Banner Heart Hospital

GENERAL RULES AND REGULATIONS

1.1 DEFINITIONS

1.1-1 Attending Physician: A Cardiovascular or Thoracic specialist or internist who admits and cares for his/her own patients with a cardiac specialist.

1.1-2 Admitting Physician: The specialist or internist who admits the patient to the hospital and is responsible for dictation of the history and physical and discharge summary.

1.1-3 Consulting Physician: A Specialist/Internist consulted to attend any problems that may be present or arise during the patient's hospitalization.

1.1-4 Cardiovascular Specialist: A Cardiologist or Cardiac or Vascular surgeon or Interventional Radiologist privileges for specific disease processes and procedures who accepts a cardiac/vascular patient for admission or transfer and assumes the primary responsibility for the patient. This includes the physician's coverage or substitute.

1.1-5 Thoracic Specialist: A Thoracic surgeon or Pulmonologist privileged for specific disease processes and procedures who accepts a thoracic patient for admission or transfer and assumes primary responsibility for the patient. This includes the physician coverage or substitute.

2.1 GENERAL

2.1-1 **Disaster.** In the event a disaster is declared, pursuant to the Hospital Disaster Plan, and requires evacuation of patients, all staff members shall relinquish care of their patients in accordance with the Plan. This Rule overrides any rule to the contrary.

2.1-2 **Experimentation and Research.** All experimental or research procedures require prior written approval by the Banner Health Research Institute.

3.1 ADMISSION POLICIES

3.1-1 **Admission of Patients.** Admissions are limited to patients with actual or suspected cardiovascular, vascular, or thoracic diseases who meet the admission criteria as set forth in the "Adult Admission, Transfers, Discharges and Triage: Critical Care Services of Banner Health Policy/Procedure #14146."

3.1-2 **Admitting Evaluation.** Each patient must be seen by his/her admitting physician within twelve (12) hours of admission. The attending physician must see the patient daily.

3.1-3 **Discharges.** Discharges from Banner Heart Hospital shall be accomplished in accordance with the "Adult, Admission, Transfers, Discharges and Triage Critical Care Services Criteria for Banner Health Policy and Procedure" (Patient Care Manual Policy #14146).

3.1-4 Specialist as attending or consulting physician. Each inpatient shall be seen by a Cardiovascular or Thoracic Specialist privileged for specific disease processes and procedures.

3.1-5 **Communicable Diseases.** Patients with communicable diseases, identifiable or suspect, shall be treated under proper isolation procedures for the protection of other patients and hospital staff.

4.1 CONSULTATIONS AND REFERRALS

4.1-1 **Consultations Required.** Except in an emergency, consultations with another qualified physician should be obtained when the attending physician does not have privileges in cardiology, cardiovascular surgery, or thoracic surgery at Banner Heart Hospital and/or for cases 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, and/or 4) when requested by the patient. Nursing personnel or current consultants who believe the patient requires, but the attending physician is not seeking, appropriate consultation should contact the appropriate Department Chair or President of the Staff. The Chair or President may request consultation where the patient so agrees.

4.1-2 **Physician Responsibility to Arrange.** The attending physician is responsible for ordering consultations by documenting in the physician's orders. All consultations shall be requested by specifying the individual physician or physician group name and the reason for the requested consultation. If the named consultant is not available, then the requesting physician shall be notified and provided a listing of physicians on staff within that specialty and shall assume responsibility for obtaining the consultation. If the consultant requires additional information than is available in the consultation order, the consultant shall contact the requesting physician directly.

4.1-3 **Consultation Examination.** A satisfactory consultation includes examination of the patient as well as the medical record. When operative procedures are involved, the consultation shall be recorded prior to the operation (except in an emergency).

4.1-4 **Stat/Urgent/Routine Consultations.** Stat consultations shall be performed as soon as possible. Urgent consultations shall be performed within six (6) hours of the order and notification of the consultant. Routine consultations shall be performed within twenty-four (24) hours of the order and notification of the consultant.

5.1 INFORMED CONSENT

5.1-1 **Informed Consent.** The Hospital Conditions of Admission contain a general consent for routine diagnostic tests for patients. Specific written informed consent is required for any diagnostic testing or treatment that is not routine in nature. Consent forms should be in writing and properly signed, dated, timed, and witnessed. It is acceptable practice for someone other than a physician to obtain and witness a patient's signature on a consent form. Signed, dated, and timed consent forms will be made a part of the patient's permanent medical record. Disclosure of whether practitioners other than the operating practitioner, including residents and allied health professionals, will be performing important tasks related to the procedure shall be included on the informed consent.

5.1-2 **Consents for Transfer/Transport**. "Transport" means a hospital sending a patient to another health care institution for outpatient services with the intent of returning the patient to the sending hospital. "Transfer" means a hospital discharging a patient and sending the patient to another licensed health are institution as an inpatient or resident, without intending that the patient be returned to the sending hospital. "Transport" and "transfer" require a physician order and a signed, dated, and timed consent shall be obtained by the patient's physician following the discussion of the risks and benefits of transfer with the patient/family, based on patient's medical condition and the mode of transportation. The consent form shall be in writing and properly signed, dated, timed and witnessed. (See Patient Care "Discharge or Transfer of an Inpatient to Another Health Care Facility Policy/Procedure" and "Transport of Inpatient to Another Hospital When Services Are Not Available Policy/Procedure."

5.1-3 **Physician Responsibilities.** The physician performing the surgical or invasive procedures is responsible for informing the patient of 1) the nature of the condition for which the procedure is to be performed, 2) the nature and the probability of the reasonably foreseeable risks and benefits, and 3) alternative treatments. The physician must document this discussion with the patient. The anesthesiologist must document the discussion leading to informed consent to anesthesia.

5.1-4 **Waiver of Informed Consent.** Informed consent may be waived if no legally authorized individual is available to give consent and the physician has determined that a medical/surgical emergency exists; that immediate care is needed to avoid serious or permanent injury to the patient; and that delay of treatment to secure express consent would materially increase the risk to the patient's life or health. The physician must document that an emergency existed and that immediate treatment was necessary. The physician should also complete, sign, date and time the "Physician's Certificate of Emergency and Necessity" form.

5.1-5 **Capacity to Consent or Refuse Treatment.** An adult patient eighteen (18) years or older with decision-making capacity generally has the right to consent or refuse to consent to medical treatment. Spouses and other family members do not have the right to consent or refuse consent for competent patients. Where the patient is unable to make or communicate health care decisions, the patient's legal guardian, agent or Surrogate may give or refuse consent. For unemancipated minors and wards, parents or guardians generally have the right to consent. (See the Banner Heart Hospital Policy and Procedure entitled"Consents")

5.1-6 **Advance Directives.** Patients may execute Living Wills/Advance Directives to either direct or guide their future health care decisions when they no longer have decision-making capacity. Risk Management should be consulted whenever a surrogate's decisions are known to conflict with directives given by the patient in an Advance Directive. The physician must transfer care of the patient to another physician if the surrogate's decisions violate the physician's conscience.

6.1 PHYSICIAN ORDERS

6.1-1 General Information

A. Admitting orders are provided by the responsible physician.
B. All physician orders are to be entered electronically or written in dark ink (blue or black). Felt pens and pencils will not be accepted.
C. All physician orders will be timed, dated and signed as soon as possible, but will be considered delinquent at 22 days.
D. BHH will not honor rubber stamp signatures. An electronic signature from your computer system is acceptable provided that it states "electronically signed by" and has the date and time documented.
E. All orders must be timed, dated and signed by the physician when written and timed, dated and signed by the nursing staff transcribing the order. When a verbal order is taken by the nurse, pharmacist, respiratory therapist, dietician, etc. the verbal order must also be timed, dated and signed.
F. A signature date, and time must be present on the order; a digital date from a fax machine is not valid.
G. Orders as originally written cannot be changed or added to at some future time. When it is necessary to change an order, it must be completely rewritten with a current signature, date and time.
H. The practitioner must authenticate all pages of the orders. Where the practitioner adds, deletes or modifies any order set or if the order set contains selections, the practitioner

must also authenticate the page with signature, date and time where any change was made.

I. Nurses have the responsibility of questioning any order that they feel might harm the patient. In areas other than nursing, registered pharmacists, occupational therapists, physical therapists, registered dietitians, speech therapists, and respiratory care practitioners also have the responsibility of questioning any order that they feel might harm the patient.

J. The practitioner name/signature shall be legible and on their order form for reference if needed

K. Orders, which are not legible, will be clarified with the responsible physician before they are carried out.

L. Orders written on another facility's transfer form are confirmed with the attending physician. Verification of appropriateness is written on the Banner Heart Hospital's physician order sheet.

M. Automatic Stop Orders
For Labs and X-Rays – all daily labs and chest x-ray orders shall be discontinued automatically after three days unless:
1.) The order specifies an exact period of time
2.) The attending physician reorders the daily lab, or;
3.) The physician has not been notified before the discontinuance

6.1-2 Orders for Surgery/Invasive Procedures

A. A physician order is needed to obtain consent for surgery or for any invasive procedure. The order will state the specific procedure to be performed. The procedure listed on a signed fax preoperative order form can serve as the surgical consent order. The physician is responsible for signing, dating and timing the orders and verifying that the correct surgical/invasive procedure has been indicated for telephone orders.

B. Do not use "rule out," "suspect," "probable" or "questionable." These are not valid diagnoses for outpatient procedures and a new order will be requested.

C. Anesthesia medication orders given by the anesthesiologist performing the case will take precedence over other preanesthesia medication orders.

D. The surgeon should give all routine admission orders.

E. Post-operative orders shall be written, signed, dated and timed by the practitioner. Note: "Resume Preoperative Orders" is not an appropriate postoperative order.

F. All orders for medications shall be ordered and dispensed pursuant to the relevant Banner Health "System Pharmacy" Policies and Procedures.

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

6.1-3 Orders for Outpatient Tests

A. A signed, dated and timed order must be received prior to performing outpatient procedures/tests.

B. A statement of the reason for the test and/or diagnosis must be indicated on the order and it must also contain a physician signature, date and time.

C. The practitioner must authenticate all of the orders. Where the practitioner adds, deletes or modifies any order set or if the order set contains selections, the practitioner must also authenticate the page with a signature, date and time and where any change was made.

D. The following facsimiles or original orders are accepted:
1. Hospital outpatient scheduling form
2. Prescription form
3. Referral form (can be payor specific)
4. Notation in patient's history and physical

5. Physician order sheet
6. Physician office letterhead (stationary)

6.1-4 Preprinted and Faxed Orders

A. Preprinted orders for medications may be used by the medical staff after review and approval of the appropriate Department. These orders will be individualized for each patient by the ordering physician by drawing a line through the unwanted items and adding any additional orders as indicated. The physician must sign, date and time these orders.

B. If faxed orders are transmitted to the Banner Heart Hospital by the attending physician, his/her orders must be transmitted on the attending physician's letterhead or on the Banner Heart Hospital physician order sheet. The order will be dated, signed and timed and placed in the patient's medical record. If presigned faxed orders have additional writing, the order will be flagged for an original signature, date and time.

6.1-5 Verbal and Telephone Orders

A. Verbal and telephone orders may be accepted only by a registered nurse (RN) on nursing units. In areas other than nursing, certain telephone and verbal orders may be taken by personnel in each department who are most qualified to accept them. Registered pharmacists, occupational therapists, physical therapists, registered dietitians, speech therapists, and respiratory care practitioners may accept telephone or verbal orders pertaining to their discipline. The director of the department will be responsible for the acceptance of such orders, and the designation, if necessary, of personnel with the appropriate skills to accept telephone or verbal orders. All such orders will be strictly limited to the area of expertise of the department. These orders shall be signed, dated and timed as soon as possible.

B. Only physicians and authorized allied health professionals are permitted to give telephone or verbal orders for inpatient services. Practitioner non-licensed office staff are not permitted to give telephone or verbal orders.

C. Registered pharmacists are permitted to give telephone or verbal orders under physician ordered pharmacotherapy consultation.

D. All verbal and telephone orders shall be verified with a "read-back to the practitioner by the qualified personnel accepting the order. The qualified personnel taking the order will write down the order, date and time the order and then read it back verbatim to the practitioner who initiated the order. The practitioner shall then verbally confirm that the order is correct. For emergency situations only, a repeat back of the order is acceptable prior to writing the order down. An emergency situation is defined as any patient condition requiring rapid intervention in order to stabilize the patient's condition to avoid an adverse outcome.

E. 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 disciplines.

6.1-6 Do Not Resuscitate (DNR) Orders

A. Do not resuscitate (DNR) and/or withdrawal of care orders shall require discussion with the patient and/or the patient's legally authorized representative. The primary Cardiovascular Specialist or Thoracic Specialist who accepts and assumes care of the patient shall be involved in the decision making prior to the code status orders being written. If the physician is unable to concur and implement those stated wishes, he/she should transfer the care of the patient to another physician.

B. All Do Not Resuscitate (DNR) orders and/or withdrawal of care orders are entered in the patient's medical record and signed, dated, and timed by the primary Cardiovascular

Specialist or the Thoracic Specialist who has assumed the primary responsibility for care of the patient. The progress note should contain the physician's medical reasons for the order and his/her discussion with the patient, or where the patient lacks medical decision-making capacity, with the patient's agent or surrogate decision maker.

C. Telephone Do Not resuscitate (DNR) orders are discouraged. However, if the 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 Do Not Resuscitate (DNR) status. The physicians will sign, date and time the Do Not Resuscitate (DNR) order upon their next visit and document the reasons (as in paragraph B. above) even though the patient may have already expired.

D. 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. The medical record will reflect whether the DNR order is to be suspended and, if so, for what period of time perioperatively and post-anesthesia.

7.1 VENDOR REPRESENTATIVES

7.1-1 Without exception, all vendor representatives shall complete the Banner Health Materials Management Protocol prior to being authorized access to a patient unit. Vendor representatives may not serve, as a required physician observer.

8.1 MEDICAL RECORDS

8.1-1 General

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

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

8.1-2 Purpose of the Medical Record

The purposes of the medical record are:

A. to serve as a detailed database for planning patient care by all involved practitioners, nurses, and ancillary personnel;

B. to document the patient's medical evaluation, treatment, and change in condition during the hospital stay or during an ambulatory stay;

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

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

E. to assist in protecting the legal interest of the patients, the hospital, and practitioners responsible for the patient and to provide data for use in the areas of quality and resource management, billing, education, and research.

8.1-3 Electronic Medical Record (EMR)

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

A. **Use of EMR**

All medical record documents created after the patient is admitted will be created utilizing Banner Health approved forms or Banner Health electronic systems to allow for patient information to be exchanged and shared electronically among healthcare providers. This includes operative reports, consultations, discharge summaries, and progress notes. The following documents are exceptions:

1. Documents from contracted/credentialed external sources that pertain to the delivery of patient care, such as radiology and telemedicine reports and select physician's orders, with approval by the Banner Health System Forms Committee. These reports must meet the time requirements and contain the data elements specified in the medical staff rules and regulations.
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.
3. Other documents that are created utilizing Banner Health unapproved forms or non-Banner Health electronic systems after the patient is admitted may be accepted only through approval of the Banner Health System Forms Committee.

B. **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.

C. **EMR Training**

Practitioners who are appointed to the medical staff or allied health staff pending Banner electronic medical record training (EMR) and who have not completed this training within six (6) months from the effective date of temporary privileges or Board approval 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 to case basis to be determined by the facility CEO.

D. **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 and regulatory guidelines and Banner records retention policy.

8.1-4 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 constitute grounds for disciplinary action.

8.1-5 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 hospital only in accordance with State and Federal law, a court order, or subpoena, the permission of the hospital'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 hospital or disclosure of patient information constitutes grounds for disciplinary action.

8.1-6 Passwords

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

8.1-7 Information from Outside Sources

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

8.1-8 Abbreviations

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

8.1-9 Responsibility

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

8.1-10 Counter-Authentication (Endorsement)

a. Physician assistants: All physician assistant entries into the medical record, as described in the appropriate scope of practice, must be counter-authenticated timely by the physician according to individual facility medical staff policies. Each clinical event must be documented as soon as possible after its occurrence.

b. Nurse Practitioners: All nurse practitioner entries into the medical record, as described in the appropriate scope of practice, must be counter-authenticated timely by the physician according to individual facility medical staff policies. Each clinical event must be documented as soon as possible after its occurrence.

8.1-11 Legibility

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

8.1-12 Medical Record Content

A. The medical record documentation and the content the medical record must identify the patient, support the diagnosis, justify the treatment, and document

the course and results of treatment, and facilitate continuity of care. The medical record is sufficiently detailed and organized to enable:

1. the responsible practitioner to document continuing care that allows another practitioner to determine, at a later date, what the patient's condition was at a specified period of time;
2. the time, and review diagnostic/therapeutic procedures performed and the patient's response to treatment;
3. a consultant to render an opinion after an examination of the patient and review of the health record;
4. another practitioner to assume care of the patient at any time;
5. retrieval of pertinent information required for utilization review and/or quality assurance activities, and;
6. accurate coding diagnosis in response to coding queries.

B. **History and Physical Examination (H&P)**

A history and physical examination must be performed within 24 hours after admission or registration for inpatients or observation or prior to surgery or invasive procedure or any procedure in which conscious sedation or anesthesia will be administered. The H&P shall be completed by a physician or allied health professional that is approved by the medical staff to perform admission history and physical examinations, and place in the patient's medical record.. The completed H&P must be on the medical record or the case will be cancelled unless the responsible physician documents in writing that such delay would constitute a hazard to the patient. A new history and physical is required to be completed for all patients admitted or transferred to a rehabilitation unit. A legible office history and physical performed within thirty (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 history and physical as long as all the elements required in the document, for history and physical 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 twenty-four (24) hours after registration or admission, but prior to surgery or a procedure requiring anesthesia services. The organized medical staff monitors the quality of medical history and physical examinations.

2. Contents of history and physical for all inpatients, observation patients, and for those outpatients having procedures requiring general, spinal, epidural anesthesia, or IV moderate sedation, the history and physical must include the following documentation as appropriate:

   a. Medical history;
   b. Chief complaint;
   c. History of the current illness including, when appropriate, assessment of emotional, behavioral, and social status;
   d. Relevant past medical, family and/or social history, appropriate to the patient's age;
   e. Review of body systems;
   f. A listing of current medications;
   g. Any known allergies, including past medication reactions and biological allergies;
   h. Existing co-morbid conditions;
   i. Physical examination (current physical assessment);

j. Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination;
k. Initial plan: statement of the course of action planned for the patient while in the hospital;

C. **Progress Notes**
Progress notes should be electronically created with a frequency that reflects appropriate attending involvement, but at least every day. Progress notes should describe not only the patient's condition but also include response to therapy.

D. **Admitting Notes**
The responsible provider must see the patient and document an admitting note that justifies admission and determines the plan of treatment, within twenty-four (24) hours of admission.

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

F. **Pre-Operative Anesthesia Sedation Evaluation**
A pre-anesthesia/sedation evaluation must be conducted and documented by an individual qualified to administer anesthesia or conscious sedation, within twenty-four (24) hours prior to the procedure. A pre-anesthesia sedation evaluation of the patient must include pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, and other pertinent anesthetic experience, any potential anesthetic problems, American Society of Anesthesiologists (ASA) patient status classification and orders for pre-operative Medication, except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before the pre-operative medication has been administered. Immediately prior to the induction of anesthesia while the patient is on the procedural table, the patient's vital signs, airway and response to pre-procedure medication must be assessed and the equipment checked.

G. **Intra-Operative Record and Post-Anesthesia Record**
An inter-operative anesthesia/sedation record will be maintained for each patient and include drugs/agents used, pertinent events during anesthesia/sedation, indications, maintenance of emergence from anesthesia/sedation, all other drugs, intravenous fluids, and blood components given.

1. Documentation of the post-anesthesia care includes the patient's level of consciousness upon entering and leaving the area, vital signs, and status of infusions, drains, tubes, catheters, and surgical dressing (when used), unusual events or complications and management.
2. A post-anesthesia evaluation for proper recovery of anesthesia must be completed and documented by an individual qualified to administer anesthesia, within forty-eight (48) hours after the procedure or prior to the patient being discharged or transferred from post-anesthesia care, regardless of type or location where anesthesia was performed.

H. **Operative and Procedure Reports**

Operative and procedure reports must contain, as applicable, the post-operative diagnosis, a detailed account of the findings, the technical procedures used, and the specimens removed, the estimated blood loss, and the name of the primary performing practitioner and any assistants. The full report must be documented immediately, as well as the recording of a post-operative progress note to be made available in the record after procedure, providing sufficient and pertinent information for use by any practitioner who is required to attend the patient. Procedures requiring documented operative reports are identified in this document.

I. Prior to any operative/invasive procedure, the medial record must contain an informed consent.

J. **Tests and Special Procedures**

1. The following tests/procedures do not require an H&P:
   a. Echocardiograms
   b. Duplex Studies
   c. Doppler Studies
   d. Venous (legs/arms) Studies
   e. Ultrasounds
   f. Stress Tests
   g. Nuclear Medicine Stress Test
   h. Electrocardiogram
   i. Tilt Table Procedures

2. Special procedures (EEGs, EKGs, treadmill stress tests, echocardiograms, tissue, medical imaging) and other special procedure report will be interpreted and documented within twenty-four (24) hours of notice. Notice will be a communication to the physician or agent to inform the provider of the test completion.

K. **Discharge Documentation**

1. 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 forty-eight (48) hours or greater in length. The discharge summary shall include:
   a. the reason for hospitalization;
   b. a concise summary of diagnoses, including any complications or co-morbidity factors;
   c. documentation concerning the hospital course, including significant findings;
   d. the procedures performed and treatment rendered;
   e. the patient's condition on discharge, describing limitations;
   f. the patient/family instructions for continued care and/or follow-up

2. The final discharge progress notes should be documented immediately upon discharge for inpatient stays less then forty-eight hours, observations and extended recoveries. The final discharge progress note should include:
   a) the final diagnosis (es);
   b) the condition of patient;
   c) the discharge instructions, and

d) the follow-up care required.

L. **Documentation of Death**
A death summary is required for all deaths regardless of length of stay and must be documented at the time of death but no later than seven 24 hours thereafter by the responsible practitioner.

M. **Documentation for Inpatient Transfers to Another Facility**
The transferring physician must dictate or electronically create a transfer summary at the time of transfer, regardless of length of stay, to include documentation that the patient was advised of risks/benefits of transfer.

N. **Amending Medical Record Entries**

1. **Electronic Documents (Structured, Text, and Images)**
   a. An individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error or omission through the EMR. The EMR will track all changes made to entries.
   b. 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 electric addendum in which the individual will document the erroneous information, authenticate the entry, and the system will date and time stamp the entry.
   c. 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.
2. **Paper-Based Documents**
   a. Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error by drawing a single line through the erroneous entry, but not obliterating it, and initial and date the error.
   b. 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 health information services department to permit a review of the erroneous documentation for recording in-error criteria within the EMR.
   c. Any physician who discovers a possible error made by another individual should immediately, upon discovery, notify the supervisor of that clinical or ancillary area.

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

of the information copied, that the data was entered by another provider. If referencing a form within the record, the form must be referenced with sufficient detail to identify the source. Example: "for review of systems, see form dated 6/1/10".

8.1-13 Timely Completion of Medical Records

A. **Complete Medical Record**

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

B. All medical record documents shall be completed within the time frames defined below:

1. Admitting progress note: documented within 24 hours of discharge/disposition from the ED;
2. History and physical: documented within 24 hours of admission and before invasive procedure;
3. Consultation reports: documented within 24 hours of consultation;
4. Post-operative note: documented immediately post-operatively when there is a delay in the availability of the full report;
5. Provider coding clarification: documented within 24 hours of notice;
6. Operative report: documented immediately post-op and no later than 24 hours after the procedure;
7. Special procedures report: documented within 24 hours of notice;
8. Discharge summary report: documented at the time of discharge but no later than 24 hours after discharge;
9. Discharge progress note: documented at the time of discharge but no later than 24 hours after discharge;
10. Death summary: documented at the time of death but no later than 24 hours after death;
11. Transfer summary: documented at the time of transfer but no later than 24 hours;
12. Signatures: authentication of transcribed or scanned reports and progress notes within 7 days from the date of notice;
13. Verbal orders: dated, timed, and authenticated as soon as possible, but will be considered delinquent at 72 hours;
14. Psychiatric evaluation: documented within 24 hours of admission.
15. Death Pronouncement Note: completed at the time the patient is pronounced but within 24 hours.

C. **Medical Record Deficiencies**

Failure to Comply with 8.1.13-B Can Result in Suspension of Privileges:

1) Suspension process

(a) Notice of Missed Deadline:
HIMS promptly notifies physician via electronic inbox of missed deadline and reminds the physician that they will be eligible for suspension if the record is not completed within 7 days.

(b) MEC Review:
Seven days after the reminder by HIMS, Medical Staff Services notifies the member that he/she has been suspended and that the member is invited to attend the next regularly scheduled BHH MEC meeting after onset of suspension to explain his/her delinquent status. If the physician completes the

delinquent records prior to the next MEC meeting, his/her attendance at that meeting is not required. If the physician fails to complete the delinquent records and fails to attend the MEC meeting, suspension continues and MEC may take additional disciplinary action.

2) Sanctions, Temporary Medical Records Suspension:
Members who fail to complete charts as required shall lose the privileges to:
(a) admit and attend patients;
(b) schedule a patient for any elective invasive or surgical procedure;
(c) Consult and/or;
(d) Fill shifts (as ED Physicians or Hospitalists), until the delinquent records are completed.

The MEC may also deny the physician any prerogative to be on ER call and BHH may report
the physician to the appropriate State Licensing Board.

3) Continuing Responsibilities of Physicians on Medical Records Suspensions
(a) Physicians under Medical Records Suspension (other than those practicing by shifts) shall continue to provide the following care:
1. ER-Call and admissions resulting from such ER-Call, unless MEC has suspended the physician's ER-Call privileges.
2. Routine care for his/her own patients already in the Hospital at the time of suspension. ("Routine care" does not include consultations, invasive procedures or surgery assist.)
3. Prompt emergency care for Hospital patients requiring medical services. The physician's department will review the appropriateness of the "emergency care" designation.

(b) Suspended physicians must provide cover by one or more physicians with appropriate privileges to assume his/her patient care duties, including ER-call, if the Executive Committee has denied the physician the prerogative to cover call.

4) Prohibited Circumvention:
If a suspended Staff member admits a patient under another Staff physician's name, and exercises any clinical privileges with respect to the hospitalized patient, this matter will be forwarded to the appropriate clinical department meeting for disciplinary action.

5) Permanent Loss of Privileges.
Recurring or continuing violation of the HIMS Rules and Regulations may result in further disciplinary action by the MEC.

8.14 Organized Healthcare Arrangement: HIPAA Compliance

The Hospital and all members of the Medical Staff shall be considered members of, and shall participate in, the Hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information. An OHCA allows the Hospital to share information with practitioners and their offices for purposes of payment and practice operations. Each Medical Staff member, practitioner with temporary privileges and Allied Health Professional with practice prerogatives agrees to comply with the Hospital's policies as adopted from time to time regarding the use and disclosure of protected health information ("PHI") as those terms are defined by HIPAA.

9.1 MEDICATIONS

9.1-1 General Information.

All medications administered to patients at the Banner Heart Hospital will be supplied by the Banner Heart Hospital Pharmacy unless otherwise defined by policy or by pharmacy approval. The Pharmacy maintains a formulary as authorized by the Medicine and Surgery Departments. The formulary is an established compendium of approved medications available at the hospital for diagnostic, prophylactic, therapeutic or empiric treatment of patients. The pharmacy is not required to stock more than one brand of an approved individual medication. Medications ordered by trade name may not necessarily be filled by that name unless the physician states "do not substitute" on the order. The pharmacy will be permitted to make therapeutic substitutions of medications only within clearly defined parameters established by the Medicine and/or Surgery Departments and approved by the Executive Committee. Outpatient prescriptions, with the few exceptions defined in pharmacy policy will not be filled at Banner Heart Hospital.

9.1-2 Medications from Outside.

Medications brought into the hospital by patients must be specifically ordered by the physician and identified according to approved policy before being administered by the Banner Heart Hospital personnel. These medications will be maintained according to the Banner Health System "Medications Brought in by the Patient" Policy and Procedure. Medications may be kept at the patient's bedside for self-administration only upon specific written orders of the physician and in accordance with the Banner Health System "Self Administration of Medications" Policy and Procedure. Medications brought in by the patients that cannot be identified will not be administered to the patient by Banner Heart Hospital personnel nor should they be taken by the patient.

9.1-3 Medication Orders.

A. Medication Orders must be legible and accurate, including date, time and signature. All orders for medications must be complete including medication name, dosage form, dose, strength, route (if medications can be administered by more than one route), frequency, rate, method, and site of administration. Medications ordered as "PRN" must specify frequency and indication. The use of abbreviations should be minimized and only standard abbreviations on the Banner Heart Hospital's approved list can be used. Medication dosages should be expressed in the metric system and the use of unnecessary decimal points or zeros after a decimal point should be avoided. A zero should be placed in front of a leading decimal point.

B. All medication orders must be reviewed by a pharmacist prior to the administration of the drug unless a physician controls the ordering, dispensing, and administration of the drug, such as in the CVOR or, in emergency situations in which the clinical status of the patient would be significantly compromised by the delay that would result from the pharmacist review.

C. 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.

9.1-4 Authorization to Order Medications

Medical practitioners with clinical privileges and licensed by the State of Arizona to prescribe

medications may write orders for medications. Allied Health Professionals may write orders as defined in the Allied Health Scope of Practices. Registered pharmacists are permitted to order medications under physician ordered pharmacotherapy consults or within clearly defined clinical protocols as defined by the Department of Medicine or the Department of Surgery and approved by the Executive Committee.

9.1-5 Authorization to Administer Medications.

A. Only appropriately licensed personnel or approved personnel working under the direction of a licensed person may be allowed to administer medications and/or diagnostic contrast media.

The following categories of personnel may administer medications at the Banner Heart Hospital under the order of a qualified, licensed practitioner.

1. Physicians and Physicians' Assistants.
2. Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Certified Registered Nurse Anesthetist and Clinical Perfusionist.
3. Respiratory Care Practitioners, Levels 1, 2, 3, and 4 (medications related to respiratory therapy treatments only).
4. Respiratory Care Coordinator, Supervisor and Education Coordinator (medications related to respiratory therapy treatments only).
5. Respiratory Technical Specialists (medications related to respiratory therapy treatments only).
6. Radiology Technologist and Nuclear Medicine Technologist (medications related to radiology/nuclear procedures only).
7. EEG Technician and Cardiovascular Technician (CVT) (oral medications only) and Anesthesia Technicians
8. Physical Therapist (topical medications only)
9. Nursing and Respiratory students under direct supervision of a preceptor.

B. For those job categories, listed above, not licensed by the State of Arizona to administer medications and whose educational preparations do not include training in administering medication, a training and skills assessment program should be in place.

10.1 PATHOLOGY

A. Tissues and foreign bodies removed during a surgical procedure shall be sent to the Banner Heart Hospital pathologist for evaluation. 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.

1. Specimens sent to the laboratory shall be examined by a pathologist. The determination of which categories of specimens require only a gross description and diagnosis shall be made conjointly by the pathologist and the medical staff, and documented in writing. Categories of specimens that are exempted from the requirement to be examined by a pathologist are the following:
   a. Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance;
   b. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;
   c. Foreign bodies (for example, bullets) that for legal reasons are given directly in

the chain of custody to law enforcement representatives;

d. Specimens known to rarely, if ever, show pathological change, and removal of this is highly visible postoperatively.

11.1 SITE IDENTIFICATION AND MARKING

The Banner Heart Hospital "Invasive Procedure and Surgical Site Identification and Marking Policy and Procedure" shall be utilized to prevent wrong patient, wrong site, and wrong procedure errors to the operative or high-risk invasive procedure patient.

12.1 USE OF PHYSICAL RESTRAINTS

12.1-1 The Banner Heart Hospital supports the right of each patient to be free from restraint of normal physical movement and will use mechanical or physical restraints only as such are clinically necessary to provide care and/or protection of patients or others and only after less restrictive alternatives have been attempted and in a manner less likely to affect the medical condition
.

12.1-2 Physicians and Allied Health Staff must comply with the Banner Health Policy/Procedure "Restraint Use in Non-Violent Situations" and "Restraint Use in Violent Situations".

13.1 AUTOPSIES

13.1-1 Autopsies will be encouraged for inpatients as a part of the facility's quality assurance program and at no cost to the family under the following circumstances:

A. Deaths in which an autopsy may help explain unknown and unanticipated medical complications and for educational interest.
B. Deaths in which the cause is not known with certainty on clinical grounds.
C. Unexpected and unexplained deaths occurring within forty-eight (48) hours after any medical, surgical or dental, therapeutic or diagnostic procedures that do not fall under medico-legal jurisdiction.
D. Deaths occurring in patients who are at time of death, participating in clinical trials (protocols) approved by institutional review boards.
E. Sudden, unexpected, or unexplained deaths, which are apparently natural and not subject to forensic medical jurisdiction.
F. Natural deaths that are subject to, but waived by medico-legal jurisdiction.
G. Deaths resulting from high-risk infectious and contagious diseases, which have been waived by the Medical Examiner.

13.1-2 In certain instances, patient advanced directives, physician preference, and family requests may preclude performing an autopsy.

13.1-3 The attending physician or his/her designee requests and obtains permission for an autopsy from the family. Signed, dated and timed consent must be obtained from the patient's immediate next of kin (father, mother, spouse, or adult child) or an individual providing proof of power of attorney or guardianship.

A. It must be witnessed by at least one person present at the time of signing.
B. Any exclusion (e.g. brain) or "none" must be noted on the autopsy consent form at the time of signing.
C. 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 exclusion is submitted directly to the HIMS Department.

13.1-4 A Pathologist may refuse to perform an autopsy under the following situations:

A. The case meets the criteria of a Medical Examiner's case.

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

13.1-5 The pathologist determines who can be present during an autopsy.

13.1-6 Families requesting an autopsy when the attending physician will not authorize the autopsy may contact an independent pathologist to perform the post mortem exam. A list of outside pathologists will be provided. The hospital will not be responsible for any arrangements nor charges associated with independent autopsies.

13.1-7 The pathology department of the hospital will notify the medical staff, specifically the attending physician, when an autopsy is being performed.

14.1 QUALITY RESOURCES AND UTILIZATION MANAGEMENT

14.1-1 In the management of any admission, it is the attending physician's responsibility to utilize medical resources efficiently, including to:
A. Obtain pre-admission or pre-procedure certification if necessary.
B. Admit patients on the day of their elective surgery or procedure or provide documented reasons of medical necessity for earlier admission.
C. Initiate timely discharge planning.
D. Facilitate, when possible, the appropriate pre-admission testing and medical clearance for elective surgical admissions.
E. Cooperate with physician advisors when issues or questions arise regarding necessity for admission or continued stay.
F. Participate in appeal of outside denials if the denial is felt to be unjustified.

14.1-2 Where a managed care plan has prospectively denied hospitalization, the physician should not order discharge until it is medically justifiable; should immediately appeal with the plan for reevaluation of medical necessity; and inform the patient of the denial to permit the patient to appeal and/or to authorize medical services at his/her own expense.

15.1 PEER REVIEW AND SENTINEL EVENT INVESTIGATION

15.1-1 Practitioner peer review shall be accomplished as provided in the Banner Heart Hospital policy/procedure entitled "Peer Review."

15.1-2 Sentinel event investigations shall be accomplished as provided in the Banner Health "Sentinel Event Policy."

16.1 INFECTION CONTROL: PHYSICIAN RESPONSIBILITIES

16.1-1 Hand washing: All medical staff members must wash their hands in a manner as described in the infection control policies and procedures, both before and after they examine patients or perform procedures.

16.1-2 Diagnostic Infections: Medical Staff members who suspect their patient may have a communicable infection are expected to order appropriate studies sufficient to diagnose or rule out conditions requiring isolation.

16.1-3 Restricted Antibiotics: To ensure that antibiotics are used to the best advantage for individual patients and with the smallest impact upon the hospital environment, the use of certain antibiotics may be limited by the Executive Committee.

16.1-4 Reportable Communicable Diseases: The BHH Infection Control Specialist reports communicable diseases as required by Arizona law and will determine whether a disease is required by Arizona law and will determine whether a disease is required to be reported. Upon being provided with the pertinent patient information.

16.1-5 Infection Control Policies: Medical Staff members may access Banner Infection Control policies via the Banner Intranet available at every nursing station.

16.1-6 Standard Precautions: It is hospital policy to consider the blood of every patient as potentially infected with blood borne pathogens. Medical Staff members must utilize personal protective equipment as described below. Medical Staff members must wear gloves when:

a) drawing blood;
b) handling blood materials during and after surgery;
c) pathological examinations and autopsies;
d) having contact with blood or body fluids or materials contaminated;
e) cleaning incontinent patients, and/or;
f) changing surgical, wound, or other types of dressings.

16.1-7 Face Shields: Medical Staff members must wear face shields or masks and eye coverings in all situations in which blood contamination of the mouth, face, or eyes might be anticipated.

16.1-8 Gowns: Medical Staff members must wear impervious gowns or aprons in all situations in which contamination of the clothing by blood or body fluids might be anticipated.

16.1-9 Conflict Resolution: The Chair of the Department of Medicine is authorized to institute prevention or control measures when there is reason to believe that patients or personnel are in danger. Intervention that impacts a specific patient is permitted after diligent efforts to involve the attending physician

17.1 READING PANELS

17.1-1 EKG Reading Panel

A. Qualifications for EKG reading panel membership shall include:
   1. membership in good standing on the Banner Heart Hospital Medical Staff;
   2. admission or consultation of at least twenty-five (25) patients annually;
   3. board certification or qualification for examination in cardiology, and
   4. having requested and been granted EKG interpretation privileges at Banner Heart Hospital.

B. Reading requirements EKG reading panel members include:
   1. interpretation of all electrocardiograms and rhythm strips, on a daily basis, during the contracted physician's assigned panel rotation, and
   2. the availability of the contracted physician to read EKGs seven (7) days per week, twenty-four (24) hours per day.

C. Under the direction of the Banner Heart Hospital Medical Director, contracted physicians who fail to interpret EKGs within twenty-four (24) hours within a two (2) day reading period may be subject to removal from the reading panel for the remainder of the contract.

17.1-2 Echo Reading Panel

A. Qualifications for echo reading panel membership shall include:
   1. membership on the Banner Heart Hospital Medical Staff in good standing;

2. admission or consultation of at least twenty-five (25) patients annually;
3. board certification or qualification for examination in cardiology, and
4. having requested and been granted echocardiogram interpretation privileges at Banner Heart Hospital.

B. Reading requirements for echo reading panel members include:
1. interpretation of all unassigned echocardiograms, color flows, Cardiac Dopplers, holter monitors and stress tests for cases with no cardiology consultant;
2. that the physician reader shall provide dictated reports on unassigned (non-EKG) tests within twenty-four (24) hours after being notified of the test being completed, and
3. interpretation of all echocardiograms, color flows, dopplers, holter monitors, and stress tests with an assigned cardiology consultant not dictated within forty-eight (48) hours will be reassigned to the contracted physician for interpretation within twenty-four (24) hours.

C. Under the direction of the Banner Heart Hospital Medical Director, contracted physicians who fail to interpret within twenty-four (24) hours, within a two (2) day reading period may be subject to removal from the reading panel for the remainder of the contract.

17.1-3 <u>Vascular Study Reading Panel</u>

A. Qualifications for vascular study reading panel membership shall include:
1. successful completion of a formal training program (residency or fellowship) that included appropriate didactic and clinical vascular laboratory experience as an integral part of the program and have experience in interpreting the following minimum number of studies under supervision: 100 carotid duplex studies, 100 peripheral arterial physiologic tests, 100 peripheral arterial duplex studies, and 100 venous duplex studies, or
2. having an established practice with training and experience considered appropriate for a physician who has worked in a vascular laboratory for at least three (3) years and has interpreted the following minimum number of vascular studies: 300 carotid duplex studies, 300 peripheral arterial physiologic tests, 300 peripheral arterial duplex studies, and 300 venous duplex studies;
3. membership on the Banner Heart Hospital Medical Staff in good standing;
4. admission or consultation of at least twenty-five (25) patients annually;
5. board certification or qualification for examination in cardiology, vascular, or cardiovascular medicine, and
6. having requested and been granted privileges for carotid duplex studies, peripheral arterial physiologic tests, arterial duplex studies, and venous duplex studies at the Banner Heart Hospital.

B. Reading requirements for all vascular study reading panel members shall include:
1. interpretation and dictation of all assigned studies within twenty-four (24) hours of study completion;
2. signature on the final dictation report within forty-eight (48) hours, and
3. review of all data, tapes, and technician notes before the final report is issued.

C. Under the direction of the Banner Heart Hospital Medical Director, contracted physicians who fail to interpret studies within twenty-four (24) hours, within a two (2) day reading period may be subject to removal from the reading panel for the remainder of the contract.

17.1-4 <u>Qualified Readers not on the Reading Panels Shall:</u>

A. Meet the same qualifications and reading requirement as panel members.
B. Shall incur the same interpretation requirements as reading panel members.

C. May be subject to loss of reading privileges if not compliant with the reading requirements described above.

18.1 DISCHARGE OF PHYSICIAN OR PATIENT

18.1-1 When an inpatient discharges his/her physician from his/her further care, either the physician shall make arrangements for another physician to assume care of the patient or the medical staff services department staff shall provide the patient with a listing of all staff physicians within the same specialty so that the patient can contact one of these physicians to assume his/her care. However, the physician shall be responsible to provide care of the patient until a new physician has agreed to assume care of the patient.

18.1-2 if the patient's attending physician becomes unable (e.g., emergency, illness) or unwilling to care for the patient, it is the physician's responsibility to make arrangements for another staff physician to continue care of the patient. If the patient's attending physician is unable to make these arrangements, the chair of the appropriate department, or his/her designee, shall be contacted and shall arrange for an appointee to the department to assume care of the patient.

18.1-3 If a physician discharges the inpatient and the inpatient physically refuses to leave the hospital, the chair of the appropriate department, or his/her designee, shall be contacted to review and discuss the matter with the attending physician and/or the patient and provide for the care of the inpatient by a staff physician, until discharge arrangements can be made.

19.1 PROFESSIONAL RELATIONS

Medical Staff members who have complaints about operational matters or question the professional judgment or conduct of an individual Medical Staff member or hospital personnel should communicate their concerns as follows:

19.1-1 Concerns About Hospital Operational Issues and Other Medical Staff Members

Medical Staff members shall communicate their concerns about other Medical Staff members to the President of the Medical Staff who shall determine whether or not the concern should be forwarded to the Medical Staff Department Chair for review. Its confidentiality is protected to the extent permitted by law, consistent with Medical Staff Services Policies and Procedures approved by the Executive Committee.

19.1-2 Concerns About Hospital Personnel

Medical Staff members shall attempt to resolve concerns about hospital personnel when and where the issue arises, in a respectful manner. If the problem cannot be resolved in that manner, the Medical Staff members shall communicate their concern to the appropriate Department Director or Administrator. Its confidentiality is protected to the extent permitted by law, consistent with the Medical Staff Services Policies and Procedures approved by the Executive Committee.

20.1 AMENDMENT

These General Rules and Regulations shall be a part of the Bylaws, subject to approval by the Board. The General Rules and Regulations may be amended or repealed, in whole or in part, by a resolution of the Executive Committee and approval by the Board.

ADOPTION AND APPROVAL

Adopted and recommended to the Banner Health Board of Directors by the Banner Heart Hospital Executive Committee on June 26, 2014.

Approved and adopted by the Banner Health Board of Directors on this July 21, 2014