms, including discussions concerning risk, benefits and alternatives of surgery, documented in the surgeon's office must be provided to the Medical Center to be placed on the patient record.

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

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

1.9 **Treatment of Family Members**

Practitioners may not treat immediate family members as the primary care provider absent an emergency or the unavailability of another practitioner with similar privileges. Immediate family member is defined as parents, children, sibling or spouse.

ARTICLE 2: ADMISSION POLICIES

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

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

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

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

2.5 Patients admitted for dental service must be admitted by a Medical Staff physician. Patients admitted for podiatric surgical procedures must be co-admitted with a physician member of the Medical Staff. A Medical Staff physician is responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization and determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient. In all cases, an H&P is required on each patient.

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

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

2.7.1 Patients admitted to the Critical Care Unit within 12 hours

2.7.2 All others within 24 hours.

Patients must be seen sooner if their condition warrants physician intervention. (Exceptions may be granted for obstetrical patients.)

Attending physicians or their physician designees are required to see patients daily thereafter. Physicians are required to see behavioral health patients at least three days per week. Allied Health staff visits shall not suffice for physician rounding. The appropriate section or department chairman is to be notified by Administration if a patient is not visited by the attending physician or physician designee within the designated time. If the patients' condition is sufficiently stable, the patient may be discharged without being seen on the day of discharge by the attending physician.

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

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

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

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

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

2.9 Intensive Care Units/Telemetry – any physician on the medical staff, with admitting privileges, may admit a patient to the Intensive Care Unit or the Telemetry Unit if the patient requires intensive treatment, observation or nursing care. All patients admitted to the Intensive Care Units will be consulted by a BTMC Intensivist. Interqual admission and discharge criteria will be followed and adhered to by all practitioners utilizing these units.

ARTICLE3: CONSULTATIONS

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

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

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

all cases where a policy of the Medical Center requires consultation and in the care of free patients, the consultant shall give his service without charge to the patient. The attending physician should state clearly if the consultant requested is only to make recommendations, is to write orders, or is to assume care of the patient.

3.4 Consultation must be rendered on a timely basis in consideration of the attending physician's request. Consultants are expected to see the patient or for remote consultations, review the patient and/or electronic data images, and write or dictate a report within 24 hours unless the patient's condition is considered imminently serious or potentially life-threatening in which case, the patient needs to be seen and a report written or dictated, as soon as reasonably possible.

3.5 All consults performed by a Nurse Practitioner or Physician Assistant must be signed by the sponsoring physician or his designee within twenty-four (24) hours of notification of consultation being initiated. Preoperative consults require approval by the sponsoring physician in person before the procedure begins. The NP or PA is to dictate the discussion and recommendations in the consultation note. The sponsoring physician must sign the consult acknowledging the communication with the NP or PA did occur and the recommendations reflected in the consult note are accurate.

3.6 Remote consultations must meet the needs of the requesting physician and be approved by MEC. A consultation may consist of a remote review of the patient and/or electronic data images by the physician with bedside assistance from the physician's Nurse Practitioner (NP) or Physician Assistant (PA) or the Hospital Based Nurse Practitioner (HBNP) or Hospital Based Physician Assistant (HBPA).

In order to facilitate efficient discharges, non-emergent consultations for a discharge evaluation requested near the end of the patient's hospital stay may be conducted by the physician's NP or PA or by the HBNP or HBPA without the supervising physician seeing the patient before discharge if it meets the attending/requesting physician's needs. The evaluation must be communicated to the supervising physician by the physician's NP or PA or by the HBNP or HBPA. The physician's NP or PA or the HBNP or HBPA should arrange appropriate follow up for the patient, as indicated. The physician's NP or PA or the HBNP or HBPA will communicate the findings and discharge follow up plans with the attending/requesting physician.

Consultations without bedside assistance may be deemed appropriate for physicians performing services such as eICU, teleradiology, or other telemedicine capabilities.

3.7 When a patient is admitted to the Hospital for attempted suicide or when a patient attempts suicide while in the Hospital, it is recommended that a psychiatric consultation be obtained. Patients who have attempted suicide or are thought to be suicidal must be cleared for discharge from the Emergency Room via phone consultation or in person by a psychiatrist who is a member of the Medical Staff of Banner Thunderbird Medical Center. Patients seen in the Emergency Room for other psychiatric problems must be cleared for discharge from the Emergency Room via phone consultation or in person by a physician who is a member of the Medical Staff of Banner Thunderbird Medical Center.

ARTICLE 4. MEDICAL RECORD POLICIES

A. General

4.1 **General**

4.1.1 Medical record is established and maintained for each patient who is 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.

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

4.2 **Purposes of the medical record is**:

4.2 1 To serve as a detailed data base for planning patient care by all involved practitioners, nurses and ancillary personnel.

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

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

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

4.2.5 To assist in protecting the legal interest of the patient, Medical Center and practitioner responsible for the patient and to provide data for use in the areas of quality and resource management, education, and research.

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

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

4.4.1 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.

4.4.2 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 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.

4.4.3 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.

Copying and Pasting – Medical Staff members and 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 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."

4.5 **Access to the EMR**: Access to patient information on the EMR will be made available to Medical Staff and their staff through Clinical Connectivity. All access to electronic records is tracked and unauthorized access to a patient's record is not tolerated.

4.6 **EMR Training** – Practitioners must be trained by Banner to use the electronic medical record and computerized order entry system (CPOE) prior to being granted privileges on to the Medical Staff or the Allied Health Staff. For reasons of patient safety all members of the Medical or Allied Health Staff must utilize the CPOE. Exceptions will be made on a case by case basis to be determined by the facility CEO. Members of the Medical Staff who consistently refuse to use the EMR and/or CPOE may be suspended or removed from the Medical Staff.

4.7 **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.

4.8 **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 of defacement or medical records constitutes grounds for disciplinary action.

4.9 **Release of Patient Information** – Banner Health releases patient information only on proper written authorization of the patient or as otherwise authorized by laws 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.

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

4. 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.

4. 12 **Abbreviations -** Practitioners shall be responsible to use only approved symbols or abbreviations in the medical record. See Banner Health's "Medical Record Abbreviations and Symbols" list.

4.13 **Responsibility:** The attending physician is responsible for each patient's medical record. The 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 musts be accurately dated, timed and individually authenticated by the responsible physician; group signing of documentation is not permissible. Authentication means to establish authorship by written or electronic signature and shall consist of the practitioner's name and professional title indicating the professional credential. Electronic signature authentication of medical records is the standard practice.

4.14 **Counter-authentication (Endorsement)**

4.14.1 Physician Assistants – History and Physical Reports, Operative/Procedural Notes, Consultations and Discharge Summaries must be counter-authenticated timely by the physician according to individual facility medical staff policies. Each clinical event must be documented as soon as possible after its occurrence. Requirements for countersignature of Progress Notes will be established and monitored by the supervising physician.

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

4.14.3 Medical Students

4.14.3.1 – 1st and 2nd Year – Access to view the patient chart only. May not document in the medical record.

4.14.3.2 - 3rd and 4th Year – Any and all documentation and orders (if permitted) must be endorsed (countersigned, counter-authenticated) timely by the physician.

4.14.4 House Staff, Resident, and Fellows – Requirements for countersignature 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.

4.15 **Legibility:** All practitioner entries in the record must be legible, pertinent, complete and current.

B. Medical Record Content

4.16 **Medical Record Documentation and Content:**
The medical record must identify the patient, support the diagnosis, justify the treatment, document the course and results of treatment and services and facilitate continuity of care. The medical record is sufficiently detailed and organized to enable:

4.16.1 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.

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

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

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

4.16.5 Accurate coding diagnosis in response to coding queries.

4.17 **History and Physical Examination ("H&P"):** A history and physical examination must be performed within 24 hours after admission or registration for patient 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.

4.17.1 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.

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

4.17.3 For patients admitted to the Rehabilitation Unit, the admitting rehabilitation physician must conduct an 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.

4.17.4 For patients receiving electro-convulsive therapy in a behavioral health unit, a current H&P must be completed prior to each treatment.

4.17.5 If approved by the Medical Staff, the Emergency Room Report or Consultation report may be used as the H&P as long as all of the elements in section 4.19 are included and the document is filed as a History and Physical on the EMR.

4.18 **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 complete the H&P, and assess the medical risks of the procedure to the patient. Dentists and podiatrists are responsible for their part of their patient's H&P that relates to dentistry or podiatry, and, if authorized by the medical staff, may be responsible for the complete H&P.

4.19 **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:

4.19.1 Medical history
4.19.2 Chief complaint
4.19.3 History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status.
4.19.4 Relevant past medical, family and/or social history appropriate to the patient's age.
4.19.5 Review of body systems.
4.19.6 A list of current medications.
4.19.7 Any known allergies including past medication reactions and biological Allergies
4.19.8 Existing co-morbid conditions
4.19.9 Physical examination: current physical assessment
4.19.10 Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
4.19.11 Initial plan: statement of the course of action planned for the patient while in the Medical Center.

4.20 **Behavioral Health Documentation (This section 4.20 only applies to inpatient behavioral health units.)**

4.20.1 A psychiatric evaluation including an initial plan of treatment, mental status examination, diagnosis and estimated length of stay, shall be completed and documented within 24 hours after admission of the patient. Physicians will complete the psychiatric evaluation and above documentation.

4.20.2 A physical examination shall be performed and documented within 24 hours of admission or registration of the patient. Physical examinations may be used from the previous hospitalization if the examination was within 30 days. Physical examinations

may be accepted from a doctor's office if the examination was done within 30 days of admission and meets the standards as defined by hospital policy and procedure. If the patient was transferred from another hospital, the physical examination may be accepted if done within the last 30 days provided they are updated within 24 hours of admission or registration by the attending physician.

4.20.2.1 In the above three cases, the attending physician must validate the physical examination in the medical record (on the physical exam) by noting that there are no significant findings or changes and signs and dates the report.

4.20.3 Pertinent progress notes related to diagnosis and to treatment plan goals and objectives, sufficient to permit continuity of care shall be recorded at the time of observation. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress note and correlated with specific orders, as well as results of tests and treatments. A progress note shall be documented, authenticated and dated after each visit by the attending physician.

4.20.3.1. Physicians shall document abnormal diagnostic values and their response to such;

4.20.3.2 Consultants shall document, authenticate, time, and date all assessments, diagnostic tests, and treatments, etc. whenever they see a patient.

4.20.3.3 All entries must be dated, timed and authenticated by the person making the entry and must include his/her discipline.

4.20.4 Therapeutic Leaves of Absences (Passes) the attending physician shall write an order specifying date and length of the pass, therapeutic goals and the identity of any person to accompany the patient. The attending physician will indicate any medication to be taken by the patient. The attending physician will indicate any medication to be taken by the patient during the pass by a specific order.

4.20.5 Discharge Documentation

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

4.20.5.1.1 AMA discharge orders must be given by the attending physician or his/her designee. Exceptions may only be made by the Medical Director who has the authority to discharge a patient for administrative reasons.

4.20.5.2 At the time of discharge but no later than 24 hours after, the attending physician shall complete the discharge summary according to DSM-5 terminology or according to current psychiatric diagnostic terminology.

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

4.20.5.4 Discharge Summaries may be constructed by an approved non-physician. Utilizing a non-physician for medical record analysis, information compilation and discharge summary construction is the prerogative of the attending physician. Physicians who chose this practice must give prior authorization of their intent, obligation and responsibility of their intent, obligation and responsibility to read, review, approve and authenticate every clinical resume.

4.20.5.5 The attending physician ensures that the content of the dictated discharge summaries (M.D. dictated and non-M.D. dictated) is accurate, complete, and meets all pertinent requirements.

4.20.5.6 Against Medical Advice (AMA) Discharged at insistence of self or family when patient is not considered imminently suicidal or homicidal, but is in such a

condition that there is serious risk of rapid relapse or other clinical complication.

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

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

4.22 **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 five (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 the 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.

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

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

4.24.1 Pre-Operative Anesthesia/Sedation Evaluation - A preanesthesia/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/sedation evaluation of the patient must include review of the medical history, including anesthesia, drug and allergy history; review and examination of patient; notification of anesthesia risk (per ASA classification); identification of potential anesthesia problems, particularly those that suggest potential complications or contraindications; additional pre-anesthesia as applicable; and development of the plan for anesthesia care, including type of medications for induction, maintenance, and post-operative care and discussion with the patient of risks and benefits. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before the pre-operative medication has been administered. Immediately prior to the induction of anesthesia while the patient is on the procedural table, the patient's vital signs, airway and response to pre-procedure medication must be assessed and the equipment checked.

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

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

4.25 **Operative and Procedure Reports -** An operative or other high-risk procedure report is documented upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level.

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

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

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

- The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
- The name of the procedure performed
- A description of the procedure
- Findings of the procedure
- Any estimated blood loss
- Any specimen(s) removed
- The postoperative diagnosis

4.25.4 When a full operative or other high-risk procedure report cannot be documented 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.

4.26 **Consents:** Prior to any operative/invasive procedures, the medical record must contain an informed consent. The responsible practitioner will discuss with the patient or his/her Legally Authorized Representative adequate information about the Procedures so that an informed decision can be made, including:

- An explanation of the material risks and anticipated benefits of the Procedure and anesthesia, including the likelihood of each, based on the available clinical evidence, as informed by the responsible practitioner's clinical judgment;
- An explanation of alternatives, including material risks and benefits;
- An explanation of the consequences if declining recommended or alternative treatments;
- Disclosure of whether practitioners other than the operating practitioner, including residents, will be performing important tasks related to the Procedures.

The following Procedures require written informed consent:

- All surgical procedures (whether or not anesthesia is required);
- Administration of anesthetic agents (e.g. general regional spinal) moderate sedation;
- Invasive vascular procedures (e.g. arterial lines, subclavian catheters). Excluded procedures include: venipuncture, intravenous lines, arterial sticks and/or intravenous, intradermal, subcutaneous or intramuscular injections.
- All invasive procedures, whether or not performed in the surgical suite, including invasive diagnostics (i.e. lumbar puncture, thoracentesis, EMG, arteriogram, chest tube insertion);
- All biopsies, whether or not performed in the surgical suite;
- All cardiodiagnostic procedures (e.g. cardiac catheterization, angioplasty, stress tests, cardioversions);
- All procedures that require regional or general anesthesia;
- All endoscopic examinations (e.g. bronchoscopy, sigmoidoscopy),
- All HIV-related testing;
- All transfusions of blood and blood products;
- All experimental or investigational treatments, procedures or medications; and
- All autopsies.

Emergency: Consent is implied in an emergency. An emergency is defined as a situation that exists if all of the following circumstances are met:

- The person is in immediate need of medical attention;
- An attempt to secure express consent would result in delay of treatment;
- Delay in treatment would increase the risk to the person's life or health; and
- The person has not refused this emergency medical treatment at a time when he/she had decisional capacity.

The scope of emergency treatment is treatment that can range from elementary first-aid to surgery, but cannot, without express consent, exceed that which is necessary to remedy the condition creating the emergency.

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

4.28 **Discharge Documentation**

A discharge summary must be documented at the time of discharge 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 vaginal

deliveries do not require a discharge summary regardless of 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.

4.28.1 The discharge summary shall include:

4.28.1.1 Reason for hospitalization

4.28.1.2 Concise summary of diagnoses including any complications or co-morbidity factors

4.28.1.3 Hospital course, including significant findings

4.28.1.4 Procedures performed and treatment rendered

4.28.1.5 Patient's condition on discharge (describing limitations)

4.28.1.6 Patient/Family instructions for continued care and/or follow-up

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

4.28.2.1 Discharge Progress note shall include:

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

4.29 Home Health (Face to Face Discharge Documentation)

When home health services or DME or ordered, the medical record must include a face-to-face assessment, which must occur within 90 days prior to the start of home health or within 30 days after the start of care. The Face to Face encounter documentation must include:

1. Date and time of the face to face encounter;
2. The patient's clinical condition;
3. A brief narrative description of the patient homebound status and the need for skilled services. If the documentation was completed by nurse practitioner, physician assistant, clinical nurse specialist, or resident, the physician must authenticate the documentation.

4.30 **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.

4.31 **Documentation of Inpatient Transfers** – 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.

4.32 **Amending Medical Record Entries**

4.32.1 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 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.

4.32.2 **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 initial, date, and time 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 and time of the change and reason for the change. 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 shall 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 seen and relied upon the original entry shall be notified as appropriate.

4.33 **Timely Completion of Medical Records**

4.33.1 **Complete Medical Record** - The Medical Record is not considered complete until all its essential elements are documented and authenticated, and all final diagnoses and any complications are recorded, consistent with these Rules. No medical record shall be considered complete without fulfilling the documentation requirements except on order of the Medical Executive Committee.

4.33.2 **Timely Completion of Medical Record Documents -** All medical record documents shall be completed within time frames defined below:

Documentation Requirement	**Timeframe**	**Exclusions**
Emergency Room Report	Documented within 24 hours of discharge/disposition from the ED	
Admitting Progress Note	Documented within 24 hours of admission	
History & Physical	Documented within 24 hours of admission and before invasive procedure	
Consultation Reports	Documented within 24 hours of consultation	

Post op Progress Note	Documented immediately post-op	
Provider Coding Clarification	Documented response no later than 7 days post notification to the provider	
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 for all admissions less than 48 hrs or for normal vaginal deliveries and normal newborns	
Home Health (Face to Face Discharge Documentation	Documented at the time of discharge but no later than 24 hours after discharge	
Death Summary **Death Pronouncement Note**	Documented at the time of death but no later 24 hours Completed at the time the patient is pronounced but no later than within 24 hours	
Transfer Summary	Documented at the time of transfer but 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 72 hours from order	

Psychiatric Evaluation	Documented within 24 hours of admission	

4.34 **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 4.33. 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.

4.35 **Medical Record Suspensions/Sanctions** – A medical record is considered eligible for suspension/sanction based on the timeframes in section 4.33.

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

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

Upon temporary suspension, the delinquent member shall have no admitting, surgical and/or consultative privileges, other than patients in labor or patients needing emergent care, until delinquent records have been completed. A member whose privileges have been suspended under this Section shall be allowed to continue the medical and surgical care only of patients who were in the Medical Center under their care prior to imposition of the temporary suspension of privileges, or for those patients who are pre-scheduled for surgery/procedures. Specifically, a suspended physician shall not: schedule new admissions, schedule admissions under an associates/covering physician's name, accept admissions in transfer or referrals through the Emergency Department, perform consultations, schedule inpatient or outpatient surgeries or other procedures, assist in surgery, administer anesthesia,

round on patients of associates/covering physician's patients, or participate in Emergency Department Call unless the ED Call is mandatory or if the Medical Executive Committee has determined that there is an inadequate number of physicians to adequately care for patients. It is the responsibility of the physician to arrange coverage for Emergency Department call for which that physician is scheduled.

Automatic Termination of Privileges for Delinquent Medical Records
Temporary suspension shall become automatic permanent suspension following 60 cumulative days of temporary suspension within a running year, absent extenuating circumstances. At that time, the practitioner's privileges will automatically move to permanent suspension for failure to complete medical records. Affected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if all incomplete and delinquent records have been completed. In addition, the practitioner must pay a $500 fine. The request for reinstatement must include assurance to the Medical Executive Committee of the practitioner's ability to stay in compliance with the medical record completion requirements outlined in these Rules and Regulations. If the practitioner has not been reinstated the practitioner shall be deemed to have voluntarily resigned from the staff.

Neither temporary nor permanent suspension of privileges or revocation of membership and privileges under this Section entitles a staff member to rights pursuant to the Fair Hearing Plan. Physicians may submit evidence demonstrating why the suspension/revocation is unwarranted to the Medical Executive Committee pursuant to Article 12.5 of the Bylaws.

ARTICLE 5: INPATIENT ORDERS

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

Banner Thunderbird seeks to facilitate timely and accurate execution of physician and Allied Health Practitioner orders to deliver quality patient care, and to provide guidelines within which its medical staff, Allied Health staff, nursing service, and employees can best accomplish this objective. Orders for treatment shall be dated, timed and authenticated. It is the responsibility of the physician who is transferring the patient to a new level of care to review all active orders for clinical accuracy and appropriateness. New orders must be generated after a surgical procedure.

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

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

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

5.1.4 Physician or Allied Health Practitioner orders are required for transfer of a patient to a different level of care within the facility. It is the responsibility of the physician or Allied Health Practitioner who is

transferring the patient to a new level of care to review all active orders for clinical accuracy and appropriateness.

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

5.2 **Orders for Inpatient Medical Imaging Tests/Procedures**

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

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

5.3 **Orders for Surgery**

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

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

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

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

New physician orders must be generated after a surgical procedure.

5.4 **Orders for Outpatient Tests**

1) A signed order must be received prior to performing any outpatient procedure, test or service.
2) Orders must be dated, timed and signed by the physician or Allied Health Practitioner. Exception: Orders written prior to the patient's arrival (e.g., scheduled services) do not require time to be included on the order. The time of the order will be documented in the hospital patient registration system upon scheduling or registration of the patient. All other outpatient orders written while the patient is on site being treated will require time.
3) Orders for outpatient services are acceptable from BTMC Medical Staff, non-staff physicians, out of state physicians and practitioners licensed with prescriptive authority (including PA's and NP's).

4) Orders must include a statement of the reason for the test and/or diagnosis and it must be authenticated and dated by the physician or licensed Allied Health Professional.
5) Unless otherwise specified on the order, for recurring accounts the order will expire after twelve (12) months. If there is a change in the patient's condition which warrants a change in treatment, a new physician order is required.

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

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

5.5 **Verbal and Telephone Orders**

- Verbal (face to face) orders are not acceptable except in the case of an emergent situation where immediate written or electronic communication is not feasible. Verbal orders will be accepted only by a registered nurse (RN) or licensed practical nurse (LPN). Licensed Respiratory Care Practitioners (RCP) and registered pharmacists can accept verbal orders provided the orders are directly related to their specialized discipline. The physician will authenticate these orders within 48 hours.
- Verbal or telephone orders for chemotherapy and initial parenteral nutrition may not be accepted. Chemotherapy dose modifications may be accepted.
- 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.
- Registered pharmacists are permitted to give telephone orders under physician ordered pharmacotherapy consultation.
- RNs or LPNs are permitted to accept telephone orders on nursing units. Registered pharmacists, Occupational Therapists, Physical Therapists, Registered Dietitians, Speech Therapists and Respiratory Care Practitioners (RCPs) can accept telephone orders directly related to their specialized discipline. All telephone orders must be read back to verify accuracy and signed by the receiving individual. Telephone orders will be authenticated by the responsible physician or Allied Health Practitioner.

5.6 **No Code Orders**

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

ARTICLE 6: GENERAL PHARMACY POLICIES

6.1 General Information

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

6.2 Medication Management

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

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

c) Samples – Medication samples will not be used for the management of patients at BTMC.

d) Outpatient Prescriptions - Outpatient prescriptions with the exception of those provided to patients receiving care in the ATU) will not be filled by BTMC Pharmacy.

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

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

and any product designated by the Food and Drug Administration (FDA) as a medication.

6.3 **Medications**

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

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

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

6.4 **Medication Orders**

All medication orders must be complete, including medication name, dose, route, and, frequency. Medications ordered by "PRN" must specify route, frequency and indication.

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

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

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

6.5 **Authorization to Order Medications**

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

6.6 **Authorization to Administer Medications**

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

Physicians

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

Respiratory Care Practitioners (medications related to respiratory therapy treatments only).

Radiology Technologist and Nuclear Medicine Technologist (medications related to radiology/nuclear procedures only).

EEG Technician and Cardiovascular Technician (CVT) (oral medications only) and Anesthesia Technicians (medications related to EEG and Cardiovascular therapy treatments only).

Physical Therapist (topical medications only. Medications related to physical therapy treatments only)

ARTICLE 7: GENERAL SURGICAL POLICIES

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

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

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

7.4 A post operative progress note shall be entered into the medical record immediately (before the patient is transferred to next level of care) after the procedure.

Operative reports shall be dictated or electronically created within 24 hours after surgery.

7.5 All tissues and specimens removed from the body during a surgical procedure shall be sent to the Medical Center's Laboratory Department for gross and/or microscopic examination except at the discretion of the surgeon. See policies for handling of specimens – routine permanent and foreign bodies. Specimens shall be properly labeled, packaged as designated, and identified as to patient and source in the operating room at the time of removal. If the surgeon chooses not to send the specimens to the laboratory, he/she shall dictate a descriptive note of the specimen in the operative report.

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

- Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance;

- Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;
- Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;
- Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant;
- Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics.

7.7 **Operative and High Risk Invasive Procedure Site Identification**

- The correct surgical or invasive procedure site will be marked for those cases involving right/left distinction, or multiple structures (toes/fingers), or levels (spine) – the general level of the procedure (cervical, thoracic, or lumbar) as well as anterior vs. posterior. The physician, patient and the surgical or invasive procedure team will verify that the correct site is marked prior to the start of the procedure.
- Laterality of all procedures will be verified and spelled out in its entirety on the consent form.
- Prior to the start of the procedure, the surgical or invasive procedure team will pause (conduct a "time-out") and using active communication will prior to the incision:

Verify that relevant documentation, images, implants or special equipment is readily available;

Verbally confirm the correct patient, correct side and site, correct patient position and correct procedure as identified on the consent for operation. Verification will be documented in the medical record.

Resolve any questions or discrepancies prior to start of the procedure.

The exact interspace to be operated on will be identified intraoperatively via x-ray.

Compliance with this policy will be monitored concurrently.

ARTICLE 8: RESTRAINTS

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

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

RESTRAINTS FOR PHYSICAL SAFETY

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

Summary of Physician/NP actions:

a) Give order for initial episode of restraint.
b) Within 24 hours: perform face to face assessment of patient and document type and need for restraint and authenticate (if verbal) previous order.
c) Every 24 hours: perform face to face assessment of patient and enter a new order for restraints if need continues.

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

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

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

Summary of Physician/NP actions:

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

ARTICLE 9: ADVANCE DIRECTIVES AND END OF LIFE

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

9.1 WITHDRAWAL OF LIFE SUPPORT

1) Withdrawal of life support should occur in conjunction with best efforts to ascertain the wishes of the patient given the circumstances of his/her illness. If the patient is unable to speak on his/her own behalf, decisions should be made with appropriate family members or defined surrogate. Discussions with patient, family members or surrogate decision maker should be documented in the medical record. If the physician can not locate the family member or surrogate decision maker, the physician may make health care decisions for the patient after a consultation with and recommendation of the Bioethics Committee.
2) The primary responsibility for coordinating withdrawal of life support in a humane and ethical fashion lies within the attending physician. Other clinicians involved in the care of the patient (including nurses, respiratory therapists and others) are not obliged to participate in or carry out withdrawal of life support unless they are comfortable with the level of involvement of the attending physician.
3) The spiritual and emotional well being of the patient and family should be addressed. Appropriate resources that may be called upon to assist in this regard include social services, pastoral care, palliative care services and hospice.
4) All efforts should be undertaken to ensure that the patient does not suffer during withdrawal of life support. Analgesic and sedative medications should be administered when necessary in order to alleviate suffering. The doses used should be guided by direct observation of the patient. In general, doses should be sufficient to minimize pain, dyspnea, anxiety, and other symptoms that may accompany withdrawal of life support.

9.2 Pronouncement of Death

In the event of a Medical Center death, pronouncement of death shall be made by the attending practitioner within a reasonable time. If the physician is not present, two (2) registered nurses will assess the vial signs (BP, apical pulse and aspirations), and will document this in the nurses' progress notes. The RN will place a call to the attending physician and obtain a physician order to accept 2 RN's assessment of the death if the appropriate. If no physician is willing to sign the death certificate, the case will be referred to the Medical Examiner.

9.3 Autopsies

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

1) Deaths in which an autopsy would help explain unknown and unanticipated medical complications.
2) Deaths in which the cause is not known with certainty on clinical grounds.

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

The attending physician or his/her designee requests and obtains permission for an autopsy from the family.

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

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

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

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

1) The case meets the criteria of a Medical Examiner's case.
2) The case was waived by the Medical Examiner's office, but appears to have criminal and/or other legal implications.
3) The Consent for Autopsy appears to be invalid, incomplete, or questionable.
4) The pathologist believes that the case represents a risk to him/her or hospital personnel that the facility is not equipped to handle (e.g. Cruetzfeidt-Jacob Disease).
5) Autopsy fails to meet quality assurance or education criteria.

The pathologist determines who can be present during an autopsy.

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

Pathologist may discuss the case with the attending physician. The attending physician may attend the autopsy.

ARTICLE 10: INTERN, RESIDENT AND FELLOW ROTATIONS

Supervision of Interns, Residents and Fellows

Professional Graduate Medical Education Programs wishing to rotate Interns, Residents or Fellows through Banner Thunderbird Medical Center will require approval by the appropriate Department, Committee, the Medical Executive Committee and Medical Center CEO. This approval will be based

upon information provided by the GME training program. Once approved, the professional liability coverage and competencies of each resident or fellow will be confirmed. Successful completion of training on Banner's electronic medical record is required before start of the assigned rotation.

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

Documentation By Interns, Residents And Fellows

The attending physician shall be responsible for each patient's medical record. When interns, residents or fellows are involved in patient care at Banner Thunderbird, 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 Banner Thunderbird, 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 change or addendum. 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.

ARTICLE 11: MEDICAL AND PHYSICIAN ASSISTANT STUDENTS

11.1 Medical and Physician Assistant Student Level of Participation:

Rotations will be in accordance with the Banner Health Clinical Education Rotation Agreement. Students will work under direct supervision of a member of the BTMC Medical Staff who is a college participating teaching faculty member

according to specific clinical goals and objectives developed by the college for each rotation. Students must provide documents to the Medical Staff Services Department as required by the affiliation Clinical Education Rotation Agreement prior to starting the clinical experience. Participation in specific rotations at BTMC is subject to prior approval of the Medical Executive Committee. The number of student rotations will be evaluated periodically and subject to change.

11.2 Specific Medical and Physician Assistant Student Activities:

Third and Fourth Year Medical Students and Physician Assistant Students may observe or assist in surgery if a requirement of the rotation. Student must be able to document education of aseptic technique prior to assisting in surgery. All activities are under the direct guidance and supervision of the participating teaching faculty member.

11.3 Restrictions:

Students may not create discharge summaries or operative reports, enter orders, or perform procedures without direct supervision.

11.4 Medical and Physician Assistant Student Responsibilities:

Students are required to comply with all BTMC policies and procedures during the clinical experience. Students shall have access to only patient information necessary as part of the approved rotation. Students must at all times wear a student identification badge.

ARTICLE 12: HIPAA (Health Insurance Portability and Accountability Act)

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

AMENDMENT:

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

ADOPTION:

Adopted and recommended to the Banner Health Board of Directors by the Banner

APPROVED:

Approved: 04/83
Revised: 08/89, 09/93, 06/94, 11/96, 02/98, 12/98, 5/15

Revised:
Bylaws Committee 7/14/99, 6/4/01, 8/13/01, 7/9/03
Executive Committee 7/27/99, 7/24/01, 8/28/01, 8/22/02, 2/25/03, 6/24/03, 7/24/07, 5/26/09, 11/24/09, 1/26/10, 1/26/10, 9/28/10, 10/26/10, 3/22/11, 9/27/11. 11/22/11, 3/27/12, 5/22/12, 2/26/2013, 1/27/2015, 2/27/2018
General Staff 8/24/99, NA, NA, NA, NA, NA, NA, 5/2/12, 4/15

Banner Health Board of Directors 9/14/99, 4/18/00, 8/28/01, 9/20/01, 11/20/02, 3/20/03, 7/17/03, 7/15/04, 05/18/06, 8/16/07, 6/11/09, 12/10/09, 2/11/10, 10/14/10, 11/11/10, 4/14/11, 11/10/11, 1/9/2012, 5/10/12, 9/12/13, 4/16/15, 7/12/18