JOHN C LINCOLN

MEDICAL STAFF

RULES AND REGULATIONS

Feb 2017

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John C. Lincoln Medical Center
GENERAL MEDICAL STAFF RULES and REGULATIONS
2017

1.0 RESPONSIBILITY

1.1 General

The overall responsibility for the quality of medical care rests with the Medical Staff. Therefore, the individual staff member is held accountable for the timing, efficiency, quality, and appropriateness of care rendered to patients. As a requirement to protect and support this commitment to optimal patient care, the attending physician is responsible to insure that appropriate arrangements are established with other members of the Medical Staff to provide medical treatment to patients in those instances in which the attending physician is unavailable.

Staff applicants and members must provide the names of covering practitioners when appointed and reappointed to the Medical Staff. Covering practitioners must be staff members with similar privileges. Notwithstanding the foregoing, a covering physician may request being relieved of the foregoing and the Medical Staff Executive Committee in collaboration with the Chief Executive Officer may, in its discretion waive such requirement under certain circumstances. For example: staff applicant who practices in a specialty that is unlikely to require a covering physician such as:

- Anesthesiologists
- Emergency Medicine Physicians
- Hospitalists
- Pathologists
- Radiologists
- Other specialties in which there is only one physician on the Medical Staff

1.1-1 Trauma Patients

If the patient is admitted through Trauma Services, the attending trauma surgeon will remain as attending physician until:

1.1-1.2 The patient is discharged from the facility

1.1-1.3 The patient's medical condition is such that trauma intervention is no longer required and the patient is transferred to the care of another physician.

1.1-2 Allied Health Professionals

The Medical Staff Bylaws recognize that various categories of Allied Health Professionals ("AHPs") may be authorized to perform designated patient care services as granted by the Board, including performing services as an assistant for invasive procedures, provided that such services are supervised by a member of the Medical Staff.

1.1-2.1 May evaluate and treat patients under the supervision/collaboration of their sponsoring physician/agent

1.1-2.2 May participate in the care of patients only under direct supervision/collaboration of an attending physician

1.1-1.3 The following rules apply to services performed by an AHP acting as a surgical assistant:

1.1-1.3.1 If granted authority by the Board, under the "Direct Supervision" of the supervising surgeon, the AHP may assist in the performance of the following functions: positioning and patient preparation; assist with or drape surgical field; tissue handling; provide surgical field exposure; provide hemostasis; utilize surgical instrumentation properly; and assist with power equipment, orthopedic hardware or other devices as deemed necessary through the critical portion of the procedure. Once

	the critical portion of the procedure is complete, under the "Proximal Supervision" of the physician, the AHP may assist with or perform wound care closures, skin sutures, and skin dressings.
1.1-1.3.2	At no time will the supervising physician leave the Surgery Department or Cath Lab until after the patient is transferred to PACU. The Surgery Department includes the Pre-op area, OR, RR, PACU, Same Day Surgery, family waiting area, locker room and surgical lounge.
1.1-1.3.3	"Direct Supervision" means that the supervising physician is scrubbed in and in the OR or Cath Lab.
1.1-1.3.4	"Proximal Supervision" means that the supervising physician is in the Surgery Department or the Cath Lab, but does not require the supervising surgeon to be in the OR.

1.2 Patient Safety

1.2-1 Disclosure

Any disclosure to patient of information relating to adverse event by a Medical Staff member shall be conducted in accordance with the established criteria found in the Medical Staff Policy

1.2-2 Critical Language

The physician will encourage psychological safety during stressful situations by recognizing a phrase "I need a little clarity" and with the use of that phrase work should cease and attention focused on the speaker.

1.3 Consideration for Suicidal Patients

For the protection of patients, the medical and nursing staff and the Hospital, certain principles will be met in the care of potentially suicidal patients. Any patient known or suspected to be suicidal shall be cared for according to established suicide precautions. (Reference Hospital Policy # Q.8721-448 Suicidal, Dangerous, Emotionally Disturbed Patients)

1.4 Consideration for Suspected Abuse/Neglect Patients

Any known or suspected patient abuse/neglect shall be cared for according to established criteria found in Hospital Policy P 300 & 303.

1.5 Medication Administration

Only those practitioners licensed by the State of Arizona to administer medications may do so. All medications administered to Hospital patients will be supplied by the Hospitals 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 P&T Committee. The formulary is an established compendium of approved medications available for diagnostic, prophylactic, therapeutic or empiric treatment of patients. 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 P&T Committee. 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" should specify frequency and indication.

1.5-1 Home Medications - No medication brought into the hospital by a patient shall be administered or taken unless an order is given by the attending physician authorizing that the patient may take his own medication in accordance with approved pharmacy policy. A listing of the medications that the patient may take must be written with the order and shall be administered in accordance to Hospital Policy. Medications not so ordered will be returned to the patient's family or other authorized person as soon as possible for removal from the premises.

Home medications are reconciled on the Admit Medication Reconciliation section in the EMR. The attending physician must indicate which home medications should be continued while the patient is in the Hospital. The physician may restart a patient's home medication(s) only as prescribed on the Admit Medication Reconciliation Physician Order Form section or in a separate medication order in the EMR.

1.6 Transfer of Patient Care

If a physician's services are terminated by the patient or the physician, the physician will retain responsibility for the patient's care until another physician has been contacted and personally discussed the case, and both have accepted the transfer. This transfer must be documented in the patient's medical record.

1.6-1 No Physician - If the patient is incapable of finding a new physician, the Department Chairman will be notified and will make appropriate arrangements for a physician for the patient. In the event the Department Chairman is the one being terminated, it will be the responsibility of the Chief of Staff or his designee.

1.7 Treating Self, Immediate Family Members or Domestic Partners

Physicians and other practitioners with privileges to provide medical care at the Hospital shall not treat themselves and shall not actively participate in the inpatient or outpatient treatment of their "immediate family members" or "domestic partners" in the Hospital. For purposes of this section, an "immediate family member" means the spouse, natural or adopted children, unborn children, father, mother, brothers and sisters of the practitioner and the natural or adopted children, father, mother, brothers and sisters of the practitioner's spouse; and "domestic partner" means a person of the same or opposite sex with whom the practitioner has a committed relationship.

In the case of an emergency in which there is no other qualified physician available, practitioners may treat themselves or their immediate family members or domestic partners until another physician becomes available.

Practitioners may not write prescriptions for controlled substances for themselves or their immediate family members or domestic partners.

2.0 ADMISSIONS, DISCHARGES, AND DEATHS

2.1 Admissions

Patients may be admitted to the Hospital only upon authorization of members of the Medical Staff or other licensed independent practitioners who have been granted admitting privileges. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. Upon admission to the Hospital

the provisional diagnosis will be recorded in the medical record.

For the purpose of these Rules & Regulations, the term "emergency" may be applied when all of the following are met:

- The person needs immediate medical attention; and
- A delay would increase the risk to the person's life or health, and
- There is no indication that the person has refused this emergency medical treatment.

For the purpose of these Rules & Regulations, the term "urgent" may be applied when the following are met:

- Services are medically necessary; and
- Are required for an illness or injury that would not result in further disability or death if not treated immediately;
- But require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours.

The Hospital may admit patients suffering from all types of medical problems, provided proper facilities and personnel are available to handle such patients. In those instances in which transfer to another facility is warranted, appropriate arrangements shall be made by the attending physician and administration.

Patients with identified or suspected communicable diseases shall be treated under proper universal precautions for the protection of other patients and Hospital staff.

A patient admitted to the ICU or CVICU must be seen by the attending physician within eight (8) hours of admission to the unit.

A patient admitted to a general medical/surgical floor must be seen by the attending physician within twelve (12) hours of admission to the floor. The attending physician is ultimately responsible for patient care. Once an admit order has been placed, if the patient must be temporarily held in the ED pending bed placement it is the ultimate responsibility of the attending physician to manage the patients care.

The subspecialist/consulting physician has the responsibility to evaluate the patient within twenty four (24) hours unless otherwise specified by the attending physician. The attending physician, however, is ultimately responsible for patient care.

Patients admitted to the hospital by a podiatrist or a dentist must be medically managed by a qualified member of the medical staff (DO or MD) who has been granted such privileges.

2.2 Indigent Care

All patients determined to be indigent shall be attended by members of the Medical Staff and shall be assigned to the service concerned in the treatment of the disease or injury that necessitated the admission. Private patients shall be attended by their own private physicians, provided such physicians have privileges at the Hospital. Patients admitted under emergency conditions that have no attending physician and shall be assigned to the proper service and admitted and treated by the physician on-call for the Emergency Department at the time.

2.3 Critical Care Unit(s)

Patients shall be considered appropriate for admission to the Intensive/Critical Care Unit(s) when their conditions are life threatening, require advanced technological and/or pharmacological treatment modalities or intensive nursing care. Any physician on staff of the Hospital with admitting privileges may admit a patient to the ICU/CCU. The physician responsible for the patient must be competent to diagnose and manage actual disease processes or immediately obtain appropriate consultation. ICU Admission, Transfer, Discharge Criteria shall be approved by the Critical Care Committee and the Executive Committee of the Medical Staff.

2.4 Discharges

Patients shall be discharged only on the order of the attending physician or his/her designee. All discharge orders must include disposition of the patient, e.g. Home, Skilled Nursing Facility, etc. Should a patient leave the Hospital against medical advice, a notation of the incident shall be made in the patient's medical record.

Authentication by the supervising/sponsoring physician is required for discharge of patients by a Nurse Practitioner.

2.5 Deaths

In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. When a patient is assessed to be without signs of life, a RN may make a pronouncement of death when the following conditions are present:

2.5-1 A physician's order withholding all cardiopulmonary resuscitation is present in the patient's record

2.5-2 The patient is not a known or potential organ/tissue donor (excluding corneas and skin)

2.5-3 The patient's attending physician is willing to sign the death certificate

2.5-4 The patient does not meet any criteria for referral to the Medical Examiner

Upon receipt of the registered nurse's assessment of the patient status, the attending physician may accept the RN's assessment or may make arrangements for an alternate physician to pronounce the death. Policies with respect to release of dead bodies shall conform to the Medical Examiner's policies.

In all cases in which any doubt exists regarding legal status of death, the Medical Examiner shall be notified. Autopsies should be considered by the Medical Staff in any of the following events:

- Unexplained death;
- Unexpected death;
- Post-Surgical Death; and
- Deaths occurring in patients who have participated in clinical trials (protocols) approved by the Institutional Review Board.

In all cases, the family has the option of requesting an autopsy and this should be documented in the patient's medical record. In other than Medical Examiner's cases, an autopsy may be performed only with a written consent, signed in accordance with state law. All non-Medical Examiner's case autopsies shall be performed by the Hospital

pathologist. Provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours and the complete report should be made part of the patient's medical record within sixty (60) days.

Universal Donors

In accordance with the Uniform Anatomical Gift Act, the attending physician or his/her designee shall follow the established Medical Staff and administrative protocol to discuss with appropriate patients or their legal next-of-kin their desire to donate organs and/or tissues for transplantation.

3.0 MEDICAL RECORDS

3.1 General: A medical record shall be established and maintained for each patient who has been evaluated or treated in the hospital. This includes inpatient, outpatient or emergency service patients. The Medical Record, including electronic data, medical imaging, pathological specimens and slides, are the property of the hospital. The attending physician shall be responsible for each patient's medical record. Only authorized individuals may make entries in the medical record. For purposes of this Medical Records section, practitioner includes dentists, podiatrists, advanced practice nurses, physician assistants, and other credentialed practitioners to give orders, provide consultations and/or perform surgical procedures.

3.2 The inpatient record shall include the following when appropriate:

3.2-1 Patient identification data;
3.2-2 Emergency care provided prior to arrival;
3.2-3 Chief medical complaint(s);
3.2-4 Evidence of Advanced Directives;
3.2-5 Withdrawal/Withholding of Life Support
3.2-6 Evidence of appropriate informed consent;
3.2-7 Relevant personal medical history;
3.2-8 Relevant family medical history;
3.2-9 Prenatal information in obstetrical records;
3.2-10 History of present illness;
3.2-11 Comprehensive physical examination findings/musculo-skeletal exam;
3.2-12 Diagnostic reports, medical and/or surgical treatment, pathological findings (if applicable);
3.2-13 Pertinent progress notes and observations, regarding patient's condition and response to therapy, final diagnosis, condition on discharge or applicable autopsy report; and
3.2-14 Adequate instructions shall be given to each patient and/or family at the time of discharge, and summarized in a discharge note and/or discharge summary or included on the patient discharge instruction sheet.

3.3 Emergency Department and Outpatient (including Observation) records shall include the following when appropriate:

3.3-1 Patient identification data;
3.3-2 Evidence of appropriate informed consent;
3.3-3 Information regarding time, means and method of transport;
3.3-4 Pertinent treatment prior to presentation;

3.3-5 Chief complaint;
3.3-6 History of illness or injury, physical exam as appropriate to present illness;
3.3-7 Clinical observations, laboratory and radiological findings;
3.3-8 Diagnostic and therapeutic orders;
3.3-9 Treatment rendered;
3.3-10 Discharge instructions;
3.3-11 Condition of patient on discharge; and
3.3-12 Information concerning patient leaving "against medical advice;"

3.4 Invasive Procedures (e.g. Surgical, Endoscopic and Interventional procedures such as Cardiac Cath's and Interventional Radiology, etc.) records will contain at least the following:

3.4-1 **Pre-operative**

3.4-1.1 A comprehensive history & physical examination shall be documented in the chart prior to any Invasive Procedure. A durable legible, original or reproduction of a comprehensive history and physical examination is acceptable when completed 24 hours after admission and prior to procedure or within thirty (30) days prior to admission with an interval note documenting the patient's current status 24 hours after admission and prior to procedure.

3.5 Outpatient Surgery Operative Report

3.5-1 A comprehensive history & physical examination shall be documented in the chart prior to surgery. A durable legible, original or reproduction of a comprehensive history and physical examination is acceptable when completed 24 hours after admission and prior to procedure or within thirty (30) days prior to admission with an interval note documenting the patient's current status 24 hours after admission and prior to procedure.

3.6 Electronic Medical Records (EMR): the hospital uses an electronic medical record system. 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.

3.6-1 Use of EMR: All medical record documents created after the patient is admitted will be created utilizing the EMR system to allow for patient information to be exchanged and shared electronically among healthcare providers. This includes Operative/Invasive procedure reports, consultations, discharge summaries, and progress notes.

3.6-2 EMR Training: Practitioners who are appointed to the Medical Staff or Allied Health Staff must undergo EMR training prior to being assigned a user name and password.

3.6-2.1 Practitioners who do not complete EMR training prior to go-live will be changed from their current status on the medical staff to affiliate. Upon change of status to affiliate, the practitioner shall have no admitting, surgical and/or consultative privileges, other than patients already in the hospital or patients needing emergency care. Once the practitioner completes EMR training they may request immediate reinstatement to their original status.

3.6-2.2 New practitioners must complete EMR training, including receipt of user

name and password, prior to the granting of medical staff clinical privileges and membership.

3.6-2.3 Exceptions will be made for practitioners granted privileges in emergency situations or those practitioners granted temporary privileges for the care of a specific patient on a case by case basis to be determined by the hospital CEO. In such a situation the hospital will provide an abbreviated training and assign a super user to assist the practitioner.

3.7 Access to Medical Records

All physicians involved in the care of a particular patient shall have access to that patient's medical record. Records will also be available for Medical Staff authorized for peer review, corrective action and other legally required review.

Original medical records may be removed from the Hospital's jurisdiction only in accordance with a court order, subpoena, federal or state statute, microfilming and/or storage of a patient record

3.8 Abbreviations

Only those abbreviations approved by the Medical Staff may be used in the medical record. A list of unacceptable abbreviations is posted on each patient care unit.

3.9 Authentication

All clinical entries in the patient's record must be accurately dated, timed and individually authenticated by the responsible physician. Authentication means to establish authorship by written or electronic signature and shall consist of the practitioner's name and professional title indicating the professional's credentials. Electronic signature authentication of medical records is the standard practice.

A physician PIN number determined by the Health Information Department that uniquely identifies each physician is acceptable in lieu of a signature for signing documents electronically.

4.0 History and Physical Examination Report

A comprehensive history and physical examination shall be recorded within 24 hours after admission by a physician, or qualified oral/maxillofacial surgeon*,* and filed on the record prior to any invasive or surgical procedure. This includes inpatients, observation patients, and any patient undergoing an outpatient or inpatient surgical procedure or invasive procedure. The H&P must be filed in the patient's chart prior to any invasive or surgical procedure. In emergency situations, when a delay may constitute a danger to the health and safety of the patient, and there is inadequate time to record the history and physical examination before surgery, a progress note may be placed in the EMR, to include the preoperative diagnosis, description of any known drug allergies and other clinical findings pertinent to the safety of the patient during surgery. A durable, original or reproduction of a comprehensive history and physical examination is acceptable when completed within thirty (30) days prior to admission with an interval note documenting the patient's current status within 24 hours after admission and prior to procedure. The interval note shall include that (a) the history & physical is still current; (b) an appropriate patient examination was completed within 24 hours after admission

confirming that the necessity for the procedure or care is still present; and (c) any concerns with findings and changes to the patient's condition since the H&P was originally completed have been documented.

The attending physician of record is responsible for completion of the history and physical examination. The attending physician may accept a comprehensive history and physical examination report prepared by a consultant, resident, nurse practitioner or physician's assistant. A history and physical examination report prepared by a consultant, resident, nurse practitioner or physician's assistant must be authenticated by the attending physician. If a comprehensive history and physical examination has been performed by an emergency room physician, it will suffice for an inpatient history and physical examination for the first twenty-four (24) hours of a patient's stay.

4.1 Elements of a Comprehensive Adult History & Physical Examination to be used for Inpatients

The following elements must be included:

4.1-1 Chief complaint;
4.1-2 Details of the presenting illness, with relevant assessment of the patient's emotional, behavioral, and social status;
4.1-3 Past Medical and Surgical history
4.1-4 Current Medications
4.1-5 Allergies: (e.g. drugs, food, iodine);
4.1-6 Social history; An age appropriate review of past and current activities;
4.1-7 Review of systems; An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms, which the patient may be experiencing or has experienced
4.1-8 Comprehensive physical exam;
4.1-9 Conclusion or impression; and
4.1-10 Plan of action

4.2 Elements of Pediatric History & Physical Examination

In addition for children and adolescents the following must be documented:

4.2-1 evaluation of developmental age;
4.2-2 educational needs and daily activities;
4.2-3 immunization status; and
4.2-4 family's expectations and involvement in the care of the patient.

4.3 Interval Physical Examination Report

Readmission within thirty (30) days for the same or related diagnosis will require only an interval physical examination report reflecting any subsequent changes, provided the original history and physical is readily available in the medical record of the patient's previous admission.

5.0 Orders

Orders must be placed in the EMR only within the authority scope of clinical privileges granted to the practitioner giving the orders.

Orders and prescribed medication on behalf of the supervising/collaborating physician may be entered by a Nurse Practitioner within the limits for which they have been approved by the Arizona State Board of Nursing and the Medical Staff.

5.1 Inpatient Orders

Licensed nurses are authorized to accept verbal and telephone orders. Registered Pharmacists, Licensed Physical Therapists, Respiratory Care Practitioners, Occupational Therapists, Speech Therapists, Clinical Dieticians or other qualified individuals designated and approved by the Medical Staff may take telephone and verbal orders in their areas of specialty only when the physician is unable to enter the order themselves.

It is the responsibility of the ordering physician to review and co-sign such verbal and telephone orders within 24 hours. Verification of all telephone and verbal orders must be done by the qualified person taking the order repeating the order back to the physician. The traditional abbreviations of "TO" for Telephone Order or "VO" for Verbal Orders, will be change to "RVO" for "repeated verified order." This will be reflected on the physician order sheet.

5.1.1 Order Set

Routine orders may be developed by specific physicians/physician groups for use with their own patients or by clinical areas or specialties for use with specific populations (e.g. Routine ICU Orders, weight based heparin orders). When intended to be used for specific populations, such orders must be approved by the appropriate medical staff departments/committees and by representatives of the Hospital. In either case, such orders must follow the approved Hospital policy for both format and utilization to prevent misunderstanding and medical errors and must allow for modification, as indicated to meet individual patient needs.

Routine orders, once established, shall constitute the orders for the patient's treatment and shall be followed insofar as proper treatment of the patient will allow unless they are specifically changed by a physician for a specific patient. In all cases, routine orders may be modified as necessary by the attending physician to reflect the individual needs of the patient. These orders, where necessary, shall include automatic stop orders and shall be signed by the attending physician.

5.2 Outpatient Orders

All orders for diagnostic and therapeutic tests on outpatients shall be carried out only upon receipt of an order from a physician or a qualified Allied Health Professional with the designation of a sponsoring physician to whom the results will be sent. At the discretion of the Hospital radiologist, orders for procedures which require invasive methods will be accepted from non-staff physicians who have made special arrangements with the Hospital's physician staff who has agreed to be responsible for dealing with any complications that may occur during or after the procedure. Examinations that are non-invasive may be ordered by chiropractic physicians at the discretion of the Hospital's radiologist.

If the order is from a physician's office, the documentation will include the office personnel name in addition to the ordering physician's name and the name of the qualified person who took the order. Faxed orders will be verified if they fail to indicate date, time, ordering physician or are illegible and will be documented the same as a telephone or verbal order.

5.3 Special Treatment Orders

5.3-1 Restraints - Special treatment orders, such as use of restraints, will be documented to include type of restraint, justification and time limits, **NOT TO EXCEED 24 HOURS**. Subsequent restraint orders must be added to the EMR by the physician every day of continuation of the restraint. Standing and PRN restraint orders are not permitted. When a patient is placed in restraints for behavioral reasons, new orders are required every four (4) hours for adults, two (2) hours for patients who are 9-17 years of age, and every one (1) hour for patients under the age of 9 years. **(Patient Care Standards Policy 14.37.06)**

5.3-2 Cardiopulmonary Resuscitation Withholding - No Code Arrest Orders - The appropriateness of withholding CPR shall be determined by the attending physician based on his/her knowledge of the patient **(Patient Care policy p-754)**. A "No Code" order means that there will be no extraordinary intervention in a potentially terminal event. The "No Code" order will be entered by the admitting physician or his/her designee and the rationale for this order will be documented in the medical record. It is recommended that a copy of the patient's living will and advance directives, if available, and documentation of discussion with the patient/agent/statutory surrogate be included in the medical record.

5.4 Medication Orders

5.4-1 Authorization to Administer Medications

Only appropriately licensed personnel or approved personnel working under the direction of a licensed practitioner may be allowed to administer medications. (Administration of medications will be in response to an order by an authorized individual, as set forth above) The following categories of personnel may administer medications at the Hospital under the order of a qualified practitioner:

5.4-1.1 Physician, House Staff, Physician Assistants
5.4-1.2 Registered Nurses, Licensed Practical Nurses, Nurse Practitioners, Certified Registered Nurse Anesthetists and Clinical Perfusionists. Administration of chemotherapeutic agents can only be performed by nurses trained in chemotherapy
5.4-1.3 Respiratory Care Practitioners (medications related to respiratory therapy treatments only)
5.4-1.4 Licensed Imaging Technologists (medications related to radiology/nuclear procedures only)
5.4-1.5 Physical Therapists (topical medications only)
5.4-1.6 Student nurse, under supervision of an RN or a licensed medical practitioner
5.4-1.7 Medical students under supervision of a licensed medical practitioner

5.4-2 Post Operative/Post Procedure Medication Orders.

The physician must designate on the Medication Reconciliation Order Form or on a physician order which medications the patient should be continued on post operatively. "Resume pre-op medications" is not an acceptable order.

5.4-3 Medication Stop Orders

Unless the medication order indicates the exact number of doses to be administered or an exact period of time for the medication is specified, the physician will be contacted regarding the need to reorder the medications.

5.5 Automatic Cancellation of Orders

All previous orders are automatically discontinued when the patient goes to surgery or is transferred to a higher level of services. It will be the responsibility of the physician to write new orders for continuation of the patient's care after surgery. "Resume pre-operative orders except medications" is an acceptable alternative if the patient's condition warrants.

5.6 Countersignatures

Authentication by a sponsoring and/or supervising physician is required for any order written by a first year resident, an intern or a physician assistant.

Authentication by a sponsoring and/or supervising physician is required for history & physicals, procedures and discharge summaries prepared by a resident (regardless of post-graduate level) or a physician assistant.

Note: Emergency Department Physician Assistants may write Treat and Release Orders without a Physician Authentication.

Pursuant to Arizona Department of Health Service regulatory requirements, countersignature by a sponsoring and/or collaborating physician is required for history & physical performed and dictated by a nurse practitioner.

In the event that a patient is being transferred from the Emergency Department or from the obstetrical area to another health care facility after a medical screening examination by a nurse practitioner or physician assistant, the signature of the collaborating physician must be present on the transfer form along with the signature of the nurse practitioner or physician assistant.

5.7 Consultation Reports

The attending practitioner is primarily responsible for calling for a consultation from a qualified member when indicated or required. Direct physician to physician communication is encouraged for all consultations. The request for consultation must include an indication for the consultation.

Each consultation report shall contain documentation of opinion by the consultant that reflects, when appropriate, an actual examination of the patient and a review of the patient's medical record. Consultations must be completed within twenty-four (24) hours. In the case of urgent or emergent consultations, the attending physician should document the extent of the verbal or written communications with the consulting physician. Specific instances in which consultations are required may be outlined in the individual Medical Staff Clinical Department Rules and Regulations. The attending physician should request the consultation in writing on the order sheet. The consultant must be a member of the Medical Staff. The consultant will see the patient daily unless discussed, in writing, with the attending physician**.** In general, a consultation may be appropriate under the following circumstances:

5.7-1 When the patient is not a good risk for medical or surgical treatment;
5.7-2 When the diagnosis is obscure;
5.7-3 When there is doubt as to the best therapeutic measure to be utilized;
5.7-4 As required by state statute, when a patient attempts suicide, overdoses on drugs, or exhibits suicidal tendencies (behavioral consultation);
5.7-5 Upon request of the attending physician, family or patient; and
5.7-6 Whenever it appears that the quality of medical service may be enhanced.

A qualified Physician Assistant or Nurse Practitioner member of the Allied Health Professional Staff may provide preliminary consultation whereby the PA or NP comes in to see the patient to begin to gather data prior to the consultant seeing the patient. A complete consultation includes examination of the patient by the consultant. The PA or NP may dictate a consultation report; provided, however, that it must be authenticated by the sponsoring physician within 24 hours.

CCU Consultations - All patients admitted to the Critical Care Unit, the consultant must see the patient within 12 hours, unless the patient was seen in the office prior to admission. The attending physician shall request appropriate specialist consultations on all critically ill patients and all patients in the CCU.

5.8 Clinical Observations (Progress Notes)

Patients will be seen and a progress note will be added to the EMR daily for all inpatients by the attending physician at 24-hour intervals and no less than daily. Additional progress notes will be added as frequently as the patient's condition warrants and should give a pertinent chronological report of the patient's course, reflect any change in condition, and describe the results of treatment. Progress notes are to be added only by those authorized by the Medical Staff. Progress notes by House Staff or Allied Health Staff may not substitute for a daily note by the attending physician.

5.9 Discharge Summary

A discharge summary shall be completed immediately and no longer than three (3) days following the date of discharge to ensure appropriate follow-up care of the patient, along with accurate and appropriate coding of the medical record sufficient for Hospital billing requirements.

The attending physician or his/her designee is responsible for the completion of a discharge summary that concisely summarizes the reason for hospitalization, the significant findings, the procedures performed, the treatment rendered, final diagnosis, and the condition of the patient on discharge. Any specific instructions given to the patient and/or family will be referenced on the Patient Discharge Instruction sheet. Authentication by the supervising/sponsoring physician is required for discharge summaries entered by a Nurse Practitioner.

A final progress note that contains the above elements may be substituted for the discharge summary for uncomplicated stays of under 48 hours, including normal vaginal deliveries and newborns.

Obstetrical patients having a cesarean section or other procedures require a

discharge summary.

In the event of death, a Death Summary is also required that summarizes the events leading to death.

A Transfer Summary will accompany all patients upon transfer regardless of the type of facility to which the patient is transferred.

5.10 Informed Consent

Except in an emergency, written consents are required prior to the initiation of at least the following procedures or therapies:

5.10-1 All inpatient and outpatient surgical and invasive procedures;
5.10-2 All procedures where anesthesia of any type is administered;
5.10-3 All endoscopic procedures;
5.10-4 All procedures involving blood administration including consideration to be given to options if they exist and the need for and risk of blood transfusion and available alternatives;
5.10-5 All HIV testing; or
5.10-6 All administration of investigational medications or devices.

It shall be the responsibility of the physician to inform the patient (or the patient's legal agent or "statutory surrogate") about the risk, benefits and alternatives associated with the proposed procedure(s) and/or therapy(s), to secure the patient's informed consent prior to the initiation of any procedure and/or therapy and to document the explanation in the chart.

Informed consent must be documented in writing and properly executed by the patient or the patient's designated agent who has health care power of attorney that meets the requirements of A.R.S. Section #36-3221, spouse, parent or legal guardian (if the patient is a minor). Exceptions are as in accordance with **Network Informed Consent Policy AD3050.** Nursing staff may obtain and witness signatures on consent forms when requested by the physician to do so, and after the physician has fully described the risks, benefits and alternatives with the patient or the patient's authorized representative.

5.10-7 Surgery Requirements

5.10-7.1 Preoperative Diagnosis
The individual who is responsible for the patient must record a preoperative diagnosis in the patient's medical record prior to surgery.

5.10-7.2 First Assistants
Hazardous surgical cases require a non-physician or physician first assistant to be scrubbed. Hazardous procedures are defined as complex operative procedures such as: Cardiac, Spine, Abdominal, Urological, or Orthopedic. A comprehensive listing can be obtained from the American College of Surgeons

5.10-7.3 Pre-Anesthesia
There will be a pre-anesthesia evaluation on each patient for whom anesthesia is contemplated. The evaluation will be performed by a practitioner with appropriate clinical privileges.

5.10-7.4 Post-Anesthesia

All patients are evaluated on admission to the post-anesthesia recovery area and within 48 hours of the surgical procedure by the individual physician who administered the anesthesia. All patients are evaluated prior to discharge from the post-anesthesia recovery area by the individual performing the post-anesthesia evaluation based on approved discharge criteria. All patients receiving anesthesia, regardless of the location, must be re-assessed within 48 hours of the procedure.

5.10-7.5 Tissue

All tissue and foreign objects removed during any operation (except those described below) shall be sent to the Hospital pathologists who shall make such examination as he or she may consider necessary to arrive at a pathological diagnosis and he or she shall document in the EMR. All tissue obtained in this manner shall remain the property of the Hospital.

If an outside pathology consult is requested, the staff pathologist will coordinate this consult. Tissue exceptions are as follows:

5.10-7.5.1 Newborn circumcisions
5.10-7.5.2 Certain foreign bodies, particularly those without medicolegal implications
5.10-7.5.3 Cataracts
5.10-7.5.4 Placenta from uncomplicated, normal single birth deliveries, discarded after the first 24 hours
5.10-7.5.5 Teeth
5.10-7.5.6 Fingernails and toenails removed for acute trauma debridement
5.10-7.5.7 Arthroscopy shavings
5.10-7.5.8 Bone fragments

All tissues and foreign bodies not submitted for pathologic review shall be described and recorded in the medical record by the operating surgeon or physician removing the tissue or foreign body.

5.10.7-6 Frozen Section Consults

All intraoperative frozen section consults will be performed by the hospital pathologists. If an outside pathology consult is requested, this consult will be coordinated by the staff pathologist.

5.10.7-7 Operative Reports

Operative reports shall be dictated or written immediately following an operative procedure. Operative procedure includes cardiac catheterizations, interventional radiology and endoscopy procedures. Each report shall contain a description of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, the estimated blood loss, and the name of the primary surgeon and any assistants. When there is a transcription and/or filing delay, a comprehensive operative progress note shall be entered in the medical record immediately after surgery to provide pertinent information for use by any practitioner who is required to attend to the patient.

6.0 Delinquency and Termination Policies for Incomplete Medical Records

6.1 Failure to Complete Medical Records on a Timely Basis

The Medical Records Department will notify physicians or their designee about incomplete records within sixteen (16) days following discharge. The physician then has five (5) days before temporary suspension is imposed.

Upon temporary suspension, the practitioner shall have no admitting, surgical and/or consultative privileges, other than patients already in the hospital, patients in labor or patients needing emergency care and patients already in the hospital. The practitioner will be removed from the emergency call schedule.

All medical records shall be completed within the timeframes defined:

6.1-1 H&P – dictated or handwritten within 24 hours of admission & before invasive procedure
6.1-3 Consultation Reports – dictated or handwritten within 24 hours of consultation
6.1-4 Operative Report – within 24 hours of procedure
6.1-5 Discharge Summary – within 72 hours of discharge
6.1-6 Death Summary – within 72 hours of death
6.1-7 Transfer Summary – at the time of transfer
6.1-8 Authentications – within 21 days of discharge. Electronic signature is acceptable
6.1-9 Verbal Orders – within 48 hours of discharge and are considered delinquent after 5 days

If a vacation prevents the practitioner from completing his/her medical records, the physician must notify the Medical Records Department in advance of the vacation; otherwise the suspension will remain in effect until the deficient documentation is complete.

If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the physician or the physician's office must notify the Medical Records Director.

When an individual practitioner has notified the Medical Records Director of being out of town or ill prior to being placed on suspension, the suspension process will be waived. The practitioner will be given one week after his/her return to complete any delinquent records.

6.2 Termination for Incomplete Records

Permanent suspension of membership and privileges will become automatic following 60 cumulative days of temporary suspension within a calendar year. After 60 cumulative days, the practitioner's privileges will automatically move to permanent suspension for failure to complete medical records. The physician shall be notified by the Chief Executive Officer (or his designee), as the agent of the Board of Directors, of the permanent suspension of his/her staff appointment.

6.2.1 Practitioners may request reinstatement during a period of 30 calendar days following permanent suspension. Thereafter, such practitioners shall have voluntarily resigned from the medical staff.

6.2.2 Following voluntary resignation from the medical staff, a physician must:

(1) wait a minimum of 30 days before reapplication; and
(2) pay an amount equal to the current application fee.

6.3 Suspension/Termination for Medicare Records/PRO Correspondence

If a physician fails to complete his reply to a Federal Professional Review Organization pre-denial letter within the time specified by the letter, the same penalties as outlined in section 4.2 will apply.

7.0 EMERGENCY DEPARTMENT

Any individual who presents for examination or treatment in the Emergency Department shall be appropriately screened and examined, to include ancillary service testing to determine whether or not an emergency medical condition exists. The emergency medical condition shall be stabilized to the extent possible prior to a patient's transfer if definitive treatment is beyond the capabilities of the Hospital.

Each Medical Staff Clinical Department is responsible for establishing its Emergency Department call requirements.

A physician serving on the Emergency Department call rotation must (1) respond to the Emergency Department if requested to do so by the Emergency Department physician and (2) accept any patient who has been referred from the Emergency Department for one office visit or until the patient can be safely and legally discharged to the care of another source regardless of the patient's financial status.

An on-call physician must be available and accessible by telephone during time on-call and must respond to all calls. The on-call physician must respond in person, if requested to do so by the Emergency Department physician.

If a patient is admitted through the Emergency Department within thirty (30) days following discharge from the Hospital, the initial physician assigned and/or his/her covering physician is responsible for the patient as well as his/her covering physician. If after the thirty (30) day period the patient fails to follow-up with the physician as recommended, the physician has the right of first refusal.

When a patient is admitted via the Emergency Department, in-house orders may be written by the Emergency physician at his/her discretion to initiate and expedite the delivery of care.

Discussion of treatment plan by the Emergency physician with the attending physician is recommended and any orders shall be co-signed. The attending physician shall assume and is responsible for all further medical direction, including orders written by the Emergency physician.

If an emergent situation arises and Nursing is unable to contact the attending physician or consultant, then Nursing shall initiate a Critical Care Physician consultation.

A patient admitted through the Emergency Department to the ICU or CVICU must be seen by the attending or consulting physician within eight (8) hours of admission to the

unit unless the patient's condition dictates otherwise. A patient admitted through the Emergency Department to a general medical/surgical floor must be seen by the attending or consulting physician within twelve (12) hours of admission to the floor unless the patient's condition dictates otherwise. The attending physician, however, is ultimately responsible for patient care.

8.0 Peer Review

It is the responsibility of the Medical Staff through its clinical departments to participate in peer review activities for the purpose of reducing morbidity and mortality and for the improvement of patient care provided in the Hospital. Such activities shall include reviewing the nature, quality and necessity of the care provided and the preventability of complications and deaths occurring in the Hospital.

8.1 Definition

Peer review is the process by which medical decision-making or other medical activities of a physician or other medical staff member are reviewed and critiqued by other physicians/members in the same or similar specialties. Peer review is based on the applicable standard of care.

8.2 Impartiality

Physicians and other medical staff members engaged in peer review shall do so impartially. Individuals with blood relationships, employer/employee relationships, or other potential conflicts that might prevent giving an impartial assessment or that might give the appearance of potential bias either for or against the subject are excluded from peer review. Such factors will be taken into consideration by hospital staff when requesting peer review assistance. Physicians who are asked to conduct peer review shall disclose such relationships and conflicts and decline the request.

8.3 Process

Whenever a practitioner's clinical course of treatment is identified as being outside the normal range of established criteria, a practitioner reviewer within the practitioner's Clinical Department, shall evaluate the reason the case(s) were referred for review for all or, if appropriate, selected aspects of the care provided. The Chairman of the Clinical Department shall be notified when a practitioner reviewer identifies aberrant clinical behavior involving a practitioner. The Chairman shall evaluate the outcome of a pattern/trend/analysis, and the recommendation of the practitioner reviewer. Action proposed may include:

(a) department review of the case(s) with the practitioner reviewer and practitioner being invited for discussion of the case. If either or both practitioners are unable to attend, peer review may proceed without them;
(b) an educational letter without required response;
(c) a letter noting an opportunity for improvement in management of care and documentation;
(d) a request for further professional review or corrective action pursuant to Article 6 of the Medical Staff Bylaws.

8.4 Timeframe to Conduct Peer Review

The normal course for the conduct of departmental peer review involving an individual practitioner, and excluding the corrective action process, shall occur as expeditiously as possible, and ideally within 120 days from the date of discharge or the date identified, whichever is later. Thoroughness and credibility of the process are more important than the speed of completion. The affected practitioner shall be notified of the departmental peer review process, and given an opportunity to participate in the process.

9.0 CONTINUING EDUCATION

Each individual with delineated clinical privileges is expected to participate in continuing educational activities that relate to privileges granted.

10.0 IMPROVING ORGANIZATIONAL PERFORMANCE

As a component of the hospital's ongoing process for the assessment and improvement of organizational performance, each medical staff member shall participate in the ongoing monitoring and evaluation of patient care activities.

11.0 INVESTIGATIONAL RESEARCH INVOLVING HUMAN SUBJECTS

Prior to their use, all investigational devices, drugs, isotopes, or drug therapies administered to hospital patients must be approved by an Investigational Review Board for Human Subjects approved by the Executive Committee and the Hospital's Administration. Pursuant to federal guidelines specific to the conduct of research, the IRB will maintain and adhere to policies required by federal statute.

Investigational drugs and devices shall be used only under the direct supervision of the Principal Investigator, who shall be a member of the Medical Staff and who will provide to the Pharmacy, necessary committees and the Nursing staff, all appropriate information concerning such drugs or devices. This includes dosage, strengths available, actions and use, side effects, symptoms of toxicity, and any other pertinent information.

12.0 NEW PROCEDURES

Requests for clinical privileges to perform a procedure or service not currently being performed at the Hospital, or a new technique to perform an existing procedure will not be processed until: (1) a determination has been made that the procedure will be offered by the Hospital; and (2) minimum criteria for granting such procedure has been established.

Whenever the Medical Staff Services Department is requested to establish credentialing criteria for a New Procedure, information regarding the New Procedure, per specialty, shall be submitted to the Chief of Staff and or applicable Clinical Department Chairman who shall assist Medical Staff Services personnel in determining if the New Procedure warrants further investigation or specific credentialing criteria. This decision may be made with the assistance of appropriate experts who may be members of the Medical Staff including members who are requesting to perform the New Procedure.

The applicable clinical department ("department") and the Medical Staff Executive Committee ("MEC") shall make a recommendation as to whether the New Procedure should be offered taking into consideration whether the Hospital has the capabilities, including support services, to perform the New Procedure.

After receiving the recommendations from the department and the MEC, the Board of Directors shall determine whether the New Procedure will be offered. If the Department recommends approval of the Procedure part of the recommendation shall include privileging criteria for the New Procedure. The Department shall develop recommendations regarding: (1) the minimum education, training and experience necessary to perform the New Procedure; and (2) the monitoring and observation requirements that may be warranted when privileges are granted.

Once the minimum threshold qualifications are approved by the Executive Committee and the Board of Directors, specific requests from eligible applicants may be processed.

13.0 HIPAA (Health Insurance Portability and Accountability Act)

All members of the Medial Staff are participants in the HonorHealth Organized Healthcare Arrangement (OHCA). All members of the Medical Staff are required to follow the HonorHealth Network's ("Network") Notice as to Protected Health Information (PHI) whenever they generate or receive PHI from the Network's facilities.

The Notice will serve as the Notice of Privacy Practices at the Hospital for all Medical Staff Members. This Notice governs the handling of all PHI generated at or received from the Hospital by Medical Staff members. Each Medical Staff member will abide by the provisions of this Notice for all such PHI. Failure to abide by the Notice may result in discipline or corrective action, pursuant to the Medical Staff Bylaws and the Rules and Regulations.

The Health Insurance Portability and Accountability Act (HIPAA) requires each Medical Staff member to provide a separate Notice of Privacy Practices in his or her private office setting. The Medical Staff member's own Notice of Privacy Practice will not, however, apply to PHI the Medical Staff member generates at or receives from the Hospital. Medical staff members therefore will not provide their own Notice of Privacy Practices developed for their office to patients while they are being treated at a Network facility.

14.0 INFECTION CONTROL

Standard precautions shall be implemented for all patients pursuant to Hospital Infection Control policies and procedures.

Patients with identified or suspected communicable diseases shall be treated under proper standard precautions for the protection of other patients and Hospital staff.

Physicians and employees potentially occupationally exposed to contaminated bodily fluids through needle puncture, wound, scalpel cut, or other broken skin or mucous, membrane exposure should immediately follow procedures set forth in the Infection Control policies and procedures and contact the Network's Infection Control Practitioner.

Infectious waste shall be handled pursuant to Infectious Waste policies and procedures as set forth in the Hospital Infection Control policies and procedures.

15.0 PATIENT SAFETY COMMITTEE

Each member of the Medical Staff, including Allied Health Professionals, shall comply with the Medical Staff Policies and Procedures, as recommended by the Patient Safety Committee and approved by Medical Executive Committee.

15.1 Central Line Bundle Policy and Checklist PS-001 (QA Policy Q-459)

The central line bundle checklist will be completed for all possible central line insertions.

15.2 Network Surgical Safety Checklist PS-002

The Network Surgical Safety checklist will be completed for all surgical cases.

16.0 DESIGNEE

Whenever in these Rules and Regulations action is required to be taken by the Chairman of the Board of Directors, the Chief Executive Officer, the Chief of Staff or the Chairman of a clinical department, such action may be taken by such person's designee in such person's absence.

17.0 DISASTER PLAN

The Hospital shall have a plan for the care of mass casualties at the time of any major disaster, based on the Hospital's capabilities in conjunction with other emergency facilities in the community.

The Disaster Plan shall make provisions for:

1. Authorization to the Chief Executive Officer and/or the Chief of Staff or their respective designees, pursuant to Article 5.5 of the Bylaws, to grant privileges as necessary to accommodate patient population during an emergent situation;
2. Availability of adequate basic utilities and supplies including gas, water, food and essential medical supportive materials;
3. An efficient system of notifying and assisting personnel
4. Unified medical command under the direction of the Emergency Department physician(s) on duty;
5. Conversion of all usable space into clearly defined areas for efficient triage for patient observation and for immediate care;
6. A special disaster medical record, such as an appropriately designated tag that accompanies the casualty at all times and contains specific required information;
7. Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy;
8. Maintaining security in order to keep relatives and unauthorized personnel out of the triage area;
9. Establishment of a centralized public information center with designated spokesman;
10. A pre-established radio communication for use when telephone communications are unavailable;
11. Assignments of all available physicians to posts, either in the Hospital or in satellite casualty stations. The Emergency Department physician(s) on duty at the time of the disaster will be in charge of all matters relating to direct patient care until such time as they are relieved by the Medical Director of Emergency Services or the Chief of Staff. The command physician will work with the Administration to coordinate all activities and support services; and
12. The Disaster Plan will be reviewed to ensure conformance with the Hospital's Disaster Plan

Policies and Procedures.

18.0 AMENDMENT

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

19.0 ADOPTION

19.1 Medical Staff

The Executive Committee shall be responsible for the development and biennial review of these General Rules and Regulations of the Medical Staff, which shall be consistent with Hospital's policies, Bylaws and applicable laws.

These General Rules and Regulations of the Medical Staff were originally adopted on April 6, 1989.

19.2 Board of Directors

These General Rules and Regulations of the Medical Staff were approved and adopted by resolution of the John C. Lincoln Health Network Board upon the recommendation of the Executive Committee on April 6, 1989.

Revisions: 9/90, 9/95, 6/97, 1/98, 4/98, 12/99, 12/00, 3/01, 10/01, 01/03, 10/04, 01/07, 01/08, 10/08, 12/10, 10/11, 12/11, 3/12, 2/13, 7/14, 5/15, 1/16, 3/16, 10/16, 2/2017