BANNER GATEWAY MEDICAL CENTER
MEDICAL STAFF RULES AND REGULATION

ARTICLE I. GENERAL

1.1 The Active Medical Staff shall consist of physicians who are involved in the care of twenty (20) or more patients at the Medical Center during each calendar year. Any Medical Staff Member who has not been involved in the care of twenty (20) or more 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 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 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.

1.3 Emergency Department Call - Physicians serving on the call roster of the Emergency Room are responsible to cover their call or assure coverage by a Banner Gateway Medical Center Medical Staff member with appropriate privileges, and to notify the Medical Staff Services' office of any changes prior to any changes being made. (See Emergency Department Call Policy and Procedure)

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

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

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

1.7 Consent - The patient, or in special circumstances, someone acting for the patient, gives consent. Spouses and other family members do not have the right to consent or refuse consent for most patients. For unemancipated minors and wards, parents or guardians generally have the right to consent. (See Banner Gateway Medical Center policies on consent for further information.) Consent forms should be in writing and properly signed and witnessed. It is acceptable practice for someone other than a physician to obtain and witness a patient's signature on a consent form. However, it is essential that the physician provide the medical explanation including the risk, benefits, and potential complications associated with procedures leading to the patient's consent for surgeries or other significant procedures. Signed consent forms will be made a part of the patient's permanent medical record.

1.8 Availability - Physicians with patients in the hospital must be readily accessible by pager or cell phone. Emergent call and/or critical result call to a treating physician must be answered within 20 min. of the call; failure to respond is subject to disciplinary action by the MEC and Department committee.

1.9 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.

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. Requests for admission are made by the physician, but the final approval rests with the Medical Center CEO. Members of the Medical Center's Medical Staff may admit patients suffering from all types of diseases, injuries and conditions provided proper facilities and personnel are available to handle such patients. Physicians shall be held responsible for giving such information as may be necessary to assure the protection of other patients and 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. The attending physician is considered the primary physician and shall be responsible for the primary care from admission through discharge.

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

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

2.5 Patients admitted for dental service or podiatric care 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, an H & P is required on each patient.

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

who are a source of danger from any cause whatsoever, or to assure protection of the patient from self-harm.

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

2.7.1 Patients admitted to Critical Care status—within 6 hours;

2.7.2 Patients admitted to Telemetry status—within 16 hours;

2.7.3 All others—within 24 hours.

Patients must be seen sooner if their condition warrants physician intervention. Patients must be seen daily thereafter by the physician, or more often if the patient's condition warrants. (Exceptions may be granted for obstetrical patients that have a discharge order entered from the day prior) The appropriate department chairman and the Professional Review Committee is to be notified if a patient is not visited by the attending physician or his/her physician designee within the designated time following admission and daily thereafter.

2.8 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.

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

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

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

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

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

ARTICLE III. CONSULTATIONS

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

3.2 If appropriate consultation is not sought by the attending physician, the Chairman of the appropriate department or the Professional Review Committee Chairman should 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.

3.3 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 specific reason for the consultation should be included with the entered or verbal order for the consultation. The attending physician is responsible for requesting the consultation with a physician order. All consultations shall be requested by specifying the individual physician. Routine consultation requests will be called at

the time the consultation is ordered to the number designated by the physician as his office contact number. Each member of the medical staff is expected to work with his or her answering service to develop an appropriate triage protocol for those routine consultation requests that may come in during the hours the physicians office is closed.

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

3.5 Consultation must be rendered on a timely basis. Consultants are expected to see patient within 24 hours 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 attending physician will coordinate orders unless he/she specifies differently.

3.6 Any patient evaluated in the emergency department who is being admitted or is already in the hospital and who is known or suspected to be suicidal or any patients who attempts 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 of Banner Gateway Medical Center.

ARTICLE IV. MEDICAL RECORD POLICIES

4.1 General

4.1.1 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.

4.1.2 For purposed 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.

4.2 Purpose of the Medical Record - the purposes of the medical record are:

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

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

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

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

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

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

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

4.4.1 Documents from contracted/credentialed external sources that pertain to the delivery of patient care, such as radiology and telemedicine reports and select physician orders, with approval by the BH System Forms Committee. These reports must meet

the time requirements and contain data elements specified in the Medical Staff Rules and Regulations.

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

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

4.5 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.

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

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

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

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

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

4.11 Information from Outside Sources- Health record information obtained on request from an outside source is placed in the medical record and is available to the professional staff treating the patient. This information will contain source facility name/address. Results of examination (laboratory and medical imaging) performed prior to admission of the patient to the Medical Center and that are required for or directly related to the admission are made a part of the patient's Medical Center record.

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

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

4.14 Counter-Authentication (Endorsement) - All clinical entries in the patient's record must be accurately dated, timed and individually authenticated; 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.

4.14.1 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. Requirements for countersignature of Progress Notes will be established and monitored by the supervising physician.

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

4.14.3 Medical Students-

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

4.14.3.2 3rd & 4th Year- Any and All documentation must be endorsed (countersigned, counter-authenticated) timely by the physician.

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

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

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

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

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

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

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

4.16.5 Accurate coding diagnosis in response to coding queries

4.17 History and Physical Examination ("H&P") - A history and physical examination in all cases 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 within 24 hours after admission. The completed H&P must be on the medical record prior to surgery or invasive procedure (see section 4.17.1), or any procedure in which conscious sedation will be administered or the case will be cancelled unless the responsible physician documents in writing that such as delay would constitute a hazard to the patient. A legible office

history and physical performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. If approved by the Medical Staff the Emergency Room Report or Consultation report may be used as the H&P as long as all the elements in section 4.19 are included and the document is filed as a History and Physical on the EMR. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services. The Obstetrical H&P will consist of the prenatal record, where applicable, updated in the EMR by the responsible physician or Allied Health professional.

4.18 Invasive Procedures require an H&P prior to being performed, except in an emergency, include but not limited to:

- Main OR procedures
- Ambulatory surgeries
- C-section deliveries/tubal ligations
- Endoscopies
- Interventional Cardiac Procedures – Permanent Pacemakers
- Interventional Radiology Procedures: Percutaneous Transluminal Angioplasty (PTA), Nephrostomy Tube Insertion, Transjugular Intrahepatic Portosystemic Shunt (TIPS), CT Guided Biopsies, Thoracentesis, Paracentesis, Epidural Blocks, Nerve Root Blocks, Facet Infections, Angiograms
- Venograms
- Transesophageal Echocardiogram (TEE)
- Cardioversions
- Bone Marrow Studies
- Lumbar Puncture

4.19 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&P's performed prior to admission by a practitioner not on the medical staff are acceptable provided that they were updated timely by the attending physician. An oral surgeon with appropriate privileges who admits a patient without medical conditions may perform the H&P, and assess the medical risks of the procedure to the patient. Dentists and podiatrists are responsible for the part of their patients' H&P that relates to dentistry or podiatry, in addition to the medical history and physical.

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

4.20.1 Medical history:
4.20.2 Chief complaint
4.20.3 History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status.
4.20.4 Relevant past medical, family and/or social history appropriate to the patient's age.
4.20.5 Review of body systems.
4.20.6 A list of current medications and dosages.
4.20.7 Any known allergies including past medication reactions and biological allergies
4.20.8 Existing co-morbid conditions
4.20.9 Physical examination: current physical assessment
4.20.10 Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
4.20.11 Initial plan: Statement of the course of action planned for the patient while in the Medical Center.
4.20.12 For other outpatient (ambulatory) surgical patients, as necessary for treatment
4.20.12.1 Indications/symptoms for the procedure.
4.20.12.2 A list of current medications and dosages.
4.20.12.3 Any known allergies including past medication reactions
4.20.12.4 Existing co-morbid conditions
4.20.12.5 Assessment of mental status
4.20.12.6 Exam specific to the procedure performed.
4.20.13 IV Moderate Sedation- For patients receiving IV moderate sedation, all of the above elements in section 4.20.1-4.20.12.6, plus the following:

4.20.13.1 Examination of the heart and lungs by auscultation.
4.20.13.2 American Society of Anesthesia (ASA) Status
4.20.13.3 Documentation that the patient is appropriate candidate for IV moderate sedation.

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

4.21.1 Time and means of arrival
4.21.2 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.
4.21.3. Clinical observations, including results of treatment
4.21.4 Diagnostic impressions
4.21.5 Condition of the patient on discharge or transfer
4.21.6 Whether the patient left against medical advice
4.21.7 The conclusions at the termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment and services

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

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

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

4.24 Pre-Operative, Intraoperative and Post Anesthesia/Sedation Evaluation Record for General, Regional or Monitored Anesthesia

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

4.24.2 Intraoperative Anesthesia/Sedation Record - will also include the name of the practitioner who administered anesthesia and the name of the supervising anesthesiologist or operating practitioner; techniques used and patient position(s), including the insertion/use of any intravascular or airway devices; name and amounts of IV fluids, including blood or blood products 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.

4.24.3 Post-Anesthesia Evaluation - must be completed and documented by an individual qualified to administer anesthesia or conscious sedation no later than 48 hours after surgery or a procedure requiring anesthesia services and, for outpatients, prior to discharge. The record must include respiratory function, including respiratory rate, airway patency and oxygen saturation; cardiovascular function, including pulse rate

and blood pressure; mental status; temperature, pain; nausea and vomiting; and postoperative hydration.

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

4.25.1 The exception to this requirement occurs when an operative or other high-risk procedure progress notes is documented immediately after the procedure, in which case the full report must be documented 24 hours post procedure. If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be documented in the new unit or area of care.

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

4.25.2.1 The name(s)s of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)

4.25.2.2 The name of the procedure performed

4.25.2.3 A description of the procedure

4.25.2.4 Findings of the procedure

4.25.2.5 Any estimated blood loss

4.25.2.6 Any specimen(s) removed

4.25.2.7 The postoperative diagnosis

4.25.3 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, findings, estimated blood loss, specimens removed, and post-operative diagnosis.

4.26 Consents - Members of the Medical Staff or authorized Allied Health Professional must obtain a patient's informed consent, prior to performing any of the operative and/or invasive procedures listed below ("Procedures"), 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:

4.26.1 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;

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

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

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

4.26.5 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.

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

4.27.1 The person is in immediate need of medical attention;
4.27.2 An attempt to secure express consent would result in delay of treatment;
4.27.3 Delay in treatment would increase the risk to the person's life or health; and
4.27.4 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.

4.28 Special Procedures- EEG's EKG's, treadmill stress test, 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 practitioner of the test completion.

4.29 Discharge Documentation – A discharge summary must be documented at the time of discharge, but no later than seven (7) days 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

A final discharge progress note should be documented immediately upon discharge an may be substituted for the discharge summary for patients with a length of stay less than 48 hours or less as well as for normal newborns and normal vaginal delivery cases regardless of the length of stay. The note shall include:

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

4.30 Documentation of Deaths - 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 seven (7) days thereafter by the responsible practitioner.

4.31 Documentation for Inpatient Transfers to another facility – The transferring physician must document a transfer summary at the time of transfer regardless of length of stay to include documentation that patient was advised of risks/benefits of transfer.

4.32 Amending Medical Record Entries

4.32.1 Electronic Documents (Structured, Text and Images) - Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error or omission through the EMR. The clinical information system 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.

4.32.2 Paper-Based Documents - Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error by drawing a single line through the erroneous entry, but not obliterating it, and initialing and dating the error.

Errors or omissions discovered at a later time shall be corrected by the individual with a new entry. The person making the change shall sign and note the date of the change and reason for the change. The new entry shall also state who was notified of the change and the date of such notification. The individual must notify the HIMS Department to review the erroneous documentation for recording in-error criteria within the EMR. Any physician who discovers a possible error made by another individual shall immediately upon discovery notify the supervisor of that clinical or ancillary area. Upon confirmation of the error, the patient's attending physician and any other practitioners, nurses or other individuals who may have seen and relied upon the original entry shall be notified.

4.33 Timely Completion of Medical Records

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

4.33.2 Timely Completion of Medical Record Documents – All medical record documents shall be completed within the 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 Query	Documented response no later than 7 days post notification to the provider	
Operative Report	Immediately after procedure	
Special Procedures Report	Documented within 24 hours of completion of procedure	
Discharge Progress Note	Documented at the time of discharge/disposition but no later than 7 days post discharge for all admissions less than 48hrs or for normal vaginal deliveries and normal newborns	

Death Summary	Documented at the time of death/disposition but no later than 7 days post discharge	
TNM Staging Forms	Documented and signed by the responsible provider/surgeon within 15 days from the date of notification to the provider	
Transfer Summary	Documented at the time of transfer	
Signatures	Authentication of transcribed or scanned reports and progress notes, within 15 days from the date of discharge	
Verbal Orders	Dated, time and authenticated within 48 hours from order	
Psychiatric Evaluation	Documented within 24 hours of admission	

4.34 Medical Record Deficiencies – Physicians are advised of incomplete documentation via the physician inbox. The Health Information Management Services Department shall advise physicians by fax, mail, or electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has reached fifteen (15) days from the date the deficiency is assigned (allocation date). The notice will include a due date and a list of all incomplete and delinquent medical records. No additional notification is given.

If a vacation prevent the practitioner from completing his/her medical records the practitioner or agent must notify the Health Information Management Services Department in advance of the vacation; otherwise the temporary suspension may remain in effect until the documentation is completed.

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

4.35 Medical Record Temporary Suspensions – A medical record is considered eligible for temporary suspension when it has aged 22 days from the date the deficiency is assigned (allocation date).

If the delinquent records are not completed timely, practitioners will receive a notice, indicating that their admitting, surgical and/or consultative privileges will be temporarily suspended until all medical records are completed. Upon temporary suspension, the delinquent member shall have no admitting, surgical and/or consultative privileges, other than patients in labor or patients needing emergent care, until delinquent records have been completed. A member whose privileges have been suspended under this Section shall be allowed to continue the medical and surgical care only of patients who were in the Medical Center under their care prior to imposition of the temporary suspension of privileges, or for those patients who are pre-scheduled for surgery/procedures. Specifically, a suspended physician shall not: schedule new admissions, schedule admissions under an associates/covering physician's name, perform consultations, schedule inpatient or outpatient surgeries or other procedures, assist in surgery, administer anesthesia, round on patients of associates/covering physician's patients, or participate in Emergency Department Call. It is the responsibility of the physician to arrange coverage for Emergency Department call for which that physician is scheduled.

A suspension list will be generated weekly and made available by the Health Information Management Services Department. The Suspension List is made available to the Executive Committee, Department Chairs, Administration, Medical Staff Services, Patient Registration, Patient Placement, Emergency Department, Cardiology, Inpatient and Outpatient Surgery areas.

Restoration of admitting privileges can be accomplished only by completion of all available records assigned to the suspended physician. It shall be the responsibility of the Health Information Management Services Department to immediately notify appropriate parties upon completion of delinquent records, as well as to remove the name of the practitioner from the suspension list.

The HIMS Department will prepare and submit upon request for the Medical Executive Committee meeting a list of physicians whose privileges have been suspended and those who have been restored.

4.36 Continuous Temporary Suspension/Automatic Termination of Privileges for Delinquent Medical Records - Temporary suspension shall become automatic permanent suspension following 60 cumulative days of temporary suspension within a calendar year. At that time, the practitioner's privileges will automatically move to permanent suspension for failure to complete medical records. Affected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if all incomplete and delinquent records have been completed. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff. In order to reinstate their staff privileges following such action, the physician will be required to re-apply for medical staff membership, including 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. Physicians may submit evidence demonstrating why the suspension/revocation is unwarranted to the Medical Executive Committee pursuant to Article 6.6 of the Bylaws.

ARTICLE V. PHYSICIAN ORDERS

5.1 Physician Orders – Banner Gateway 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. 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.

- 5.1.1 An admission order shall be documented by the attending/consulting or covering physician for all inpatient or observation patients, and extended recovery.
- 5.1.2 Physician orders are required for all tests, services and procedures.
- 5.1.3 Transfer of a patient's care to another physician must be documented via a physician order.
- 5.1.4 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.
- 5.1.5 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 inpatient medical services, the physician must also converse with the accepting physician to ensure continuity of care when the patient is transferred to another Medical Center for acute inpatient medical services.
- 5.1.6 Orders may be generated only by members of the medical staff with medical staff privileges or by Allied Health Staff (NP's, PA's) according to their scope of practice.

5.2 Orders for Surgery

- 5.2.1 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 for telephone orders verifying that the correct surgical procedure has been indicated.

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

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

5.2.4 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.

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

5.2.6 Anesthesia pain medication orders are for PACU use only unless the patient is on a PCA, Epidural drip or Intrathecal Injection of Narcotic. Surgeon pain medication orders are not to be followed until after PACU.

5.3 Orders for Outpatient Tests

5.3.1 Orders for outpatient 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 (PA's, NP's).

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

5.3.3 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 (PA's or NP's).

5.3.4 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)

5.4 Verbal and Telephone Orders

5.4.2 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) or licensed practical nurse (LPN). Licensed Respiratory Care Practitioners (RCP), ~~and~~ registered pharmacists, speech therapists and dieticians can accept verbal orders provided the orders are directly related to their specialized discipline. The physician will authenticate these orders within 48 hours.

5.4.3 Only physicians and authorized allied health professionals are permitted to give telephone orders for inpatient services. Office staff are not permitted to give telephone orders.

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

5.4.5 RNs or LPNs are permitted to accept telephone orders on nursing units. Registered pharmacists, Occupational Therapists, Physical Therapists, Registered Dietitians, Speech Therapists and Respiratory Care Practitioners (RCPs) can accept telephone orders directly related to their specialized discipline. All telephone orders must be read back to verify accuracy and signed by the receiving individual. Telephone orders will be authenticated by the responsible physician.

5.4.6 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.

5.5 Do Not Resuscitate (DNR) Orders

5.5.2 Do Not Resuscitate (DNR) orders are entered in the patient's medical record and authenticated, timed and dated by the responsible physician. A properly documented no code order will include the physician's medical reasons for the order and his/her

discussion with the patient's family, or with the patient. This should be documented in the progress note.

5.5.3 Telephone Do Not Resuscitate (DNR) orders are discouraged. However, if ~~no code~~ Do Not Resuscitate (DNR) orders must be placed by telephone, the RN taking the order will have a witness on the telephone to verify and document the ~~no code~~ Do Not Resuscitate (DNR) status. Physicians will sign the ~~no code~~ Do Not Resuscitate (DNR) telephone order upon their next visit and document the reasons even though the patient may have already expired.

5.5.4 All Do Not Resuscitate (DNR) Orders will be reviewed with the patient and/or the patient's legally authorized representative prior to surgery by the performing physician and anesthesiologist. The medical record will reflect whether the DNR order is to be suspended and, if so, for what period of time peri-operatively and post-anesthesia.

ARTICLE VI. GENERAL PHARMACY POLICIES

6.1 General Information - All medication administered to patients at Banner Gateway 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 Pharmacy & Therapeutics Committee. The formulary is an established compendium of approved medications available at Banner Gateway for diagnostic, prophylactic, therapeutic or empiric treatment of patients. The pharmacy is not required to stock more than one brand of an individual medication unless directed differently by the Pharmacy & Therapeutics 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 Pharmacy & Therapeutics Committee and approved by the Executive Committee. Medication samples may not be used or stored in any area of the hospital unless the use is approved by the Pharmacy Department. If approved and used, all samples will be left with and stored in the Pharmacy Department.

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

6.2.1 These medications will be kept in the patient specific bin located in the med room at the nursing unit. Medications may be kept at the patient's bedside for self-administration only upon specific written orders of the physician.

6.2.2 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.

6.2.3. Outpatient prescriptions, with the few exceptions defined in pharmacy policy, will not be filled at Banner Gateway Medical Center. If a medication is to be sent home with a patient, a prescription must be written.

6.2.4 All medications taken out of the Medical Center by a patient on a pass must be properly labeled.

6.3 Medication Orders

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

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

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

6.3.4 All medication orders must be reviewed when a patient is transferred from one medical service to another, for example, to or from Intensive Care Units. 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.

6.4 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 and/or the nurse caregiver. Nursing personnel should not be used as an intermediary in the resolution of those questions regarding pharmacotherapy or dosing. The pharmacist must contact the prescriber directly.

6.5 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.

6.6 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.

6.7 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 Banner Gateway Medical Center 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.

6.8 Authorization to Administer Medications

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

i. Physician, including house staff officers
ii. 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.
iii. Respiratory Care Practitioners, Levels 1, 2, 3 & 4 (medications related to respiratory therapy treatments only).
iv. Respiratory Care Coordinator, Supervisor and Education Coordinator (medications related to respiratory therapy treatments only).
v. Respiratory Technical Specialists (medications related to respiratory therapy treatments only).
vi. Radiology Technologist and Nuclear Medicine Technologist (medications related to radiology/nuclear procedures only).
vii. EEG Technician and Cardiovascular Technician (CVT) (oral medications only) and Anesthesia Technicians (medications related to EEG and Cardiovascular therapy treatments only).
viii. Physical Therapist (topical medications only. Medications related to physical therapy treatments only)
ix. Students under direct supervision of a preceptor from number 1 through 8 above.

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

ARTICLE VII. GENERAL SURGICAL POLICIES

7.1 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.

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

7.3 Pre Operative orders for surgical cases performed in the main OR shall be entered electronically into the clinical information system by two (2pm) 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.

7.4 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.

7.5 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.

7.6 Tissues and foreign bodies removed during a surgical procedure shall be sent to the Medical Center pathology department for 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.

7.7 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:

- 7.7.1 Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance;
- 7.7.2 Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;
- 7.7.3 Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;
- 7.7.4 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;
- 7.7.5 Placentas that are grossly normal and have been removed in the course of operative and nonoperative obstetrics.

7.8 <u>Operative and High Risk Invasive Procedure and Site Identification</u>

- 7.8.1 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.
- 7.8.2 Laterality of all procedures will be verified and spelled out in its entirety on the consent form.

7.8.3 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.

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

7.8.5 Compliance with this policy will be monitored concurrently.

ARTICLE VIII. RESTRAINTS

8.1 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. Non-violent restraint for patient safety: If the physician is not present, the primary RN may initiate restraint and obtain a verbal order immediately after the application. LIP must perform the face-to-face assessment and sign verbal order for restraint within 24 hours of application.

Summary of physician/NP actions:

i. Give an order (verbal) or enter order, to restrain the patient.
ii. Every 24 hours: perform face-to-face assessment of patient and enter a new order for restraints if need continues.
iii. 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.

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 IX. ADVANCE DIRECTIVES AND END OF LIFE

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

9.2 Withdrawal of Life Support

9.2.1 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 with appropriate family members or defined surrogate (e.g. designated medical power of attorney). Discussions with patient, family members or surrogate decision maker should be documented in the medical record.

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

9.2.3 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.

9.2.4 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.

9.3 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 vial signs (BP, apical pulse and aspirations), and will document this in the nurses' progress notes. The RN will place a call to the attending physician and obtain a physician order to accept 2 RN's assessment of the death if the appropriate. If no physician is willing to sign the death certificate, the case will be referred to the Medical Examiner.

9.4 Autopsies

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

i. Deaths in which an autopsy helps explain unknown and unanticipated medical complications.
ii. Deaths in which the cause is not known with certainty on clinical grounds.
iii. Unexpected and unexplained deaths occurring within 48 hours after any medical, surgical or dental, therapeutic or diagnostic procedures that do not fall under medico-legal jurisdiction.
iv. Death occurring in patients who are at time of death, participating in clinical trials (protocols) approved by institutional review boards.
v. Deaths resulting from high risk infectious and contagious diseases which have been waived by the Medical Examiner.
vi. All obstetric deaths.
vii. All neonatal and pediatric deaths.

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

9.4.3 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.

9.4.4 In certain instance, patient advanced directives, physician preference, and family requests may preclude performing an autopsy. A Pathologist may refuse to perform an autopsy under the following situations:

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

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

9.4.6 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.

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

ARTICLE X. INTERN, RESIDENT AND FELLOW ROTATIONS

10.1 Supervision of Interns, Residents and Fellows - Professional Graduate Medical Education Programs wishing to rotate Interns, Residents or Fellows through Banner Gateway 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 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 BGMC 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 are not entitled to any of the rights set forth in the Medical Staff Bylaws. By way of example, they may not admit patients, hold elected office or vote. They are not required to pay staff dues; however, they may attend meetings or serve on committees if invited by the organized medical staff.

10.2 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 Gateway, 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.

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

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

ARTICLE XI. MEDICAL AND PHYSICIAN ASSISTANT STUDENTS

11.1 Medical and Physician Assistant Student Level of Participation

11.1.1 Medical Student Rotations through Banner Gateway Medical Center will be in accordance with the Banner Health Clinical Education Rotation Agreement.

11.1.2 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.

11.1.3 Clinical goals and objectives will be reviewed, in advance, by the Graduate Medical Education Committee at Banner Good Samaritan Medical Center or a subcommittee to include interested BGMC medical staff members.

11.1.4 Participation in specific rotations at BGMC is subject to prior approval of the Medical Executive Committee.

11.1.5 The number of students participating will be reevaluated periodically and subject to change.

11.2 Specific Medical Student Activities

11.2.1 Year one and two medical students may observe only.

11.2.2 Year three and four medical students may participate in care and management of patients.

11.2.3 Year three and four medical students may dictate H&Ps and procedural notes. Electronic Medical Record training (view only) must be completed prior to beginning any patient care activities.

11.2.4 Documentation is countersigned by faculty promptly. Faculty members are ultimately responsible for all required components of the medical record.
11.2.5 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.
11.2.6 Students may assist in surgery if a faculty member is participating and the patient has consented to this.
11.2.7 All activities are under the direct guidance and supervision of faculty.

11.3 Specific Physician Assistant Student Activities

11.3.1 PA students may participate in care and management of patients.
11.3.2 Electronic Medical Record training (view only) must be completed prior to beginning any patient care activities.
11.3.3 Faculty members are responsible for all required components of the medical record.
11.3.4 PA students may not dictate.
11.3.5 PA students may assist in surgery if completing a family practice, obstetrics/gynecology or surgical rotation and if assisting the faculty member.
11.3.6 PA student must be able to document education of aseptic technique prior to assisting in surgery.
11.3.7 All activities are under the direct guidance and supervision of faculty.

11.4 Restrictions

11.4.1 Students may not create discharge summaries or operative reports;
11.4.2 Students may not enter orders.
11.4.3 Students may not independently perform procedures without direct supervision.

11.5 Medical and Physician Assistant Student Responsibilities

11.5.1 Students are required to comply with all BGMC policies and procedures during the clinical experience.
11.5.2 Students shall have access only to patient information that is a necessary part of the approved rotation.
11.5.3 Students, as participants in an educational program, must at all times wear a Student Identification Badge issued by Human Resources.

11.6 Application and Approval Process - A request for approval for medical and physician assistant student rotation at BGMC must be submitted to the Medical Staff Services Department for processing at least one month in advance of the rotation.
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 BGMC Medical Executive Committee, individual students may be accepted for rotation upon successful completion of the above application process.

11.7 Orientation - Medical and PA Students will be oriented to Banner Health policies, programs, and channels of communication.

11.8 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 Banner Gateway Medical Center including access to: patient (with consent); education and teaching areas; computer systems and training, and meals provided in the doctor's lounge.

ARTICLE XII. COMMITTEES

12.1 Pharmacy & Therapeutics Committee - The P&T committee shall meet on a date and time agreed upon by its members.
12.1.1 The Committee shall consist of:

i. A Chairman appointed by the President of the Medical Staff, with MEC approval, and at least four other members of the medical staff.
ii. Administrative representative
iii. Quality management representative
iv. Pharmacy Director
v. Clinical Pharmacy Coordinator
vi. Nursing representative

12.1.2 The P&T Committee shall perform the following functions:

i. Development and provide for on-going maintenance and continued review of hospital Drug Formulary. This formulary shall prevent unnecessary duplication, be evidenced based, promotes therapy on the basis of patient need, optimizes patient outcomes, safety and cost effectiveness to the hospital.
ii. Serve in an advisory capacity to the Medical Staff and Pharmacy Department in the selection or choice of medication which meet the most effective therapeutic quality standards.
iii. Evaluate objectively the clinical data regarding new medications or agents proposed for use in the hospital.
iv. Serve in an advisory capacity to the Medical Staff and hospital administration in all matters pertaining to the safe use of medications.
v. Assess and evaluate medication therapy through an on-going Medication Use Evaluation program designed to proactively identify issues related to the utilization of medications. Information shall be shared with multidisciplinary teams with the goal of evaluating opportunities for improvement in patient care.
vi. Develop and utilize evidence based approaches for medication use in order sets, forms, guidelines and protocols. Methods shall be developed for periodic review to help determine compliance, outcomes and improvement processes.
vii. Review, approve and provide for on-going maintenance of policies/procedures related to the evaluation, selection, procurement, storage, distribution, administration and monitoring of medications.
viii. Review and make appropriate recommendations with regard to adverse drug events and medication occurrences which are reported at the hospital. This would include developing and implementing strategies to prevent and minimize future occurrences as well as monitoring the impact or outcome of a given action.
ix. Create and monitor the effectiveness of various communication strategies to inform nurses, patients, pharmacists and physicians at the acute care delivery sites of a given decision and associated implementation timeline.
x. Improve pharmacy related (intra and interdepartmental) clinical and process quality.
xi. Present recommendations from the Pharmacy and Therapeutics Committee to the appropriate medical staff committee(s) and/or the Medical Executive Committee.

12.2 Infection Control Committee - The Infection Control committee shall meet on a date and time agreed upon by its members.

12.2.1 The Committee shall consist of:

i. A Chairman appointed by the President of the Medical Staff, with MEC approval, and at least two other members of the medical staff.
ii. Infection Control Director

12.2.2 Representatives from the following areas:

i. Quality Management
ii. Pharmacy
iii. Interventional/Surgical Services
iv. Supplies Processing Department
v. Dialysis
vi. Occupational Health
vii. Emergency Department
viii. Administrative representative

12.2.3 Adhoc members as necessary from:

i. Safety

ii. Culinary Services
iii. Environmental Services
iv. Materials Management
v. Departments/nursing units
vi. Microbiology

12.2.4 The Infection Control Committee shall perform the following functions:

i. Support and direct the Infection Control Program
ii. Determine surveillance activities and interventions to promote a safe environment for patients and employees and improve trends in nosocomial infection rates as a part of the facilities organization wide approach to designing, measuring, assessing and improving its performance.
iii. Review of antimicrobial susceptibility profiles of pathogens identified in the laboratory.
iv. Make recommendations and direct the Infection Control Program in corrective action based on review of infections and potential for infection among patients, physicians and hospital personnel.
v. Review and implement proposals for all special infection control studies and any subsequent findings.
vi. Provide input into the scope and content of the Occupational Health Program.
vii. Institute appropriate control measures or studies when there is a potential danger to a patients, physicians or hospital personnel safety.
viii. Review written policies and procedures, as appropriate, related to the facility's Infection Control Program at least every three years; revise as necessary and develop new policies and procedures where appropriate.

12.2.5 Authority Statement - The Infection Control Committee Chair and/or Infection Control Practitioner have delegated the authority for hospital administration to institute control measures, studies, enforce policies; to direct change in institutional policies and practices to achieve immediate control over an outbreak; and, act on a suspected or defined problem when indicated by findings or through surveillance mechanisms.

12.3 Operating Room Logistics (OR) Committee - The OR committee shall meet on a date and time agreed upon by its members.

12.3.1 The committee shall consist of:

i. Co-chaired by a chair appointed by the chief of staff and the Director of Perioperative Services
ii. Membership of at least one member of General Surgery, OB/GYN, Orthopedic and Anesthesia
iii. O.R. Nursing Director
iv. O.R. Clinical Manager
v. Administrative Representative
vi. Chief Medical Officer
vii. Chief Nursing Officer

12.3.2 The OR Committee shall perform the following functions:

i. Support and facilitate day to day functions, scheduling issues and nurse/physician problems in the O.R.
ii. Review and access equipment and supply issues for O.R.
iii. Review capital priority requests relating to O.R. needs.
iv. Review written policies and procedures, as appropriate, related to the facility's O.R. at least every three years; revise as necessary and develop new policies and procedures where appropriate.

12.3.3 The OR Committee, which consists of a multi-disciplinary representation, will report directly to the Medical Executive Committee.

12.4 Hospital Based Ancillary Services Committee - The Hospital Based Ancillary Services Committee is the oversight committee for the Departments of Pathology and Radiology. The committee will meet on a day and time agreed upon by its members.

12.4.1 The Committee will be co-chaired and multi-disciplinary in nature consisting of the following:

i. Pathology Department Chairman

ii. Radiology Department Chairman
iii. Medical Staff Members from radiology, pathology, surgery, medicine and OB/GYN
iv. Nursing representatives
v. Laboratory representatives
vi. Radiology representatives
vii. Quality Management Specialist
viii. Administrative representative

12.4.2 Functions of the Committee:

i. Measuring, assessing and improving the medical assessment and treatment of patients. Ensure communication of findings, conclusions, recommendations and actions taken to improve organization performance.
ii. The Department Chairman is responsible for the professional functions, duties and responsibilities within the department as outlined in Section 8.4-5 of the Medical Staff Bylaws.
iii. Review of transfusion services including but not limited to justification of blood use; blood ordering practices; adequacy of transfusion services; and policies related to blood use and transfusion.

12.4.3 The Hospital Based Ancillary Services Committee will report directly to the Medical Executive Committee.

12.5 Women's and Children Services Committee - The Women's and Children Services Committee is the oversight committee for the departments of OB/GYN and Pediatrics. The Committee will meet on a day and time agreed upon by its members.

12.5.1 The Women's and Children Services Committee will be co-chaired and multi-disciplinary in nature consisting of the following:

i. OB/GYN Department Chairman
ii. Pediatric Department Chairman
iii. Medical Staff Members from OB/GYN and Pediatrics
iv. Nursing representatives
v. Quality Management Specialist
vi. Administrative representative

12.5.2 Functions of the Committee:

i. Measuring, assessing and improving the medical assessment and treatment of patients. Ensure communication of findings, conclusions, recommendations and actions taken to improve organization performance.
ii. The Department Chairman is responsible for the professional functions, duties and responsibilities within the department as outlined in Section 8.4-5 of the Medical Staff Bylaws.

12.5.3 The Women's and Children Services Committee will report directly to the Medical Executive Committee.

12.6 Ethics Program – The Bioethics Program at Banner Gateway Medical Center is comprised of physicians from a variety of specialties and associates as needed including but not limited to social work, chaplaincy, nursing, risk management and administration. The members of the Ethics Program are convened as needed on an adhoc basis.

Functions of the Program: The Ethics Program at BGMC provides recommendations relating to ethical dilemmas that may arise during the provision of care. The Ethics Program is an interdisciplinary group that offers consultative services for ethical issues, questions or dilemmas related to patient care, and is available to consult with families, patients, health care professionals and hospital employees desiring assistance with ethical decision making.

The MEC will serve as the oversight committee for the Ethics Program.

ARTICLE XII. HIPAA (Health Insurance Portability and Accountability Act

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

AMENDMENT:

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

ADOPTION:

Adopted and recommended to the Banner Health Board of Directors by the Banner Gateway Medical Executive Committee on December 4, 2006.

Approved and adopted by resolution of the Banner Health Board of Directors on December 21, 2006.

Revised: June 21, 2007
July 19, 2007
August 16, 2007
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