Banner Thunderbird®
Medical Center

MEDICAL STAFF

RULES & REGULATIONS

Revision 12 November 2020

Approval Log

MEC	BOARD		MEC	BOARD		MEC	BOARD
7/27/99	9/14/99		9/28/10	10/14/10		6/23/20	7/9/20
7/24/01	8/28/01		10/26/10	11/11/10		10/6/20	11/12/20
8/28/01	9/20/01		3/22/11	4/14/11			
8/22/02	11/20/02		11/10/11	11/22/11			
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6/24/03	7/17/03		2/26/13	9/12/13			
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5/26/09	6/11/09		2/27/18	7/12/18			
11/24/09	12/10/09		9/8/19				
1/26/10	2/11/10		2/25/20	3/12/20			

PART ONE: 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 Participation in the Emergency Department Call Roster and EMTALA Responsibilities

As required by federal law, this Medical Center will maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Only individual names, and not group practice names, are acceptable for inclusion on the on-call list.

Physicians serving on the call roster of the Emergency Department are responsible to cover their call or assure coverage by a Banner Thunderbird Medical Center Medical Staff member with appropriate privileges, and to notify Medical Staff Services of any changes prior to any changes being made and preferably at least 24 hours prior to the scheduled rotation.

On-call physicians will respond by phone within fifteen (15) minutes. The emergency or treating physician will determine whether the patient's condition requires the on-call physician to come to the Medical Center immediately. The determination of the emergency or treating physician will be controlling in this regard. When requested to respond, the physician response is expected within 30 minutes. If the on-call physician is on simultaneous call at another facility and is unable to respond, the on-call physician will arrange for his or her backup to respond. If there is no physician on-call within the area of expertise required by the patient's condition, the emergency physician will transfer the patient to the appropriate facility in compliance with policy.

If an on-call physician fails or refuses to respond in a timely manner, the emergency physician will immediately notify the Department Chair over the on-call physician (or his/her designee), the Chief of Staff, or the Chief Medical Officer. Refusal of any physician who is on call to provide treatment under the policies established by the Medical Center and under these Rules and Regulations will result in a report filed with the Chief Medical Officer or the Chief Executive Officer, and corrective action may be taken by the Medical Executive Committee.

In compliance with accreditation requirements of the American College of Surgeons, all on-call specialists credentialed by the Medical Center for the provision of trauma-related care shall, upon request of the attending trauma surgeon or emergency physician, arrive

promptly at the patient's bedside within 30 minutes of said request under normal driving and weather conditions.

Where call is mandatory, 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 Emergency Department call rotation. Physicians who have substantiated health reasons for being excused from call rotation may be excused by the Department Chair or the Professional Health and Wellness 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

Where the patient lacks capacity, an Agent, Guardian or Statutory Surrogate, 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 unless there is an emergency or the unavailability of another practitioner with similar privileges. In these instances, approval is required from the Chief of Staff or his/her designee. Immediate family member is defined as parents, children, sibling or spouse.

1.10 Care of Obstetrical Patients

If a female patient presents to the Emergency Department (ED) who is at least at 20 weeks gestation:

- With a pregnancy-related complaint and she does not meet criteria for an OB Rapid Response or a Trauma Activation, she will be transferred to Obstetric (OB) Triage in the Women's Services Department for the performance of an assessment, monitoring, and a medical screening examination.
- Meeting criteria for an OB Rapid Response or a Trauma Activation, she will remain in the ED and the appropriate notification will be made to the OB Rapid Response Team and/or the Trauma Team.

Pregnant patients presenting to the ED with complaints that are not pregnancy related will be evaluated in the ED by an emergency physician and/or advanced practice professional.

If a female patient who is at least 20 weeks gestation requires admission to the medical center (inpatient or observation status), she will be admitted to the most appropriate location/service based on her clinical needs:

- If she is admitted to the Intensive Care Unit, she will be admitted to the service of the medical or surgical intensivist.
    - Once downgraded from the Intensive Care Unit, she will be transferred back to the service of her OB/GYN in the Women's Services Department (or the OB Hospitalist if unassigned) with the Hospitalists (medicine) following as consultants.

- If she presents as an activated trauma patient with an injury and is admitted for management of the injury and not solely for fetal monitoring, she will be admitted to the Trauma Service.
- Otherwise, she will be admitted to the service of her OB/GYN in the Women's Services Department (or the OB Hospitalist service if unassigned).

PART TWO: ADMISSION POLICIES

2.1 General Principles

2.1.1 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. 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.

2.1.2 Each patient in the hospital is assigned one attending physician. The attending physician is responsible for the primary care from admission through discharge.

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

2.1.4 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.

2.1.5 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, a History Physical Examination is required on each patient.

2.1.6 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.

2.1.7 Patients must be seen by the patient’s attending physician or his/her physician designee within 24 hours of admission, except for patients admitted to Critical Care Units, who must be seen within 12 hours. Patients must be seen sooner if clinical conditions warrant. 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. Advanced Practice Professional staff visits shall not suffice for physician rounding. The appropriate section or

department chairman is to be notified if a patient is not visited by the attending physician or physician designee within the designated time. If a patient's condition is sufficiently stable, the patient may be discharged without being seen on the day of discharge by the attending physicians.

2.1.8 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:

i. Admit patients on the day of their elective surgery or procedure or provide documented reasons of medical necessity for earlier admission.
ii. Facilitate, when possible, the appropriate pre-admission testing and medical clearance for elective surgical admissions.
iii. Cooperate with case management and/or Medical Directors of Care Coordination when issues or questions arise regarding necessity for admission, appropriate placement, and/or continued stay.
iv. Participate in appeal of outside denials if the denial is felt to be unjustified.

2.1.9 Any physician on the Medical Staff (with admitting privileges) may admit patients to the Intensive Care Unit or the Telemetry Unit if the patient meets admission criteria. If a member of the Medical Staff with privileges in Critical Care or Trauma Surgery is not the attending physician for a patient admitted to an Intensive Care Unit then a member of the Medical Staff with privileges in Critical Care must be consulted.

PART THREE: CONSULTATIONS

3.1 When Required

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 Physician-to-Physician Communication & Consultant Response Times

Direct physician-to-physician communication when requesting a consultation is optimal for enhancing efficiency, quality, and safety of patient care, and is strongly recommended for each and every consultation request. Routine consultations must be performed within 24 hours of the request. 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, or if it is expected that the consultant see the patient in less than 24 hours (including observation status patients). This applies to all patient care areas. 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 consultant physician's name. Routine consultation requests will be called at the time the consultation is ordered. 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.

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 telehealth 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.

3.3 Consultant Responsibilities

A satisfactory consultation includes a bedside examination of the patient as well as a review of the patient's medical 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.

3.4 Role of the Consultant's Advanced Practice Professional

All consultations performed by a Nurse Practitioner (NP) or Physician Assistant (PA) must be signed by the sponsoring physician or his/her designee within 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 may dictate the discussion and recommendations in the consultation note, however the sponsoring physician must sign the consult acknowledging the communication with the NP or PA occurred and the recommendations reflected in the consult note are accurate and reflect the opinion of the sponsoring physician.

3.5 Telehealth Consultations

Telehealth consultations must meet the needs of the patient as determined by the requesting physician. A telehealth consultation may consist of a remote review of the patient and/or electronic data images by the physician with bedside assistance from an Advanced Practice Professional.

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 an Advanced Practice Professional without the supervising physician seeing the patient before discharge if it meets the needs of the patient as determined by the requesting physician. The evaluation must be communicated to the supervising physician by the Advanced Practice Professional who should arrange appropriate follow-up for the patient, as indicated. The Advanced Practice Professional will communicate the findings and discharge follow-up plans to the attending/requesting physician.

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

3.6 Behavioral Health

Patients who have attempted suicide should be evaluated by behavioral health services.

PART FOUR: MEDICAL RECORD POLICIES

4.1 General

Medical Records are established and maintained for each patient who is treated or evaluated at the Medical Center. The Medical Record, including electronic data, medical imaging, and pathological specimens and slides, are the property of the Medical Center.

4.2 Purposes of the Medical Record

a. To serve as a detailed database for planning patient care by all involved practitioners, nurses, and ancillary personnel;
b. To document patients' 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; and
e. To assist in protecting the legal interest of the patient, Medical Center, and practitioners 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

Banner Health is a "paper light" organization. As such, physicians must 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 shall be accessed by physicians and other users online and the records will not be printed for internal use.

4.4 Use of the Electronic Medical Record

All Medical Record documents created after the patient is admitted will be created utilizing Banner Health approved forms or Banner Health electronic systems to allow for patient information to be exchanged and shared electronically among healthcare providers. This includes but is not limited to 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.

4.5 Copying and Pasting

Medical Staff members and Advanced Practice 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."

4.6 Access to the Electronic Medical Record

Authorized personnel shall have access to the Electronic Medical Record through Clinical Connectivity. All access to the Electronic Medical Record is tracked, and unauthorized access to a patient's record is prohibited. All members of the Medical Staff are participants in the Banner Health Organized Healthcare Arrangement (OHCA) and are required to follow Banner Health policies as to Protected Health Information (PHI) they generate or receive from Banner Thunderbird Medical Center including access for patient care, payment information, peer review, or other legitimate patient care activities.

4.7 Electronic Medical Record Training

Practitioners must be trained by Banner Health to use the Electronic Medical Record and Computerized Provider Order Entry (CPOE) system prior to being granted privileges on to the Medical Staff or the Advanced Practice Professional Staff. For reasons of patient safety all Practitioners must utilize the CPOE. Exceptions will be made on a case by case basis to be determined by the facility CEO or CMO. Members of the Medical Staff who consistently refuse to use the Electronic Medical Record and/or CPOE may be suspended or removed from the Medical Staff.

4.8 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 Health Records Retention Policy.

4.9 Confidentiality

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.

4.10 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.

4.11 Passwords

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

4.12 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.

4.13 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.

4.14 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.

4.15 Authentication / Endorsement

Documentation by Advanced Practice Professionals, including but not limited to History & Physical Examination Reports, Operative/Procedural Notes, Consultations, and Discharge Summaries, as well as all notes and orders generated by medical students, must be counter-authenticated timely by the supervising physician. Each clinical event

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

4.16 Legibility

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

4.17 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:

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.

4.18 History & Physical Examination (H&P)

a. An H&P must be performed within 24 hours after admission or registration 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 Advanced Practice Professional who is approved by the Medical Staff to perform admission H&Ps, 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.

b. A legible office H&P performed within 30 days 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.

c. The Obstetrical H&P will consist of the prenatal record, where applicable, updated in the Electronic Medical Record by the responsible physician or Advanced Practice Professional.

d. 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.

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

f. If approved by the Medical Staff, the Emergency Department Report or Consultation report may be used as the H&P as long as all of the required elements are included and the document is filed as an H&P in the Electronic Medical Record.

4.19 Responsibility for the History & Physical Examination

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 patients' H&Ps that relates to dentistry or podiatry, and, if authorized by the Medical Staff, may be responsible for the complete H&P.

4.20 Required Elements of the History & Physical Examination

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:

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.
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 H&P
k. Initial plan: statement of the course of action planned for the patient while in the Medical Center.

4.21 Behavioral Health Documentation

a. 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.

b. 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. 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.

c. 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.

    i. Physicians shall document abnormal diagnostic values and their response to such;
    ii. Consultants shall document, authenticate, time, and date all assessments, diagnostic tests, and treatments, etc. whenever they see a patient; and
    iii. All entries must be dated, timed and authenticated by the person making the entry and must include his/her discipline.

d. 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.

e. Discharge Documentation: Patients shall be discharged only on order of the attending physician.

    i. 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.
    ii. 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.
    iii. A category of disposition must be included in the discharge summary.

iv. 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.

v. 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.

vi. Against Medical Advice (AMA): Competent patients who choose to leave the hospital when the physician believes that continued evaluation and treatment is medically necessary. Patients leaving against the medical advice of a physician should, when possible, be provided with information from the physician to help them understand the risks associated with leaving against medical advice. Such conversations should be documented in the medical record.

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.

4.23 Perioperative Documentation

a. Pre-Operative Anesthesia/Sedation Evaluation

i. 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.

ii. 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.

iii. 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.

b. 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.

i. 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.

ii. 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.

iii. 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

iv. 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.

4.24 Consents

Prior to any operative/invasive procedures, the Medical Record must contain an informed consent.

a. 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:
   i. 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.
   ii. An explanation of alternatives, including material risks and benefits;
   iii. An explanation of the consequences if declining recommended or alternative treatments;
   iv. Disclosure of whether practitioners other than the operating practitioner, including residents, will be performing important tasks related to the Procedures.

b. The following require written informed consent:
   i. All surgical procedures (whether or not anesthesia is required);
   ii. Administration of anesthetic agents (e.g. general, regional, spinal and moderate sedation);
   iii. Invasive vascular procedures (e.g. central lines, subclavian catheters, peripherally inserted catheters (PICC lines). Excluded procedures include: venipuncture, peripheral intravenous lines, arterial sticks and/or intravenous, intradermal, subcutaneous or intramuscular injections and sutures.
   iv. Invasive procedures, whether or not performed in the surgical suite, including invasive diagnostics where there is more than a minimal risk (i.e. lumbar puncture, thoracentesis, EMG, electromyography, arteriogram, chest tube insertion and amniocentesis);
   v. All biopsies, whether or not performed in the surgical suite;
   vi. Cardiological procedures (e.g. cardiac catheterization, angioplasty, stress tests, elective cardioversions);
   vii. All procedures that require regional or general anesthesia;
   viii. Endoscopic examinations (e.g. bronchoscopy, sigmoidoscopy),
   ix. Source testing for HIV testing and to authorize the release of results (except in Arizona when a healthcare worker or a first responder has an occupational exposure) (See HIV Serologic Testing policy);
   x. Transfusions of blood and blood products including: Immunoglobulin Rhogam, Rapluylac;
   xi. Medical research including: all experimental or investigational treatments, research procedures or medications see Research: Informed Consent for Participation policy)
   xii. Autopsies;

xiii. Acupuncture;
xiv. Dialysis;
xv. Bronchiograms;
xvi. Lymphangiograms;
xvii. Maggot Debridement Therapy;
xviii. Myelograms;
xix. Nuclear Medicine Programs;
xx. Pneumoencephalograms;
xxi. Spleenograms;
xxii. Sterilization (with use of proper Consent form);
xxiii. Ventriculograms;
xxiv. Radiation Therapy;
xxv. Sharp Debridement of Wounds;
xxvi. Medications and/or other therapeutics with the potential for particularly severe side effects (e.g., chemotherapeutic agents, psychotropic medications, ECT, etc);
xxvii. Whenever specified by a treating Practitioner per order or required by Medical Staff rules and regulations.

c. Emergency Consents
Consent is implied in an emergency. An emergency is defined as a situation that exists if all of the following circumstances are met:
i. The person is in immediate need of medical attention;
ii. An attempt to secure consent would result in delay of treatment;
iii. Delay in treatment would increase the risk to the person's life or health; and
iv. 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 informed consent, exceed that which is necessary to remedy the condition creating the emergency.

4.25 Special Procedures

EEGs, EKGs, 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.

4.26 Discharge Documentation

a. 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. The discharge summary shall include:

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

b. 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.

c. Discharge Progress note shall include:
   i. Final diagnosis(es)
   ii. Condition of patient
   iii. Discharge instructions
   iv. Follow-up care required.

4.27 Home Health

When home health services or DME are 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:

a. Date and time of the face to face encounter;
b. The patient's clinical condition;
c. 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.

4.28 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.

4.29 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.

4.30 Amending Electronic Medical Record Entries

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 Electronic Medical Record. The Electronic Medical Record will track all changes made to entries.

Once an entry has been authenticated and an error is found, the Electronic Medical Record 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 Electronic Medical Record 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.

4.31 Amending 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.

4.32 Timely Completion of Medical Records

a. 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.
b. All Medical Record documents shall be completed within the timeframes indicated in the following table:

Documentation Requirement	Timeframe	Exclusions
Emergency Department 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	If Home Health or DME order occurred during hospital stay, the Home Health Face to Face Discharge documentation must be 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	

4.33 Medical Record Deficiencies

Physicians are advised of incomplete documentation by the Health Information Management Services Department which shall advise physicians~~,~~ by electronic notice of incomplete Medical Records. Notice of Incomplete Records will be sent after a qualifying deficiency has met or exceeded the timeframes indicated above. The notice will include a due date and where to find 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.

4.34 Medical Record Suspensions

A Medical Record is considered eligible for suspension/sanction based on the timeframes above.

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.

4.35 Continuous Temporary Suspension

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

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

If a Practitioner accumulates 45 days of temporary suspension in a Medical Staff Year (July 1 – June 30), the Chief of Staff or designee will contact the Practitioner.

4.36 Automatic Termination of Privileges for Delinquent Medical Records

Should a Practitioner accumulate 60 days of temporary suspension within a Medical Staff Year (July 1 – June 30), the Practitioner will be required to pay a fee of $500. All records must be completed, and such fee must be paid within 15 days of notification to the Practitioner. Once all delinquent records have been completed and the fee paid, the number of suspension days will reset to zero (0). Privileges will be suspended for Practitioners who do not complete all delinquent medical records and pay the reinstatement fee within 15 days of notification. Practitioners who do not complete all delinquent medical records and pay the reinstatement fee within 45 days of notification shall be deemed to have voluntarily resigned from the staff and, to regain membership and privileges, must reapply and pay the application fee to the CVO.

Should a Practitioner accumulate another 60 suspension days within one year of the first fine, the above process will be followed, but the reinstatement fee will be $1,000. In addition, he/she will be required to submit a letter of explanation and a plan of correction for review by the Medical Executive Committee. The Medical Executive Committee can determine further action, up to and including termination from the Medical Staff or Advanced Practice/Allied Health 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 the Bylaws.

PART FIVE: INPATIENT ORDERS

5.1 Orders

Orders may be generated only by providers with clinical privileges. BTMC seeks to facilitate timely and accurate execution of orders to deliver quality patient care, and to provide guidelines within which its Medical Staff, Advanced Practice Professional staff, nursing service, and employees can best accomplish this objective. Orders for treatment shall be dated, timed, and authenticated.

a. An admission order shall be documented by the attending (or covering) physician for all inpatient or observation patients.

b. Physician or Advanced Practice Professional orders are required for all tests, services, and procedures (except for standing orders and reflex testing).

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

d. Physician or Advanced Practice Professional 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 Advanced Practice Professional who is transferring the patient to a new level of care to review all active orders for clinical accuracy and appropriateness.

e. Physician or Advanced Practice Professional orders are required for transfer/transport a patient to another facility. For transfer/transport of an inpatient to another facility, the physician or Advanced Practice Professional must explain the risks and benefits of the transfer/transport and should ensure that the patient is assessed timely and appropriately prior to transfer/transport. For transfer/transport 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 Outpatient Medical Imaging Tests/Procedures

A signed order must be received prior to performing outpatient 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 Advanced Practice Professional licensed and credentialed within Arizona with prescriptive authority.

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.

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

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

c. 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.

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

5.4 Orders for Outpatient Tests

a. A signed, dated, and timed order must be received prior to performing outpatient procedures, tests, or services with exception of screening mammograms, cardiac scoring, or services provided to the community at large for direct access testing.

b. Outpatient Orders written prior to the patient's arrival (e.g., scheduled services) do not require a 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.

c. Orders for outpatient services are acceptable from BTMC Medical Staff, non-staff physicians, out of state physicians, and practitioners licensed with prescriptive authority (e.g. Advanced Practice Professionals).

d. 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 Advanced Practice Professional.

e. 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.

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 (NURSE) 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.

a. Verbal or telephone orders for chemotherapy and initial parenteral nutrition shall not be accepted. Chemotherapy dose modifications may be accepted.

b. Only physicians and authorized Advanced Practice Professionals are permitted to give telephone orders for inpatient services. Orders from office staff are not permitted.

c. Registered pharmacists are permitted to give telephone orders under physician-ordered pharmacotherapy consultations.

d. Nurses 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 disciplines. 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 Advanced Practice Professional.

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, family, and/or legal representative/surrogate.

PART SIX: GENERAL PHARMACY POLICIES

6.1 General Information

Pharmacy Services 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 Advanced Practice Professionals 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

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.

a. 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.

b. Medication samples will not be used for the management of patients at BTMC.

c. Outpatient prescriptions will not be filled by the BTMC inpatient Pharmacy.

d. BTMC Pharmacy Services performs clinical functions such as pharmacokinetics dosing and monitoring, therapeutic interchange, antimicrobial stewardship, anticoagulation monitoring and intravenous to enteral transition as approved by the Pharmacy and Therapeutic Committee.

e. 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 Advanced Practice Professional 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 patient-specific bin on the nursing unit. Medications brought in by patients that cannot be identified will not be administered by Medical Center personnel nor should they be taken by patients.

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" orders are permitted. 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

Physicians and Advanced Practice Professionals granted clinical privileges to prescribe medications may write orders for medications. 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:

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

c. Respiratory Care Practitioners (medications related to respiratory therapy treatments only).
d. Radiology Technologist and Nuclear Medicine Technologist (medications related to radiology/nuclear procedures only).
e. EEG Technician and Cardiovascular Technician (CVT) (oral medications only) and Anesthesia Technicians (medications related to EEG and Cardiovascular therapy treatments only).
f. Physical Therapist (topical medications only. Medications related to physical therapy treatments only)

PART SEVEN: GENERAL SURGICAL POLICIES

7.1 Assistants

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.

7.2 Specimens

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.

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:

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

b. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;

c. Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;

d. Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant;

e. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics.

7.3 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.

a. Laterality of all procedures will be verified and spelled out in its entirety on the consent form.

b. 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:

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

   ii. 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.

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

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

   v. Compliance with this policy will be monitored concurrently.

PART EIGHT: RESTRAINTS

8.1 General Guidelines

a. 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.

b. PRN or standing orders will not be accepted. Qualified Medical Center staff may initiate restraints or seclusion without an order by a physician or Advanced Practice Professional but must consult with the physician or Advanced Practice Professional as soon as possible thereafter to obtain the order.

8.2 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 Advanced Practice Professional is not available to write an initial order, restraints may be initiated and a telephone order may be given. The physician, Advanced Practice Professional ,or specially trained NURSE must perform face-to-face patient assessment within 24 hours.

Summary of Physician/Advanced Practice Professional 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 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.

Age related time limits for orders:

- Every four hours for patients 18 years of age or older.
- Every two hours for patients between the ages of 9 and 17 years of age.
- Every hour for children less than age 9.

8.3 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 Advanced Practice Professional is not available to write an initial order, the physician, Advanced Practice Professional, or specially trained NURSE 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/ Advanced Practice Professional 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 with each new order (at least every 24 hours):

Age related time limits for orders:

- Every four hours for patients 18 years of age or older.
- Every two hours for patients between the ages of 9 and 17 years of age.
- Every hour for children less than age 9.
- Every 24 hours and before writing new order, assess the patient.

PART NINE: ADVANCED DIRECTIVES AND END OF LIFE

9.1 General Guidelines

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 Banner Health Health Care Directives policy for further information).

9.2 Withdrawal of Life Support

a. Withdrawal of life support should occur in conjunction with best efforts to ascertain the wishes of the patient given the circumstances of his/her illness. If the patient is unable to make healthcare decisions and communicate the decisions 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 cannot 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.

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

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

d. All efforts should be undertaken to ensure that the patient does not suffer during withdrawal of life support. Analgesic and sedative medications should be administered when necessary in order to alleviate suffering. The doses used should be guided by direct observation of the patient. In general, doses should be sufficient to minimize pain, dyspnea, anxiety, and other symptoms that may accompany withdrawal of life support. (See Banner Health Policy Provision of Appropriate End of Life Care)

9.3 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 vital signs (BP, apical pulse, and respirations), and will document this in the nurses' progress notes. The nurse will place a call to the attending

physician and obtain a physician order to accept two nurses' assessment of the death if appropriate.

9.4 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. The attending physician (or designee) requests and obtains permission for an autopsy from the family or other recognized surrogate.

a. Autopsies are at no cost to the family under following circumstances:
   i. Deaths in which an autopsy would help explain unknown and unanticipated medical complications.
   ii. Deaths in which the cause is not known with certainty on clinical grounds.
   iii. 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.
   iv. Deaths occurring in patients who are at time of death, participating in clinical trials (protocols) approved by institutional review boards.
   v. Deaths resulting from high risk infectious and contagious diseases which have been waived by the Medical Examiner.
   vi. All obstetric deaths.
   vii. All neonatal and pediatric deaths.

b. A valid, signed consent is required for autopsy and must meet the following criteria:
   i. 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.
   ii. It must be witnessed by at least one person present at the time of signing.
   iii. Any exclusions (e.g. brain) or "none" must be noted on the autopsy consent form at the time of signing.
   iv. 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.

c. Preclusion of Autopsies
   In certain instances, patient advanced directives, physician preference, and family requests may preclude the performance of an autopsy. A pathologist may refuse to perform an autopsy under the following situations:

   i. The case meets the criteria of a Medical Examiner's case.
   ii. The case was waived by the Medical Examiner's office, but appears to have criminal and/or other legal implications.
   iii. The Consent for Autopsy appears to be invalid, incomplete, or questionable.

iv. 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. Creutzfeldt-Jakob Disease).
v. Autopsy fails to meet quality assurance or education criteria.

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

e. 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.

f. The pathologist may discuss the case with the attending physician. The attending physician may attend the autopsy.

PART TEN: STUDENT, INTERN, RESIDENT, AND FELLOW ROTATIONS

10. MEDICAL STUDENTS AND RESIDENTS

10.1. REGISTRATION

Allopathic, osteopathic, dental, and podiatric medical students, residents, and fellows rotating through the Medical Center must be registered and approved through the Banner Office of Graduate Medical Education (GME). Medical students and residents are not subject to the credentialing process outlined in the Medical Staff Bylaws, are not entitled to due process rights under the Medical Staff Bylaws and are not granted membership or clinical privileges.

Students from accredited schools in the United States or Canada in hospital-recognized programs for advanced practice professions, including physician assistant and advanced practice nursing (nurse anesthetist, neonatal nurse practitioner, and other nurse practitioner) ("NP/PA students") must be registered and approved through Banner's Health Careers Program. A contract is required to be entered with their schools.

The terms "NP/PA students," "medical students," "subinterns," "interns," "externs," "residents," and "fellows" are hereby referred to collectively as "medical trainees." Supervising physicians must notify the appropriate nursing director if medical trainees will be rotating in procedural areas (Operating Room, Endoscopy, Interventional Radiology, Labor & Delivery, Emergency Department, and Cardiac Catheterization Laboratory).

Supervising physicians will ensure that patients understand and agree that medical trainees will participate in their care and/or observe/participate in procedures.

Banner Thunderbird Medical Center does not have a formal GME program and will not assist in finding practitioners willing to precept medical trainees. It is the sole responsibility of the medical trainee to find a practitioner willing to participate in the GME program and assume accompanying responsibilities. Individual members of the Medical Staff may serve as the documented preceptor ("supervising physician/surgeon") for no more than four (4) medical trainees at once.

The rotation must be approved as an official rotation of the sponsoring educational institution. A contract with the sponsoring educational institution is required.

Only Medical Staff members with clinical privileges may precept medical trainees.

Medical trainees must successfully complete training on Banner's electronic medical record before the start of the assigned rotation. The GME Office and Health Careers Program will ensure that training is completed.

The faculty GME report of the quality and scope of activity of medical trainees submitted by the GME Office will be communicated to the Medical Executive Committee on a periodic basis.

10.2. CARE PROVIDED BY MEDICAL TRAINEES

Medical trainees provide care under the supervision of designated members(s) of the Medical Staff. Medical trainees may not provide patient care beyond the scope of privileges held by the supervising member of the Medical Staff.

Medical Staff members who supervise medical trainees are responsible for reviewing all notes, orders, histories, physicals, consultations, operative reports, discharge summaries, and all other patient care documentation. Medical Staff members must comply with the documentation requirements below.

Medical trainees may perform histories and physicals, assist with procedures, make rounds, and carry out other clinical and educational assignments as directed by the supervising physicians. Medical trainees may assist with evaluating patients in the Emergency Department, however this assistance does not relieve supervising physicians of the requirement to respond to the Emergency Department and evaluate patients as delineated by Article 1, Section 1.2 of these Rules & Regulations.

Performance of medical trainees will be evaluated by the supervising physician. Failure to satisfactorily perform assigned duties shall be reported to the Chief Medical Officer and to the sponsoring academic institution. In the event that medical trainees do not respond appropriately to directions, demonstrate misconduct, or commit actions which place patients at risk, the supervising physician, the chair of the appropriate clinical department, the Chief of Staff, the Chief Medical Officer, or the Chief Executive Officer may summarily terminate the rotation. The medical trainee has no review rights if such action is taken.

Decisions about progressive involvement and independence in specific patient care activities of medical trainees are the responsibility of the supervising physician and must not exceed upon the guidelines of the sponsoring educational institution. However, duties performed by medical trainees are in addition to and not substitutes for required responsibilities of members of the Medical Staff. Questions or concerns about the knowledge or skills of individual medical trainees should be directed to the supervising physician.

10.3. FELLOWS

Fellows shall be considered equivalent to residents (see 10.4 below) for the purposes of these Rules & Regulations, hospital policies, and the Medical Staff Bylaws unless they have applied for and been granted Medical Staff membership and clinical privileges.

10.4. RESIDENTS

Residents evaluate and treat patients only under the direction and supervision of a member of the Medical Staff with clinical privileges. The supervising physician assumes complete responsibility for the care rendered by the resident and must countersign, time, and date all dictations and medical record entries. Countersignature is to be made in the record within 24 hours. Supervising physicians must be physically present during the critical or key portions of all medical and surgical services provided by residents.[1]

10.4.1. Residents are allowed to:

10.4.1.1. Perform Histories and Physicals.

10.4.1.2. Scrub in and participate in surgery (and other procedures) at the discretion of the supervising surgeon after verification that resident understands and complies with aseptic technique and standard operating room etiquette.

10.4.1.3. Make entries in the medical record, including:

10.4.1.3.1. Operative and procedure notes.
10.4.1.3.2. Therapeutic and diagnostic orders.
10.4.1.3.3. Discharge summaries.
10.4.1.3.4. Progress notes.

Supervising physicians must personally document that they performed the service or were physically present during the critical or key portions of the service furnished by residents, and that they participated in the management of the patient.[2]

All procedures performed by the resident will be directly supervised by the supervising physician. In sterile areas, this means that the supervising physician must be scrubbed in at all times while the resident is scrubbed in, except as clarified below. Residents may not admit patients or function as supervising physicians.

Provided patient safety is assured, PGY-4 level (and more senior) residents of surgical training programs may, at the discretion of the supervising surgeon, remain scrubbed in while the supervising surgeon breaks scrub if:

- The "critical portions" (see below for definition) of the procedure have been completed; and
- The supervising surgeon:
    - Remains within the immediate vicinity, to explicitly include the main OR, PACU, pre-operative holding area, OR physician lounge, and the surgery waiting room;

[1] Page 3, Centers for Medicare and Medicaid Services, Guidelines for Teaching Physicians, Interns, and Residents, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf
[2] Page 7, Centers for Medicare and Medicaid Services, Guidelines for Teaching Physicians, Interns, and Residents, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf

- Is not scrubbed into another surgical case; and
- Is immediately available.

The supervising surgeon's responsibility cannot be delegated. The supervising surgeon must be an active participant throughout the key or critical components of the operation. The overriding goal is the assurance of patient safety.[3]

The critical portions of an operation, as defined by the American College of Surgeons[4], are those segments of the operation where essential technical expertise and surgical judgment are required in order to achieve an optimal patient outcome. For the purposes of these Rules & Regulations, the critical portions begin at the Time Out and initial incision and continue until the point at which all that remains to be completed is closing surgical incisions and establishing/securing drainage equipment.

10.5. MEDICAL STUDENTS

Medical Students must be under the direction and supervision of a member of the Medical Staff at all times.

10.5.1. Medical students are allowed to do the following in conjunction with the supervising physician if permitted by the sponsoring educational institution:

10.5.1.1. Perform Histories and Physicals. An H&P performed by a medical student does not take the place of an H&P performed and documented by a supervising physician.

10.5.1.2. Scrub in and participate in surgery (and other procedures) at the discretion of the supervising surgeon, only after completing an orientation by the supervising surgeon and/or OR personnel.

10.5.1.3. Document progress notes in the medical record.

Medical students may not dictate or document operative notes or discharge summaries. All procedures performed by medical students must be directly supervised by the supervising physician. In sterile areas, this means that the supervising physician must be scrubbed in at all times while the medical student is scrubbed in. All medical record entries will be co-signed, timed, and dated by the supervising physician at the time they are completed.

10.6. NP/PA STUDENTS

NP/PA students must be under the direction and supervision of a member of the Medical Staff and/or a member of the Advanced Practice Professional Staff (NP/PA).

[3] Statement on Principles, American College of Surgeons, https://www.facs.org/about-acs/statements/stonprin
[4] Statement on Principles, American College of Surgeons, https://www.facs.org/about-acs/statements/stonprin

10.6.1. NP/PA students are allowed to do the following in conjunction with the supervising physician/NP/PA if permitted by the sponsoring educational institution:

10.6.1.1. Perform Histories and Physicals. An H&P performed by an NP/PA student does not take the place of an H&P performed and documented by a supervising physician/NP/PA.

10.6.1.2. Scrub in and participate in surgery (and other procedures) at the discretion of the supervising surgeon, only after completing an orientation by the supervising surgeon and/or OR personnel.

10.6.1.3. Document progress notes in the medical record.

NP/PA students may not dictate or document operative notes or discharge summaries. All procedures performed by NP/PA students must be directly supervised by the supervising physician/NP/PA. In sterile areas, this means that the supervising physician must be scrubbed in at all times while the NP/PA student is scrubbed in. All medical record entries will be co-signed, timed, and dated by the supervising physician/NP/PA at the time they are completed.

PART ELEVEN: AMENDMENT & ADOPTION

11.1 Amendment

This document may be amended or repealed, in whole or part, by a resolution of the Medical Executive Committee recommended to and adopted by the Board.

11.2 Adoption

Adopted and recommended to the Banner Health Board of Directors by the Medical Executive Committee of Banner Thunderbird Medical Center as indicated in the table on the cover page.