



MEDICAL STAFF RULES & REGULATIONS

BANNER OCOTILLO MEDICAL CENTER

Chandler, Arizona

MEDICAL STAFF RULES AND REGULATIONS

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**BANNER OCOTILLO MEDICAL CENTER
MEDICAL STAFF RULES AND REGULATION**

These Medical Staff Rules and Regulations shall supplement the general principles found in the Banner Health d/b/a North Ocotillo Medical Center ("Medical Center") Medical Staff Bylaws ("Bylaws"). They shall be consistent with the Bylaws and Medical Center policies and may not conflict with the Banner Health Bylaws.

ARTICLE I: GENERAL

1.1 ACTIVE STAFF

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 AVAILABILITY

Physicians and advanced practice professionals 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 or advanced practice professional must be answered within 15 minutes of the call; failure to respond may be subject to disciplinary action by the MEC and Department committee.

1.3 COVERAGE

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

1.4 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 Ocotillo 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 Medical Staff Bylaws and Emergency Department Call Policy and Procedure).

1.5 RESEARCH

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

1.6 DISCLOSURE OF UNANTICIPATED OUTCOMES

It is the policy of Banner Health that patients, their legally authorized representative, and when appropriate, their families be informed about the outcomes of care including unanticipated outcomes. The responsibility for disclosure is a collaborative effort between the physician,

Administration and Risk Management and disclosure shall be made in accordance with the Banner Health Disclosure: Communication and Optimal Resolution (CANDOR) of Unanticipated Outcomes Policy. At the time of the unanticipated outcome, physician shall objectively document the facts known about the unanticipated outcome in the patient's medical record, including the medical care provided in response to the outcome and the plan of treatment. The discussion of the unanticipated outcome with the patient/legally authorized representative/family shall be documented in the medical record. This documentation shall include the time, date and place of the discussion, the names and relationships of those present, a summary of the information provided, and questions answered, and the next steps identified during the discussion.

1.7 CONSENT

The patient, or in special circumstances, someone acting for the patient, gives consent. For unemancipated minors and wards, it may be the natural parent, legal guardian or government entity such as DCS who have the right to consent. (See Banner Health consent policy 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 or advanced practice professional 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 and document the conversation in the medical record. Signed consent forms will be made a part of the patient's permanent medical record.

1.8 MANAGEMENT OF SUSPECTED OR SUBSTANTIATED ABUSE/NEGLECT/EXPLOITATION

Members of the medical staff shall report or cause to be reported all cases of suspected or substantiated abuse or domestic violence in accordance with current Arizona State Law and approved hospital policy.

1.9 TREATING FAMILY

Unless specifically preauthorized, reviewed and deemed appropriate by the Chief of Staff, Chief Medical Officer, or designees, practitioners may not treat immediate family members at BOMC or outpatient facilities on campus EXCEPT in an imminent life-threatening emergency AND when another QUALIFIED practitioner is not available timely. If a family member is under the care of a physician's associate or AHP, there is an understanding that minor/low acuity cross-covering care may be appropriate without the need for pre-authorization. This may require access to EMR and Order Entry. Any approved elective treatment is limited to the extent preauthorized. Immediate family member is defined as parents, children, siblings and spouse.

1.10 INFLUENZA VACCINATION

As defined by Banner Policy, each Medical Staff member will submit to the Medical Staff Office a written statement that the member has received a current, CDC-approved influenza vaccination for the then-upcoming influenza season. The only exceptions shall be for religious or medical reasons as approved by the Banner Health Occupational Health Service.

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

ARTICLE II. ADMISSION POLICIES

- 2.1 The authority for admission of patients to the Medical Center has been vested in the Medical Center CEO by the Banner Health Board of Directors. 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 with appropriate privileges to manage and coordinate the patient's care, treatment and services. The attending physician is considered the primary physician and shall be responsible for the primary care from admission through discharge. Patient's placed in observation status are assigned one attending physician or APP who is considered the primary care provider.
- 2.3 Patients will not be discriminated against on the basis of race, creed, sex, national origin, or religion or disability.
- 2.4 Patients who present to the Emergency Department and who have no attending physician with appropriate privileges at the Medical Center, or whose physician cannot be reached timely, shall be treated and admission arranged for by the attending Emergency Medicine physician in the Emergency Department at the time and assigned to members of the Medical Staff on call or their designee. Physicians on ED call are responsible for patients on whom they are consulted. If the patient needs additional consults or to be transferred it is the on-call physician's responsibility to arrange the care needed. The scheduled on-call physician shall take responsibility for any referred patient with an emergency medical condition, regardless of the patient's ability to pay or identity of the third party payer.

On-call responsibility includes the follow up care of those patient's referred. The on-call physician is responsible for taking care of the patients acute problem and any follow up necessary but not for care not associated with the initial problem. A patient cannot be refused because of insurance plan or inability to pay.

- 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.)
- 2.7 Attending Patient Rounding/Visit Requirement
 - 2.7.1 Patients must be seen by the patient's attending physician within 16 hours of admission and daily thereafter. Advanced Practice Professional will not suffice for attending/admitting physician rounding.
 - 2.7.2 Patients admitted to Critical Care status must be seen within 6 hours and daily thereafter by the attending physician.
 - 2.7.3 Patients placed in observation or other outpatient status must be seen within 12 hours and daily thereafter by the attending physician or advanced practice professional.

- 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; to cooperate with Medical Director of Care Coordination when issues or questions arise regarding necessity for admission or continued stay; to participate in appeal of outside denials if the denial is felt to be unjustified.
- 2.9 Intensive Care Status – only contracted Critical Care or Hospitalists may admit a patient to the Intensive Care Status. The physician will utilize the care guidelines chosen by Banner for admission and discharge criteria. The admitting physician will determine the need for continued consultants on the case. Within 24 hours of admission the hospitalist will transition care of the ICU patient(s) unless specifically requested by the intensivist.
- 2.10 Progressive Care Status – any physician on the medical staff, with admitting privileges, may admit a patient to the Progressive Care Status. The physician will utilize the care guidelines chosen by Banner for admission and discharge criteria.
- 2.11 Any time a pediatric patient is considered for hospitalization at a non-pediatric facility, a discussion with the legal POA regarding the risks and benefits of care at the hospital without licensed pediatric bed will occur. Transfer to a facility with pediatric services will be recommended when the patient meets any of the following criteria:
- 2.11.1 The patient is less than 15 years old or less than 50kg.
 - 2.11.2 There is an anticipated need for any pediatric subspecialty care including behavioral health management.
 - 2.11.3 There is an anticipated duration of care > 36 hours.
 - 2.11.4 The facility is unable to provide a private room for the patient and at least one family member if overnight stay is anticipated.
 - 2.11.5 There are complex pharmacy needs better served at a pediatric center such as the need for weight based pediatric dosing.
 - 2.11.6 There exist social, emotional, developmental, and/or behavioral needs better served in pediatric environment.
 - 2.11.7 The legal POA requests care to be delivered at a pediatric licensed facility.
 - 2.11.8 Patients under 18 years of age with obstetrical diagnosis may be cared for in adult OB unit. Care team should be notified of possible need for additional social support.
- 2.12 Emancipated minor status does not categorically allow care in an adult facility. In such cases the clinical factors identified above should be considered.
- 2.13 Appropriate medical judgement should always be exercised. Patients unstable for transfer will be cared for in whatever unit or service area best meets the needs of the patient at that time.
- 2.14 When no suitable facility has capacity to accept the patient the house supervisor and administrator on call will be consulted.
- 2.15 Payor classification or status determination will not be considered in determining appropriate clinical decision making.
- 2.16 Standard policy and procedures relating to transfer and transport of the pediatric patient will be followed.
- 2.17 To ensure the health and safety of the pediatric patient, parents or their assigned designee will be encouraged to stay with the ill child as much as possible.

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; direct physician to physician consultation is encouraged. The specific reason for the consultation should be included with the entered 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 consultation regarding the operative management of the patient shall be recorded prior to the operation except in a life threatening situation.
- 3.5 Consultations must be rendered and electronically recorded or dictated within 24 hours of notification for situations that are not considered imminently serious or potentially life-threatening. Every effort should be made to coordinate orders between multiple consultants and the attending physician. The attending physician will coordinate orders unless he/she specifies differently. Consultant must document when he/she has signed off on the care of the patient.
- 3.6 Consulting physicians will see the patient daily until he/she signs off care of the patient. An advanced practice professional may see the patient at the discretion of the consulting physician and such visits suffice for consultant rounding. All surgical patients will be seen by the surgeon on the first post-operative day; an advanced practice professional may see the patient at the discretion of the surgeon thereafter unless the surgeon is the attending physician.
- 3.7 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 Ocotillo 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 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.

4.2 PURPOSE OF THE MEDICAL RECORD

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

4.4 USE OF EMR

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

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

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's Record Retention Policy.

4.8 CONFIDENTIALITY OF PATIENTS' MEDICAL RECORDS

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

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.

4.14.2 Nurse Practitioners- Inpatient 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. Counter authentication is not required for observation and outpatient care.

4.14.3 Medical Students -

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

4.14.3.2 3rd & 4th Year Medical Students - Any and All documentation must be endorsed (countersigned, counter-authenticated) timely concurrently 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 APP 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 or registration for all inpatient and observation patients. The completed H&P must be on the medical record prior to surgery or invasive procedure or any procedure in which anesthesia or 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). A legible office history and physical performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services.
- b). 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 4.20 are included and the document is filed as a History and Physical on the EMR.
- c). 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 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 responsible 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.

4.19 CONTENTS OF H&P

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

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

4.20 EMERGENCY DEPARTMENT REPORTS

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

- 4.20.1 Time and means of arrival
- 4.20.2 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.

- 4.20.3 Clinical observations, including results of treatment
- 4.20.4 Diagnostic impressions
- 4.20.5 Condition of the patient on discharge or transfer
- 4.20.6 Whether the patient left against medical advice
- 4.20.7 The conclusions at the termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment and services

4.21 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.

- 4.21.1 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.

4.22 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).

4.23 PRE-OPERATIVE, INTRAOPERATIVE AND POST ANESTHESIA/SEDATION EVALUATION RECORD FOR GENERAL, REGIONAL OR MONITORED ANESTHESIA

- 4.23.1 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/sedation evaluation of the patient must include review of the medical history, including anesthesia, drug and allergy history; review and examination of the patient; notification of anesthesia risk (Per ASA Classification); identification of potential anesthesia problems, particularly those that suggest potential complications or contraindications; additional pre-anesthesia as applicable; and development of the plan for anesthesia care, including type of medications for induction, maintenance, and post-operative care and discussion with the patient of risks and benefits. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before pre-operative medication has been administered. Immediately prior to the induction of anesthesia while the patient is on the procedural table, the patient's vital signs, airway and response to pre-procedure medication must be assessed and the equipment checked.
- 4.23.2 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.
- 4.23.3 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.

4.24 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.

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

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

4.25.1 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.

4.25 CONSENTS

Members of the Medical Staff or authorized Advanced Practice 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:

- 4.25.1 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;
- 4.25.2 An explanation of alternatives, including material risks and benefits;
- 4.25.3 An explanation of the consequences if declining recommended or alternative treatments;
- 4.25.4 Disclosure of whether practitioners other than the operating practitioner, including residents, will be performing important tasks related to the Procedures.
- 4.25.5 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 cardiognostic 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.

4.26 EMERGENCY

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

- 4.26.1 The person is in immediate need of medical attention;
- 4.26.2 An attempt to secure express consent would result in delay of treatment;
- 4.26.3 Delay in treatment would increase the risk to the person's life or health; and
- 4.26.4 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.

4.27 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, by the performing department, to the physician or agent to inform the practitioner of the test completion.

4.28 DISCHARGE DOCUMENTATION

A discharge summary must be documented at the time of discharge, but no later than 24 hours thereafter by the responsible practitioner on all Inpatient and Observation hospitalizations 48 hours or greater in length. Normal newborns and 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 and may be substituted for the discharge summary for patients with a length of stay less than 48 hours or less, observations, extended recovery, 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

4.29 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 24 hours thereafter by the responsible practitioner. In the case of the death of a pre-term newborn infant less than 3 hours after birth, a final discharge progress note will be documented by the physician who pronounced the death. Death pronouncement note must be completed at the time the patient is pronounced but no later than 24 hours.

4.30 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 but no later than 24 hours thereafter.

4.31 AMENDING MEDICAL RECORD ENTRIES

4.31.1 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.

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

Errors or omissions discovered at a later time shall be corrected by the individual with a new entry. The person making the change shall sign and note the date of the change and reason for the change. The new entry shall also state who was notified of the change and the date of such notification. Any physician who discovers a possible error made by another individual 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.

4.31.3 Copying and Pasting – Medical staff members and Allied Health Professionals may not indiscriminately copy and paste documentation from other parts of the applicable patient's records. If copying a template, the practitioner shall make modifications appropriate for the patient. If copying a prior entry, the practitioner shall make appropriate modifications based upon the patient's current status and condition. The practitioner must reference the date of a prior note as appropriate. When copying patient data into the medical record from another provider, the practitioner must attribute the information to the person who performed the task unless it is readily apparent, based upon the nature of the information copied, that the data was entered by another provider. If referencing a form within the record, the form must be referenced with sufficient detail to identify the source. Example: "for review of systems, see form dated 6/1/10."

4.32 TIMELY COMPLETION OF MEDICAL RECORDS

4.32.1 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

4.32.2 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	Documented immediately post-op and no later than 24 hours after procedure	
Special Procedures Report	Documented within 24 hours of completion of procedure	
Discharge Summary Report	Documented at the time of the discharge but no later than 24 hours after discharge.	Not required on all admissions less than 48 hours, or for Normal vaginal deliveries and normal deliveries
Discharge Progress Note	Documented at the time of discharge but no later than 24 hours 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 24 hours after death	
Death Pronouncement Note	Completed at the time the patient is pronounced within 24 hours	
Transfer Summary	Documented at the time of transfer no later than 24 hours after transfer	
Signatures	Authentication of transcribed or scanned reports and progress notes, within 7 days from the date of notice	
Verbal Orders	Dated, time and authenticated within 72 hours.	
Psychiatric Evaluation	Documented within 24 hours of admission	

4.33 MEDICAL RECORD DEFICIENCIES

A medical record is considered eligible for suspension/sanction based on the timeframes in section 4.32. Physicians are advised of incomplete documentation via the physician inbox. The Health Information Management Services Department shall advise physicians by electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has met or exceeded the timeframes in section 4.32. The notice will include a due date and reference the Physician Inbox for a detailed list of all incomplete and delinquent medical records. No additional notification is given.

If a vacation prevents 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. Request for deferment from suspension may be granted by the Chief of Staff, CMO, CEO or his/her designee.

4.34 MEDICAL RECORD TEMPORARY SUSPENSIONS

A medical record is considered eligible for temporary suspension based on the timeframes in section 4.32.

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.

4.35 AUTOMATIC TERMINATION OF PRIVILEGES FOR DELINQUENT MEDICAL RECORDS

Temporary suspension shall become automatic permanent suspension following 60 cumulative days of temporary suspension. 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. Permanent suspensions will be reported to the applicable licensing/certification board if required by law.

ARTICLE V. PHYSICIAN ORDERS

5.1 PHYSICIAN ORDERS

Banner Ocotillo 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. All active orders must be reviewed by the physician 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 or APP 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.

- 5.1.6 Orders for inpatients procedures may be generated only by members of the medical staff with medical staff privileges or by APP Staff according to their scope of practice.

5.2 ORDERS FOR SURGERY

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

5.3 ORDERS FOR SERVICES

- 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 (PAs or NPs). A signed order must be received prior to performing outpatient procedures/tests.
- 5.3.2 A statement of the reason for the test and/or diagnosis must be indicated on the order and it must also be authenticated and dated by a physician or Allied Health Professional licensed within Arizona with prescriptive authority (PAs or NPs).
- 5.3.3 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 payer 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

- 5.4.1 Verbal (face to face) orders are not acceptable except in the case of an emergent situation. Verbal orders will be accepted only by a registered nurse (RN). Licensed Respiratory Care Practitioners (RCP), registered pharmacists, speech therapists and dietitians can accept verbal orders provided the orders are directly related to their specialized discipline.
- 5.4.2 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.

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

- 5.5.1 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.
- 5.5.2 Telephone Do Not Resuscitate (DNR) orders are discouraged. However, if 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. Physicians will sign the Do Not Resuscitate (DNR) telephone order upon their next visit and document the reasons even though the patient may have already expired.

ARTICLE VI. GENERAL PHARMACY POLICIES

6.1 GENERAL INFORMATION

All medication administered to patients at Banner Ocotillo 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 Ocotillo 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 per system policy. If approved and used, all samples will be left with and stored in the Pharmacy Department.

6.2 MEDICATIONS

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

- 6.2.1 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.
- 6.2.2 Outpatient prescriptions, with the few exceptions defined in pharmacy policy, will not be filled at Banner Ocotillo Medical Center. If a medication is to be sent home with a patient, a prescription must be written.
- 6.2.3 All medications taken out of the Medical Center by a patient 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.
- 6.3.5 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 Ocotillo 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 BOMC 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 The immediate 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 reviewed at the time of surgery and it will be the responsibility of the physician to determine continuation of orders for 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 Operative and High Risk Invasive Procedure and Site Identification

- 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. Consistent with Banner Health Safe Surgery Policy and 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 an “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 SECLUSION/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.

Summary of physician actions:

- i. Give an order (verbal) or enter order, to restrain the patient.
- ii. Within 24 hours: perform face-to-face assessment of patient and document need for restrain and authenticate (if verbal) previous order.
- iii. Every 24 hours: perform face-to-face assessment of patient and enter a new order for restraints if need continues.
- iv. In the event of an emergency the restraint may be initiated by the nurse, after a physical and psychological assessment deems this necessary, the physician will be contacted as soon as possible for the order.

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 vital 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.

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 in all cases of unusual deaths and those of educational interest.
- 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 and has been accepted by the Medical Examiner.
 - 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. Creutzfeldt-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. The Medical Center will not be responsible for any arrangements nor charges associated with independent autopsies.

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 Ocotillo Medical Center will require approval by the 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 BOMC 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 Ocotillo, 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, i.e. 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 Ocotillo who are appropriately registered with the Arizona Medical Board and who are participants in an accredited training program, may enter patient care orders as determined by the supervising physician and the training program.

If designated by the supervising physician and the training program, interns, residents or fellows may be responsible for operative reports for surgeries performed by the surgeon they have assisted. The surgeon may modify a statement recorded by the intern, resident or fellow and

authenticate change or addendum. The attending/supervising physician will be notified of incomplete or delinquent records assigned to interns, residents, or fellows he/she supervises. Final responsibility for care of the patient rests with the attending physician or his/her designee.

ARTICLE XI: NP, MEDICAL AND PHYSICIAN ASSISTANT STUDENTS

- 11.1 Medical Student Rotations through Banner Ocotillo Medical Center will be in accordance with the Banner Health Clinical Education Rotation Agreement.
- 11.2 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.
- 11.3 Clinical goals and objectives will be reviewed, in advance, by the Graduate Medical Education Committee at Banner University Medical Center. The Banner RN Professional Practice team will review clinical goals and objectives for nurse practitioner students.
- 11.4 Participation in specific rotations at BOMC is subject to prior approval of the CEO or designee.
- 11.5 The number of students participating will be reevaluated periodically and subject to change.
- 11.6 Specific Medical Student Activities
 - 11.6.1 Year one and two medical students may observe only.
 - 11.6.2 Year three and four medical students may participate in care and management of patients.
 - 11.6.3 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.
 - 11.6.4 Documentation is countersigned by faculty promptly. Faculty members are ultimately responsible for all required components of the medical record.
 - 11.6.5 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.
 - 11.6.6 Students may assist in surgery if a faculty member is participating and the patient has consented to this.
 - 11.6.7 All activities are under the direct guidance and supervision of faculty.
- 11.7 Specific Physician Assistant Student Activities
 - 11.7.1 PA students may participate in care and management of patients.
 - 11.7.2 Electronic Medical Record training (view only) must be completed prior to beginning any patient care activities.
 - 11.7.3 Faculty members are responsible for all required components of the medical record.
 - 11.7.4 PA students may not dictate.
 - 11.7.5 PA students may assist in surgery if completing a family practice, obstetrics/gynecology or surgical rotation and if assisting the faculty member.
 - 11.7.6 PA students may assist faculty member with procedures within the scope of the faculty member's scope of practice and the patient has consented to this.
 - 11.7.7 PA student must be able to document education of aseptic technique prior to assisting in surgery.
 - 11.7.8 All activities are under the direct guidance and supervision of faculty.
- 11.8 Specific APRN Student Activities
 - 11.8.1 APRN students may participate in care and management of patients.
 - 11.8.2 At the discretion of the preceptor, APRN students may obtain Powernotes training and document in the electronic medical record. Otherwise, they will be granted view-only training and access.
 - 11.8.3 Documentation is countersigned by faculty promptly. Faculty members are

- ultimately responsible for all required components of the medical record.
- 11.8.4 NP students may not dictate.
- 11.8.5 All activities are under the direct guidance and supervision of faculty.
- 11.9 Restrictions
 - 11.9.1 Students may not create discharge summaries or operative reports;
 - 11.9.2 Students may not enter orders.
 - 11.9.3 Students may not independently perform procedures without direct supervision.
- 11.10 Student Responsibilities
 - 11.10.1 Students are required to comply with all BOMC policies and procedures during the clinical experience.
 - 11.10.2 Students shall have access only to patient information that is a necessary part of the approved rotation.
 - 11.10.3 Students, as participants in an educational program, must at all times wear a Student Identification Badge.
- 11.11 Application and Approval Process – All students must apply and receive approval for a rotation through the Banner Health Careers Program Department.
- 11.12 Orientation – All students will be oriented to Banner Health policies, programs, and channels of communication.

ARTICLE XII. COMMITTEES

12.1 UTILIZATION MANAGEMENT COMMITTEE

The Utilization Management Committee shall meet on a date and time agreed upon by its members on at least a quarterly basis.

- 12.1.1 The committee will be co-chaired by the Chief Medical Officer and the Medical Director, Care Coordination and be multi-disciplinary in nature consisting of the director of case management, physicians, clinical, administrative and ancillary staff. At least two (2) members of the committee must be physicians.
- 12.1.2 The committee shall perform the following functions:
 - i. Support and direct the Utilization Management program
 - ii. Reviews the appropriateness of:
 - a) Admissions
 - b) Level of Care
 - c) Continued Stays
 - d) Professional Services – procedures, testing and treatment
 - e) Length of Stay
 - f) Status Determination
 - g) Discharges
 - h) Transfers
 - iii. Suggests and coordinates education to address specific processes with regard to medical and utilization management.
 - iv. Recommending changes to workflows as necessary to best meet the needs of the facility and organization.
 - v. Ensuring adherence to established policies, procedures, regulatory and accreditation requirements, as well as applicable professional standards.
- 12.1.3 The Utilization Management Committee will report directly to the Medical Executive Committee.

ARTICLE XIII. 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 Ocotillo 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:

Approved and adopted by resolution of the Banner Health Board of Directors on April 9, 2020.

Amended by the Board:

July 9, 2020, September 10, 2020