BANNER/UNIVERSITY MEDICAL CENTER—TUCSON CAMPUS
MEDICAL STAFF RULES AND REGULATIONS

ARTICLE I. GENERAL

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

1.2 Availability - Physicians with patients in the hospital must be readily accessible by pager or cell phone or have delegated responsibilities to physicians with similar privileges who must be readily accessible. Emergent call and/or critical result call to a treating physician must be answered within 20 minutes of the call; failure to respond may be subject to disciplinary action by the Medical Executive Committee and Department committee.

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

1.4 Responsibility for Extenders – Physicians are responsible for their physician extenders. Physician must review their extender's orders, notes and treatment and must document concurrence in the patient's record. History and physical examinations performed by Housestaff physicians shall be documented and co-signed by an attending physician or the medical record shall contain a progress note by an attending physician within 24 hours of admission. Progress notes shall reflect collaboration between the supervising physician and Housestaff, Affiliate staff, and other authorized health professionals as appropriate. Dictated operative and procedure notes and dictated or handwritten discharge summaries shall be signed by the responsible attending physician.

1.5 Emergency Department Call - Physicians serving on the call roster of the Emergency Room are responsible to cover their call or assure coverage by a Medical Staff member with appropriate privileges, and to notify the Physicians Resource Service of any changes prior to any changes being made. (See BUMC Emergency Department On-Call Policy and Procedure).

1.6 Research - All research being conducted at, sponsored by, or otherwise affiliated with BUMC facilities and Medical Staff must be in compliance with current Banner Health policies.

1.7 Disclosure of Unanticipated Outcomes - It is the policy of Banner Health that patients, their legally authorized representative, and when appropriate, their families be informed about the outcomes of care including unanticipated outcomes. The responsibility for disclosure is a collaborative effort between the physician, Administration, QM and Risk Management and disclosure shall be made in accordance with the Banner Health Disclosure of Unanticipated Outcomes Policy. At the time of the unanticipated outcome, physician shall objectively document the facts known about the unanticipated outcome in the patient's medical record, including the medical care provided in response to the outcome and the plan of treatment. The discussion of the unanticipated outcome with the patient/legally authorized representative/family shall be documented in the medical record. This documentation shall include the time, date and place of the discussion, the names and relationships of those present, a summary of the information provided and questions answered, and any offer of assistance and the response to it.

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 admitted at the Medical Center absent an emergency or the unavailability of another practitioner with similar privileges.

1.10 Termination of Pregnancy: In emergency situations in which surgery or treatment involves the termination of a known or suspected pregnancy, the attending physician or certified nurse midwife must inform the OB/GYN Department Chairman or his/her designee prior to carrying out the surgery or treatment. The Chairman/designee will confirm notification by note in the patient's medical record at the earliest opportunity.

1.11 Influenza Vaccination: Prior to December 1 of each year, each Medical Staff member will submit to the Medical Staff Office a written statement that verifies that the member has received a current, CDC-approved influenza vaccination for the then-upcoming influenza season. The only exceptions shall be for religious or medical reasons as approved by the Banner Health Occupational Health Service.

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

ARTICLE II. ADMISSION POLICIES

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

been duly appointed to membership on the Medical Staff or have been granted temporary privileges.

2.2 Each patient in the hospital is assigned one attending physician or one certified nurse midwife with appropriate privileges to manage and coordinate the patient's care, treatment and services. The attending physician or certified nurse midwife is considered the primary practitioner and is responsible for the primary care from admission through discharge.

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

2.4 Patients who present to the Emergency Department requiring admission or follow-up will, whenever possible, be assigned to: (a) the physician with whom the patient has an existing physician-patient relationship with a physician on the Medical Staff; (b) the physician on the Medical Staff requested by the patient; (c) a physician on the Medical Staff contracted with the patient's managed care plan; or (d) the on-call physician.

2.5 Physicians on ED call are responsible for patients on whom they are appropriately consulted by the ED physician or attending physician admitting a patient who has been transferred from another ED. If the patient needs additional consults or to be transferred, it is the on-call physician's responsibility to arrange the care needed. The scheduled on-call physician shall take responsibility for an appropriately referred patient with an emergency medical condition, regardless of the patient's ability to pay or identity of the third party payor.

2.6 The ED Physicians remain responsible for patients seen in the ED. Care of patients admitted from the ED is the responsibility of the appropriate attending when the decision is made to admit the patient, regardless of whether the patient remains in the ED.

2.7 When a patient is discharged from the ED, he/she will be referred to his/her personal physician for follow up care. If no personal physician is identified, he/she will be given the phone number of the appropriate physician on call to arrange follow up.

2.8 When an admitted patient is discharged, the consulting specialty is responsible for making follow up appointments in the appropriate clinics prior to discharge. If an admitted patient has a prolonged stay beyond the time the consultant is involved in care, the consulting team will provide an appointment time or assist the primary care team in contacting the consulting service to facilitate scheduling of an appointment.

2.9 On-call responsibility includes the follow up care of those patient referred. The on-call physician is responsible for taking care of the patient's acute problem and any follow up necessary but not for care not associated with the initial problem. A patient cannot be refused because of insurance plan or inability to pay. All physicians are responsible for notifying staff of his/her on-call responsibility. An OB patient may not be discharged without provisions for definitive follow up prenatal care.

2.10 If the patient's physician and/or scheduled on-call physician fails to respond timely, the emergency physician shall attempt to find a substitute physician. If no substitute physician is reasonably available, either the Chief of Staff or the Chief of the Emergency Service shall declare that particular service "not available."

2.11 Patients admitted for dental service must be admitted by a Medical Staff physician. A Medical Staff physician is responsible for the care of any medical problem that may be present or arise during hospitalization. As in all cases, a History and Physical is required on each patient.

2.12 Except in an emergency, no patient shall be admitted to the Medical Center until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible. (For the purpose of these Rules and Regulations, the term "emergency" may be applied to any patient whose condition is such that any delay

occasioned by compliance with any of these Rules and Regulations might prejudice the physical welfare of the patient.)

2.13 Patients must be seen by the patient's attending physicians or their physician designees:
2.13.1 Patients admitted to Critical Care status—within 6 hours;
2.13.2 Patients admitted to Telemetry status—within 16 hours;
2.13.3 All others—within 24 hours.
Patients must be seen sooner if their condition warrants physician intervention. Patients must be seen daily thereafter by a physician or nurse practitioner, or more often if the patient's condition warrants. The appropriate chairman and the Professional Review Committee are to be notified if a patient is not visited as required within the designated time following admission and daily thereafter.

2.14 In the management of any admission, it is the attending physician's responsibility, as stated in 2.2-1(d) of the Bylaws of the Medical Staff, to utilize medical resources efficiently. This may involve activities listed below which are commonly needed in accomplishing the utilization management goals of the Medical Center and its Medical Staff.
2.14.1 Admit patients on the day of their elective surgery or procedure or provide documented reasons of medical necessity for earlier admission.
2.14.2 Facilitate, when possible, the appropriate pre-admission testing and medical clearance for elective surgical admissions.
2.14.3 Cooperate with physician advisors when issues or questions arise regarding necessity for admission or continued stay.

2.15 Participate in appeal of outside denials if the denial is felt to be unjustified. It is the goal of the Medical Center that patients are cleared for discharge by 11:00 a.m. whenever possible.

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

ARTICLE III. CONSULTATIONS

3.1 Consultation is to be used in cases that require evaluation, treatment, or procedures of a specialized nature. It is expected that providers will exercise professionalism when requesting consults; a "just say yes and thank you" mentality must be promoted and no consult request should ever be denied.

3.2 It is expected that both the requesting and the consulting team will communicate with each other promptly in a respectful and courteous manner to promote collaboration and to provide the highest quality of care delivered to patients in the medical center.

3.3 Attending to attending communication is strongly encouraged.

3.4 The attending physician of the consulted service or their licensed designee will respond to all requests for consultations and will initiate a consultation within the following timeframes. The urgency of the consult will be determined by the requesting service and should be predicated on the patient's condition and the need for consultant care. The attending and the service requesting the consult must be clearly communicated:
3.4.1 Emergency consult: < 1 hour
3.4.2 Urgent consult: 1 – 12 hours
3.4.3 Routine consult: 24 hours or within the next calendar day
3.4.4 Procedure-only consult: within 24 hours by resident or fellow. Must be seen by attending at least just prior to time of procedure.
3.4.5 All Emergency Department (ED) consults are considered Emergent or Urgent as determined by the ED attending.
a. Emergency ED consults should be responded to within 1 hour.

b. Urgent ED consults should be responded to within 2 hours.
c. If the consulting service is unable to respond to the ED consult request within these timeframes due to competing clinical demands the attending or licensed physician designee should call the ED physician as soon as possible and discuss situation by phone.
d. Direct verbal communication between the consulting team and the ED attending is expected immediately upon completion of the consult and a plan of care communicated to the requesting team. The plan of care can be communicated through an interim note until formal consultation is completed.

3.4.6 Patients whose discharge depends on the consult will be communicated as such and considered urgent.

3.5 Consultation is encouraged for all seriously ill patients or for those whose medical problem is not within the scope of practice of the attending physician. Each department may establish its own consultation requirements subject to approval by the Medical Executive Committee.

3.6 If appropriate consultation is not sought by the attending physician, the CMO, the Chief of Staff or the Professional Review Committee Chairman should be contacted. If the CMO, Chief of Staff or the Professional Review Committee Chairman concur that a consultation should be sought for optimum patient care, the attending physician will be contacted. If the attending physician refuses or fails to obtain the consultation, the Chairman of the appropriate department will be contacted. Where the chair concurs that consult is warranted, he/she shall contact the attending physician with the recommendation for consultation in the care of his/her patient. If the attending physician refuses to seek appropriate consultation, the Chairman of the appropriate department or the Professional Review Committee Chairman may request such consultation. The attending physician may proceed without consultation in emergencies, when delay to obtain consultation would endanger the life of the patient.

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

3.8 When operative procedures are involved, the consultation shall be recorded prior to the operation (except in an emergency). The consultant shall make and authenticate a record of his/her findings and recommendations in every case.

3.9 Consultations must be rendered and electronically recorded or dictated within 24 hours of notification for situations that are not considered imminently serious or potentially life-threatening. Every effort should be made to coordinate orders between multiple consultants and the attending physician. The primary service of the attending physician will coordinate orders unless he/she specifies differently.

3.10 Any patient being evaluated in the emergency department or has been admitted and who is known or suspected to be suicidal or any patients who attempt suicide while in the Medical Center shall have a consultation/evaluation by a psychiatrist, psychologist, or trained behavioral health professional who is a member of the Medical Staff or Allied Health Staff. The consultation must be completed within 24 hours.

3.11 If a behavioral health consultation is requested prior to discharge, the physician must contact Behavioral Health Services directly.

ARTICLE IV. HOUSESTAFF

4.1 Physicians supervising the Housestaff are responsible for care rendered by Housestaff.

4.2 On elective cases, Housestaff may start the case in the operating room once the attending surgeon is present. In life-threatening cases, the Housestaff may start a case before the attending surgeon is present.

4.3 Attending surgeons must remain in the Medical Center until the patient is stable out of the operating room or until the responsibility for the patient has been assumed by another attending physician.

ARTICLE V. CALL RESPONSIBILITIES

5.1 Call Schedule. The hospital will maintain an on-call schedule/specialty that will include all appropriate Active Staff physicians and Provisional Active Staff physicians (in accordance with Section 4.6.2). Physicians over the age of sixty-five who have taken call for the previous ten consecutive years have the option of not taking call. Each service/specialty may make recommendations about the operation of the on-call schedule, as it pertains to its physicians. The on-call schedule shall be revised (monthly) and posted thirty days before it becomes effective. The call schedule may be amended as necessary with at least thirty days' notice. A physician may not be forced to take a different or additional day of call with less than thirty days' notice.

5.2 Frequency of Call Duty. The schedule will provide approximately equal numbers of on-call days for each physician apportioned approximately evenly between weekdays and weekend/holidays. Disputes regarding the call schedule will be decided by the Chief of Service, with possible appeal to the Chief of Staff. In services/specialties with two or less, the schedule will reflect call duty for only one-third of the month per physician. Upon application from a specialty group for exemption from this provision, the MEC may, upon petition and good cause, grant exception to this requirement upon application of a different schedule that is acceptable to the hospital staff.

ARTICLE VI. MEDICAL RECORD POLICIES

A. General Rules

6.1 General

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

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

6.2.1 Purpose of the Medical Record - The purposes of the medical record are:

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

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

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

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

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

6.3 Copying and Pasting - Medical Staff members, Allied Health Professionals may not indiscriminately copy and paste documentation from other parts of the applicable patient's records. If copying a template, the practitioner shall make modifications appropriate for the patient. If copying a prior entry, the practitioner shall make appropriate modifications based upon the patient's current status and condition. The practitioner must reference the date of a prior note as appropriate. When copying patient data into the medical record from another provider, the practitioner must attribute the information to the person who performed the task unless it is readily apparent, based upon the nature of the information copied, that the data 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."

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

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

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

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

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

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

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

6.8 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 Records Retention Policy.

6.9 Confidentiality of Patients' Medical Records - The medical records are confidential and protected by federal and state law. Medical record access to confidential materials by authorized individuals is only permissible when access is sought for patient care, payment, peer review, risk management, approved research, or other appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored. In addition,

Banner Health safeguards patients' records against unauthorized disclosure and/or use, loss, defacement, and tampering. Unauthorized access or disclosure of confidential patient information or tampering, loss or defacement of medical records constitutes grounds for disciplinary action.

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

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

6.12 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.

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

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

6.15 Counter-authentication (Endorsement)

6.15.1 Physician Assistants- History and Physical Reports, Operative/Procedural Notes, Consultations and Discharge Summaries must be counter-authenticated timely by the physician. Each clinical event must be documented as soon as possible after its occurrence.

6.15.2 Nurse Practitioners- Discharge Summaries must be counter-authenticated timely by the physician. Counter authentication is required for inpatient observation and extended recovery orders.

6.15.3 Medical Students-

6.15.3.1 Any and all documentation must be countersigned or counter-authenticated timely by the physician.

6.15.4 Housestaff, Resident, and Fellows- Requirements for countersignatures will be established and monitored by specific training programs. Each clinical event must be documented as soon as possible after its occurrence. The Health Information Management Services Department does not monitor countersignatures by Housestaff, Resident or Fellows. Appropriate action will be taken by the specific training programs.

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

B. Medical Record Content

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

and facilitate continuity of care. The medical record is sufficiently detailed and organized to enable:

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

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

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

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

6.17.5 Accurate coding diagnosis in response to coding queries.

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

6.18.1 A legible office history and physical performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. 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.

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

6.18.3 The Emergency Room Report or Consultation report may be used as the H&P as long as all the elements in section 4.19 are included and the document is filed as a History and Physical on the EMR.

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

6.19 Responsibility for H&P – The attending medical staff member is responsible for the H&P, unless it was already performed by the admitting medical staff member. H&Ps performed prior to admission by a practitioner not on the medical staff are acceptable provided that they are updated timely by the responsible physician. Dentists and podiatrists are responsible for the part of their patients' H&P that relates to dentistry or podiatry.

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

6.20.1 Medical history

6.20.2 Chief complaint

6.20.3 History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status

6.20.4 Relevant past medical, family and/or social history appropriate to the patient's age.

6.20.5 Review of body systems.

6.20.6 A list of current medications

6.20.7 Any known allergies including past medication reactions and biological allergies

6.20.8 Existing co-morbid conditions

6.20.9 Physical examination: current physical assessment

6.20.10 Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination

6.20.11 Initial plan: Statement of the course of action planned for the patient while in the Medical Center.

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

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

6.22 Progress Notes - Progress notes should be electronically created with a frequency that reflects appropriate attending involvement but at least every day. Exceptions may be given to an obstetrical patient that has a discharge order entered from the day before or for a patient admitted to a psychiatric unit. Progress notes should describe not only the patient's condition, but also include response to therapy.

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

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

6.24 Pre-Operative, Intraoperative & Post Anesthesia/Sedation Record for General, Regional or Monitored Anesthesia

6.24.1 Pre-Operative Anesthesia/Sedation Evaluation – A preanesthesia/sedation evaluation must be conducted and documented by an individual qualified to administer anesthesia or conscious sedation within 48 hours prior to the procedure. A pre-anesthesia/sedation evaluation of the patient must include review of the medical history, including anesthesia, drug and allergy history; review and examination of the patient; notification of anesthesia risk (per ASA classification); identification of potential anesthesia problems, particularly those that suggest potential complications or contraindications; additional pre-anesthesia as applicable; and development of the plan for anesthesia care, including type of medications for induction, maintenance, and post-operative care and discussion with the patient of risks and benefits. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before pre-operative medication has been administered. Immediately prior to the induction of anesthesia while the patient is on the procedural table, the patient's vital signs, airway and response to pre-procedure medication must be assessed and the equipment checked.

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

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

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

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

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

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

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

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

6.27 Consents – Prior to any operative/invasive procedures, the medical record must contain an informed consent except in an emergency. Properly executed informed consent for procedures and treatments is documented in the medical record in accordance with hospital policy. Members of the Medical Staff or authorized Allied Health Professional must obtain a patient's informed consent by discussing with the patient or his/her Legally Authorized Representative adequate information about the Procedures so that an informed decision can be made, including:

6.27.1 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;

6.27.2 An explanation of alternatives, including material risks and benefits;

6.27.3 An explanation of the consequences if declining recommended or alternative treatments;

6.27.4 Disclosure of whether practitioners other than the operating practitioner, including residents, will be performing important tasks related to the procedures.

6.27.5 The following procedures require written informed consent:

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

xii. All autopsies.

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

6.28.1 The person is in immediate need of medical attention;

6.28.2 An attempt to secure express consent would result in delay of treatment;

6.28.3 Delay in treatment would increase the risk to the person's life or health; and

6.28.4 The person has not refused this emergency medical treatment at a time when he/she had decisional capacity.

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

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

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

The discharge summary shall include:

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

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

Final Discharge Progress note should include:

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

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

6.32 Documentation for Inpatient Transfers to another facility– The transferring physician must dictate or electronically create a transfer summary regardless of length of stay to include documentation that patient was advised of risks/benefits of transfer at the time of transfer but no later than 24 hours thereafter.

6.33 Amending Medical Record Entries

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

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

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

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

C. Timely Completion of Medical Records

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

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

Documentation Requirement	Timeframe	Exclusions
Emergency Room Report	Documented within 24 hours of discharge/disposition from the ED	
Admitting Progress Note	Documented within 24 hours of admission	
History & Physical	Documented within 24 hours of admission and before invasive procedure	
Consultation Reports	Documented within 24 hours of consultation	
Post op Progress Note	Documented immediately post-op when there is a delay in the availability of the full report	
Provider Coding Clarification	Documented within 7 days of notice	
Operative Report	Documented immediately post-op and no later than 24 hours after the procedure.	
Special Procedures Report	Documented within 24 hours of notice	

Discharge Summary Report	Documented at the time of discharge but no later than 24 hours after discharge.	Not required on all admissions less than 48hrs, or for Normal vaginal deliveries and normal newborns
Discharge Progress Note	Documented at the time of discharge but no later than 24 hours after discharge all admissions less than 48hrs or for normal vaginal deliveries and normal newborns	
Death Summary Death Pronouncement Note	Documented at the time of death/disposition but no later than within 24 hours after death Completed at the time the patient is pronounced within 24 hours	
Transfer Summary	Documented at the time of transfer no later than 24 hours	
Home Health (Face to Face Discharge Documentation)	Completed within 30 days of discharge	
Signatures	Authentication of transcribed or scanned reports and progress notes, within 7 days from the date of notice	
Verbal Orders	Dated, time and authenticated within the timeframe specified by state regulation Arizona = 72 hours	
Psychiatric Evaluation	Documented within 24 hours of admission	

6.36 Medical Record Deficiencies –The Health Information Management Services Department shall advise physicians, by fax, mail or electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has met or exceeded the timeframes in section 6.35. The notice will include a due date and a list of all incomplete and delinquent medical records.

6.37 Medical Record Suspensions/Sanctions - A medical record is considered eligible for suspension/sanction based on the timeframes in section 6.35. The Health Information Management Services Department shall advise physicians, by phone**,** fax, mail or electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has met or exceeded the timeframes in section 6.35. The notice will include a due date and a list of all incomplete and delinquent medical records. If a vacation prevents the practitioner from completing his/her medical records, the physician must notify the Health Information Services Department in advance of the vacation; otherwise the suspension will remain in effect until the delinquent documentation has been 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. Request for deferment from suspension may be granted by the Chief of Staff, CMO, CEO or his/her designee. If the delinquent records are not completed timely, providers will receive a notice and their admitting and surgical/procedure scheduling privileges will be temporarily suspended until all medical records are completed. A suspension/sanction list will be generated weekly and made available to the Executive Committee, Department Chairs, Administration, Medical Staff Services, Patient Registration, Patient Placement, Emergency Department, Cardiology, Inpatient and Outpatient Surgery areas.

Physicians who are suspended may treat patients already admitted, patients already scheduled for surgery, and emergency admissions. Emergency Department physicians and hospitalists will not be scheduled if on suspension. If records have not been completed within 48 hours following institution of suspension, all privileges, except for privileges to treat life-threatening emergencies will be suspended. When medical records are completed, suspension will be terminated.

6.38 Permanent Suspension shall become automatic permanent suspension if records are not completed within 30 days of notification of suspension or following 60 cumulative days of suspension. At that time, the practitioner's privileges will automatically move to permanent suspension for failure to complete medical records. The Chief of Staff will provide notice of pending permanent suspension to physicians who have not completed records within two weeks of suspension. Affected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if, all delinquent records have been completed. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff. In order to reinstate staff privileges, the practitioner will be required to reapply for medical staff membership and pay the reapplication fee. 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. Physician may submit evidence demonstrating why the suspension/revocation is unwarranted to the Medical Executive Committee pursuant to Article 6.8 of the Bylaws. Permanent suspensions will be reported to the applicable licensing/certification board if required by law.

ARTICLE VII. PHYSICIAN ORDERS

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

- 7.1.1 An admission order shall be documented by the attending/consulting or covering physician for all inpatient or observation patients, and extended recovery.
- 7.1.2 Physician or Allied Health Staff (NP's, PA's) orders are required for all tests, services and procedures.
- 7.1.3 Transfer of a patient's care to another physician must be documented via a physician order.
- 7.1.4 Physician orders are required for transfer of a patient to a different level of care within the facility. It is the responsibility of the physician who is transferring the patient to a new level of care to review all active orders for clinical accuracy and appropriateness.
- 7.1.5 Physician orders are required for transfer/transport a patient to another facility. For transfer/transport of an inpatient to another facility, the physician must explain the risks and benefits of the transfer/transport and should ensure that the patient is assessed for stability and clinical needs prior and subsequent to transport. For transfer of an inpatient to another Medical Center for acute inpatient medical services, the physician must also converse with the accepting physician to ensure continuity of care.

7.1.6 Orders for inpatients and orders for invasive outpatient procedures may be generated only by members of the medical staff with medical staff privileges or by Allied Health Staff (NP's, PA's) according to their scope of practice.

7.2 Orders for Surgery

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

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

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

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

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

7.3 Orders for Outpatient Diagnostic Tests

7.3.1 Orders for outpatient diagnostic services are acceptable within their scope of practice from Medical Staff members, non-staff physicians, out of state physicians and those licensed within Arizona with prescriptive authority (PAs and NPs). Practitioners ordering the services must be responsible for the care of the patient.

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

7.3.3 A statement of the reason for the test and/or diagnosis must be indicated on the order and it must also be authenticated and dated by a physician or Allied Health Professional licensed within Arizona with prescriptive authority (PAs and NPs).

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

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

7.3.5 Document the Allow Natural Death status. Physicians will sign the Allow Natural Death telephone order upon their next visit and document the reasons even though the patient may have already expired.

7.4 Verbal and Telephone Orders

7.4.1 Verbal (face to face) orders are not acceptable except in the case of an emergent situation. Verbal orders will be accepted only by a registered nurse (RN), Licensed Respiratory Care Practitioners (RCP), registered pharmacists, speech therapists and dieticians can accept verbal orders provided the orders are directly related to their specialized discipline. Only physicians and authorized allied health professionals are permitted to give telephone orders for inpatient services. Office staff members are not permitted to give telephone orders.

7.4.2 Registered Banner Health pharmacists are permitted to give telephone orders under physician ordered pharmacotherapy consultation.

7.4.3 RNs are permitted to accept telephone orders on nursing units. Registered pharmacists, Occupational Therapists, Physical Therapists, Registered Dietitians, Speech Therapists and Respiratory Care Practitioners (RCPs) can accept telephone orders directly related to their specialized discipline. All telephone orders must be read back to verify accuracy

and signed by the receiving individual. Telephone orders will be authenticated by the responsible physician.

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

7.5 Allow Natural Death Orders

7.5.1 Allow Natural Death orders are entered in the patient's medical record and authenticated, timed and dated by the attending physician or a resident physician acting in consultation with the attending physician. The attending physician must authenticate any "Limitation of Medical Treatment Order" written by a resident within 24 hours of the order. A properly documented Allow Natural Death order should include the physician's medical reasons for the order and his/her discussion with the patient's family, or with the patient. This should be documented in the progress note. In addition, the attending physician must sign the order within 24 hours of the order if the order was completed by a resident.

7.5.2 Telephone Allow Natural Death orders are discouraged. However, if Allow Natural Death orders must be placed by telephone, the RN taking the order will have a witness on the telephone to verify and document the Allow Natural Death status. Physicians will sign the Allow Natural Death telephone order upon their next visit and document the reasons even though the patient may have already expired.

ARTICLE VIII. GENERAL PHARMACY POLICIES

8.1 General Information - All medication administered to patients at the Medical Center will be supplied by the Department of Pharmacy Services unless otherwise defined by policy or by pharmacy approval. The Department of Pharmacy Services maintains a formulary as authorized by the Infection Control/Pharmacy & Therapeutics Committee (IC/P & T Committee). The formulary is an established compendium of approved medications available at the Medical Center for diagnostic, prophylactic, therapeutic or empiric treatment of patients. The pharmacy is not required to stock more than one brand of an individual medication as approved by the IC/P & T Committee. Medications ordered by trade name may not necessarily be filled by that name unless the physician states "do not substitute" within the order. The pharmacy will be permitted to make therapeutic substitutions of medications only within clearly defined parameters established by the IC/P & T Committee and approved by the Executive Committee. Medication samples may not be used or stored in any area of the Medical Center unless the use is approved by pharmacy per system policy.

8.2 Medications – Patients are discouraged from bringing medications into the Medical Center. Patients may not use their own medications unless the Pharmacy Department cannot supply the medication. The only exceptions to this would be those listed in policy (Medications Brought in by the Patient).

8.2.1 These medications will be loaded in the automated dispensing machine(s) for administration to the patient. Medications may be kept at the patient's bedside for self-administration (i.e. inhalers) only upon specific written orders of the physician.

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

8.2.3 Outpatient prescriptions will not be filled at BUMC.

8.3 Medication Orders

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

8.3.2 Only standard abbreviations can be used. See Banner Health Medication Orders Policy for list of abbreviations that may not be used. Medication dosages should be expressed in the metric system and a leading zero must always precede a decimal expression of less than one (i.e., 0.1 mg not .1 mg). A terminal or trailing zero is never to be used

after a decimal (e.g., 1 mg never 1.0 mg). There must be documentation of medical necessity or clinical indications in the medical record for all medication orders.

8.3.3 There will be no automatic stop order except for those medications defined by the IC/P & T 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.
All medication orders must be reviewed when a patient is transferred from one medical service to another, to or from Intensive Care Units and pre- and post-surgery. The prescriber must indicate which medications should be continued, held or discontinued. All medication orders which were entered prior to invasive surgery must be reviewed post-op and the prescriber should indicate whether to continue, hold or discontinue the medications.

8.4 Pharmacy Review - All medication orders must be reviewed by a pharmacist prior to the administration of the drug unless: A physician controls the ordering, preparation, and administration of the drug, such as in the OR, Endoscopy suite; or the ED; or, in emergency situations in which the clinical status of the patient would be significantly compromised by the delay that would result from the pharmacy review. Any problems or questions concerning a medication order must be resolved by the pharmacist in direct contact with the prescriber. Nursing personnel may be consulted, but shall not be used as an intermediary with the prescriber in the final resolution of those questions. The pharmacist must contact the prescriber directly.

8.5 Pharmacy Dosing and Changes - If the pharmacist is requested by the prescriber to dose the medication, or make any changes in the original medication orders, the pharmacist involved is responsible for entering the revised order into the patient's medical record.

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

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

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

8.8.1 Physician, including housestaff officers.

8.8.2 Physician Assistant, Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Certified Registered Nurse Anesthetist. Administration of chemotherapeutic agents can only be performed by nurses certified in chemotherapy.

8.8.3 Respiratory Care Practitioners, Levels 1, 2, 3 & 4 (medications related to respiratory therapy treatments only).

8.8.4 Respiratory Care Coordinator, Supervisor and Education Coordinator (medications related to respiratory therapy treatments only).

8.8.5 Respiratory Technical Specialists (medications related to respiratory therapy treatments only).

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

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

8.8.8 Physical Therapist (Topical medications related to physical therapy treatments only).

8.8.9 Students under direct supervision of a preceptor from number 1 through 8 above.

8.9 Reporting Adverse Drug Events - All adverse drug events shall be reported using the approved system as per BUMC Pharmacy policy.

ARTICLE IX. GENERAL SURGICAL POLICIES

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

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

9.3 Pre Operative orders for surgical cases performed in the main OR shall be entered electronically into the clinical information system by 4 pm the business day prior to scheduled surgery. Pre Operative orders for non-OR cases shall be entered prior to the patient presenting to facility. The Medical Center will not perform any pre-surgical testing except on the specific electronic order of the physician.

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

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

9.6 All tissue removed in surgery that in the opinion of the operating surgeon should be studied by Pathology will be sent to Pathology for histological evaluation according to policy. See Handling of Explanted Medical/Surgical Devices Policy and Procedure. Such specimens shall be properly labeled, packaged in preservative as designated, and identified as to patient and source in the operation room at the time of removal. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. Receipt by the laboratory of surgically removed specimens for examination shall be documented, and identity of the specimens and patients shall be assured throughout the processing and storage.

9.7 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:

- 9.7.1 Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance;
- 9.7.2 Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;
- 9.7.3 Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;
- 9.7.4 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;
- 9.7.5 Placentas that are grossly normal and have been removed in the course of operative and nonoperative obstetrics.

9.8 Operative and High Risk Invasive Procedure and Site Identification

9.8.1 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.

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

9.8.3 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.

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

9.8.5 Compliance with this policy will be monitored concurrently.

ARTICLE X. RESTRAINTS

10.1 Med/Surg Restraint – As per Medical Center policy, restraints needed to maintain a patient's safety and integrity of medical therapy require a physician order for initiation with renewal every twenty-four (24) hours. This category applies to soft restraints for intubated patients and to prevent invasive device removal such as NG or IV as well as cognitively impaired patients at risk for falling or other accidental injury (restraint will not solely be used based on a patient's history of falls without current evidence of falling). This category also applies to the use of all 4 bed rails.

10.1.1 Summary of physician actions:

i. Give an order (verbal) or enter order, to restrain the patient.

ii. Within 24 hours: perform face-to-face assessment of patient and document need for restraint and authenticate (if verbal) previous order.

iii. Every 24 hours: perform face-to-face assessment of patient and enter a new order for restraints if need continues.

iv. In the event of an emergency the restraint may be initiated by the nurse, after a physical and psychological assessment deems this necessary, the physician will be contacted as soon as possible for the order.

10.2 Behavior Restraint – Restraints needed to control violent or aggressive behavior require a physician order. This category would apply to all types of patients in all units who need to be forcibly put in restraints because of immediate, perilous danger of physical injury to self or others, or destruction of property when less restrictive measures are not adequate.

Each order for restraint or seclusion in emergent situations must state the maximum duration of the restraint or seclusion according to the following limit:

Age related time limitations for orders:

Every four (4) hours for patients age 18 and older
Every two hours for patients ages 9 through 17
Every one hour for patients less than age 9

Orders may be renewed if necessary up to a total of 24 hours in increments stated above.
Use of PRN order for restraint or seclusion is not acceptable.

The attending physician, other physician responsible for care of the patient or a registered nurse trained according to the requirements outlined in policy, must perform a face-to-face evaluation of the patient as soon as possible, but no later than one (1) hour after the initiation of emergent restraint or seclusion. If the use of restraint or seclusion is discontinued prior to the arrival of the physician, a face-to-face evaluation must still take place.

The evaluation must include the following:

The patient's immediate situation
The patient's reaction to the intervention
The patient's medical and behavioral condition
The need to continue or terminate the restraint or seclusion

If the face-to-face evaluation is conducted by a Registered Nurse trained according to policy and procedure, the attending physician or other physician responsible for care of the patient must be consulted as soon as possible after completion of the (one) 1 hour face-to-face evaluation.

ARTICLE XI. ADVANCE DIRECTIVES AND END OF LIFE

11.1 Health Care Directives **-** The Medical Center provides written information to each patient, prior to or at the time of admission as an inpatient, ED 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. (Refer to BH Advance (Health Care) Directives Policy).

11.2 Withdrawal of Life Support

11.2.1 Withdrawal of life support should occur in conjunction with best efforts to ascertain the wishes of the patient given the circumstances of his/her illness. If the patient is unable to speak on his/her own behalf, decisions should be made by the legal guardian, designated medical power of attorney, non-statutory surrogate (in this order). Discussions with patient, family members or surrogate decision maker should be documented in the medical record.

11.2.2 The primary responsibility for coordinating withdrawal of life support in a humane and ethical fashion lies with 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.

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

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

11.3 Pronouncement of Death - In the event of a Hospital 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 nursing progress notes. The RN will place a call to the attending physician and obtain a physician order to accept 2 RNs assessment of the death if appropriate. If no physician is willing to sign the death certificate, the case will be referred to the Medical Examiner.

11.4 Autopsies

11.4.1 Autopsies will be encouraged for inpatients (ED patients are not considered inpatients) for unusual deaths and of educational interest as part of the facility's quality assurance and educational program and at no cost to the family in all cases of unusual deaths and those of educational interest.

i. Any death within 48 hours of hospital admission.
ii. Any death after surgery within 72 hours.
iii. Any suspected genetic disease.
iv. Any suspected communicable infectious disease.

v. Any death with questionable diagnosis and cause of death.

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

11.4.3 Signed consent required. A valid consent 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 autopsy permission and indicating any exclusions is submitted directly to the HIMS Department.

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

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

vi. The case meets the criteria of a Medical Examiner's case and has been accepted by the Medical Examiner.
vii. The case was waived by the Medical Examiner's office, but appears to have criminal implications.
viii. The Consent for Autopsy appears to be invalid, incomplete, or questionable.
ix. The pathologist believes that the case represents a risk to him/her or Medical Center personnel that the facility is not equipped to handle (e.g. Cruetzfeidt-Jacob Disease).
x. Autopsy fails to meet quality assurance or education criteria.
xi. The pathologist determines that the autopsy does not meet the criteria as stated in the policy and procedure of the facility.

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

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

11.4.8 Pathologist discusses the case with the attending physician and invites the attending physician to be present.

ARTICLE XII. INTERN, RESIDENT AND FELLOW ROTATIONS

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

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

Interns, Residents and Fellows are not members of the Medical Staff and therefore may not admit patients, hold elected office or vote, and are not required to pay staff dues. They may attend meetings or serve on committees if invited by the organized medical staff. Physicians in training are not entitled to the rights outlined in Article Three, Section 3.2 of the Medical Staff Bylaws.

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

12.3 Orders And Operative Reports - Interns, Residents and Fellows approved for rotation through Banner University Medical Center, who are appropriately registered with the Arizona Medical Board and who are participants in an accredited training program, may enter patient care orders as determined by the supervising physician and the training program.

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

12.4 Paramedics - If paramedics are allowed to work as paramedics in the Medical Center, the Emergency Department shall provide administrative medical direction and on-line medical direction. A qualified, Emergency Department physician will be available to give on-line and/or on sight medical direction at all times while a paramedic is working in the Emergency Department.

ARTICLE XIII. NP, MEDICAL AND PHYSICIAN ASSISTANT STUDENTS

13.1 Student Level of Participation

- 13.1.1 Medical Student Rotations through the Medical Center will be in accordance with the Banner Health Clinical Education Rotation Agreement.
- 13.1.2 Students will work under the direct supervision of a college participating teaching faculty member, according to specific clinical goals and objectives developed by the college for each rotation.
- 13.1.3 Clinical goals and objectives will be reviewed, in advance, by the Graduate Medical Education Committee at Banner University Medical Center or a subcommittee to include interested Medical Staff members. The Banner RN Professional Practice team will review clinical goals and objectives for nurse practitioner students.
- 13.1.4 Participation in specific rotations at the Medical Center is subject to prior approval of the Medical Executive Committee.
- 13.1.5 The number of students participating will be reevaluated periodically and subject to change.

13.2 Specific Medical Student Activities

- 13.2.1 Medical students may participate in care and management of patients.
- 13.2.2 Medical students may document H&Ps, progress notes, clinical visits and procedural notes but not operative notes and discharge summaries. Electronic Medical Record training must be completed prior to beginning any patient care activities.
- 13.2.3 Medical students may propose and document orders but they will only be active after physician countersignature.

13.2.4 The physician must personally perform the physical examination and decision making activities before verifying student documentation. The physician must verify all student documentation and findings, including history, physical exam and other medical decision making.

13.2.5 Documentation is countersigned by faculty promptly. Faculty members are ultimately responsible for all required components of the medical record.

13.2.6 Students may observe or assist in surgery if it is a requirement of the rotation. Medical student must be able to document education of aseptic technique prior to assisting in surgery.

13.2.7 Students may assist in surgery if a faculty member is participating and the patient has consented to this.

13.2.8 All activities are under the direct guidance and supervision of faculty.

13.3 Specific Physician Assistant Student Activities

13.3.1 PA students may participate in care and management of patients.

13.3.2 Electronic Medical Record training (view only) must be completed prior to beginning any patient care activities.

13.3.3 Faculty members are responsible for all required components of the medical record.

13.3.4 PA students may not dictate.

13.3.5 PA students may assist in surgery if completing a family practice, obstetrics/gynecology or surgical rotation and if assisting the faculty member.

13.3.6 PA student must be able to document education of aseptic technique prior to assisting in surgery.

13.3.7 All activities are under the direct guidance and supervision of faculty.

13.4 Specific Nurse Practitioner Student Activities

13.4.1 NP students may participate in care and management of patients.

13.4.2 At the discretion of the preceptor, NP students may obtain Powernotes training and document in the electronic medical record. Otherwise, they will be granted view-only training and access.

13.4.3 Documentation is countersigned by faculty promptly. Faculty members are ultimately responsible for all required components of the medical record.

13.4.4 NP students may not dictate.

13.4.5 All activities are under the direct guidance and supervision of faculty.

13.5 Restrictions Student Activities

13.5.1 Students may not create discharge summaries or operative reports;

13.5.2 Students may not enter orders.

13.5.3 Students may not independently perform procedures without direct supervision.

13.6 Student Responsibilities

13.6.1 Students are required to comply with all BUMC policies and procedures during the clinical experience.

13.6.2 Students shall have access only to patient information that is a necessary part of the approved rotation.

13.6.3 Students, as participants in an educational program, must at all times wear a Student Identification Badge issued by Human Resources.

13.7 Application and Approval Process - A request for approval for medical and physician assistant student rotation at the Medical Center must be submitted to the Medical Staff Services Department for processing at least one month in advance of the rotation. NP student applications will be processed by the RN Clinical Educator and forwarded to Medical Staff Services for tracking.

Students, with the assistance of their school, will supply documentation as required by the affiliation Clinical Education Rotation Agreement prior to starting the clinical experience.

Once a specific program has received approval from the BGSMC GME Committee and the BUMC Medical Executive Committee, individual students may be accepted for rotation upon successful completion of the above application process.

13.8 Orientation – NP, Medical and PA Students will be oriented to Banner Health policies, programs, and channels of communication.

13.9 Fees and Services - A facility stipend will apply, in the amount provided in the Clinical Education Rotation Agreement, to offset expenses involved in the student rotation for those core rotations and other rotations in which the student spends a substantial amount of their time in the hospital. This fee covers services provided by the Medical Center including access to: patient (with consent); education and teaching areas; computer systems and training, and meals provided in the Physician's Lounge.

ARTICLE XIV. HIPAA (Health Insurance Portability and Accountability Act)

14.1 All members of the Medical Staff are participants in the Banner Health Organized Healthcare Arrangement (OHCA). All members of the medical staff are required to follow the Banner Health Policy as to Protected Health Information (PHI) they generate or receive from the Medical Center.

ARTICLE XV. AMENDMENT AND ADOPTION

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

15.2 **ADOPTION:** Approved and adopted by resolution of the Banner Health Board of Directors on January 8, 2015.

Revised and approved by the Banner Health Board of Directors: December 10, 2015
Reviewed by Bylaws Committee on September 14, 2017
Revised and approved by the Banner Health Board of Directors: May 10, 2018
Revised and approved by the Banner Health Board of Directors: July 14, 2018