John C. Lincoln North Mountain Hospital
GENERAL MEDICAL STAFF RULES and REGULATIONS
2008

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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.

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

1.1.2.1 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.

1.1.2.2 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.

1.1.2.3"Direct Supervision" means that the supervising physician is scrubbed in and in the OR or Cath Lab.

1.1.2.4 "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 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)

1.3 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.

1.4 Medication Administration

Only those practitioners licensed by the State of Arizona to administer medications may do so. Conscious Sedation is defined as a minimally depressed level of consciousness (LOC) that retains the patient's ability to maintain a patent airway independently and continuously, and to respond to physical and verbal stimulation.

1.4-1 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. 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 P 740. 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.

1.5 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.

1.5-2 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.

1.6 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.

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 or consulting 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 or consulting physician within twelve (12) hours of admission to the floor. The attending physician, however, is ultimately responsible for patient care.

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. 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 Intensive Care Unit

Patients shall be considered appropriate for admission to the Intensive Care Unit 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. 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 Trauma Critical Care Committee and the Executive Committee of the Medical Staff and be in accordance with Intensive Care Unit policy #6011.100.

2.4 Discharges

Patients shall be discharged only on the order of the attending physician or his/her designee. Should a patient leave the Hospital against medical advice, a notation of the incident shall be made in the patient's medical record.

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. 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:

a) Unexplained death;
b) Unexpected death; and
c) 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.

2.5.1 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 Unit Record: A unit type medical record shall be maintained for each individual who is evaluated or treated as an inpatient, outpatient or emergency service patient. The attending physician shall be responsible for each patient's medical record. Only authorized individuals may make entries in the medical record.

3.2 The inpatient record shall include the following when appropriate:

1) Patient identification data;
2) Emergency care provided prior to arrival;
3) Chief medical complaint(s);
4) Evidence of Advanced Directives;
5) Withdrawal/Withholding of Life Support (reference Hospital Patient Services Policy #P-755);
6) Evidence of appropriate informed consent;
7) Relevant personal medical history;
8) Relevant family medical history;
9) Prenatal information in obstetrical records;
10) History of present illness;
11) Physical examination findings;
12) Diagnostic reports, medical and/or surgical treatment, pathological findings (if applicable);
13) Pertinent progress notes and observations, regarding patient's condition and response to therapy, final diagnosis, condition on discharge or applicable autopsy report; and
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:

1) Patient identification data;
2) Evidence of appropriate informed consent;
3) Information regarding time, means and method of transport;
4) Pertinent treatment prior to presentation;
5) Chief complaint;
6) History of illness or injury, physical exam as appropriate to present illness;
7) Clinical observations, laboratory and radiological findings;
8) Diagnostic and therapeutic orders;
9) Treatment rendered;
10) Discharge instructions;
11) Condition of patient on discharge; and
12) Information concerning patient leaving "against medical advice;"

3.4 Outpatient Surgery records will contain at least the following:

1) **Pre-operative** History & Physicals shall include: chief complaint, history of the illness or injury, including physical findings, treatment modalities,

current levels of disability, and/or other indications for surgical intervention; surgical and anesthetic history, allergies and current medications; physical examination appropriate to the patient's health status; anesthetic risk, and type of procedure(s) and preoperative diagnosis.

2) **Post-operative**: Immediately following surgery, a description of the techniques and findings; postoperative diagnosis; and discharge instructions.

3.5 Outpatient Surgery Operative Report

1) A comprehensive history & physical examination shall be on the chart prior to surgery. A durable legible, original or reproduction of a comprehensive history and physical examination is acceptable when completed within
   - 7 days prior to admission if the patient's condition did not significantly change; or
   - 8 to 30 days prior to admission with an interval note documenting the patient's current status.
2) A short form history & physical form is an acceptable alternative to a comprehensive, dictated or office history & physical. Additionally, the short form H&P shall be required if there is not enough time for the dictated H&P to be included on the chart. An office H&P over thirty (30) days can be included to supplement the short form H&P.

3.6 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 in peer review, corrective action and other legislated 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

3.7 Abbreviations

Only those abbreviations approved by the Medical Staff may be used in the medical record.

3.8 Authentication

Signatures must be legible, include notation of credentials, and be dated.

A five-digit computer password determined by the Medical Record Department that uniquely identifies each physician is acceptable in lieu of a signature.

3.9 Correction of Errors

To correct an error in the medical record, the practitioner must line through the incorrect information, write "error," write in the correct information, his/her name and date. The incorrect information should not be obliterated.

4.0 History and Physical Examination Report (Inpatients)

A comprehensive history and physical examination shall be recorded within 24 hours of admission by a physician, or qualified oral/maxillofacial surgeon, and filed on the record 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 written by the attending surgeon with date given, 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, legible, original or reproduction of a comprehensive history and physical examination is acceptable when completed within seven (7) days prior to admission if the patient's condition did not significantly change during the period between documentation and admission to the hospital; or eight (8) to thirty (30) days prior to admission with an interval note documenting the patient's current status. The interval note shall include that (a) the history & physical is still current; (b) an appropriate assessment was completed on admission confirming that the necessity for the procedure or care is still present; and (c) any 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, nurse practitioner or physician's assistant. A history and physical examination report prepared by a consultant, nurse practitioner or physician assistant should either be dated and countersigned by the attending physician or a progress note written by the attending physician noting his or her acceptance. 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 hours of a patient's stay.

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

The following elements must be included:

1) Chief complaint;
2) Details of the presenting illness, with relevant assessment of the patient's emotional, behavioral, and social status;
3) Past history:
4) Allergies: (e.g. drugs, food, iodine);
5) Social history;
6) Review of systems;
7) Comprehensive physical exam;
8) Conclusion or impression; and
9) Plan of action

4.0.2 Elements of Pediatric History & Physical Examination

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

1) evaluation of developmental age;
2) educational needs and daily activities;

3) immunization status; and
4) family's expectations and involvement in the care of the patient.

4.0.3 Prenatal History & Physical Examination

Prenatal records will serve as the History and Physical Examination Report for patients having normal vaginal deliveries. An interval note or update of the prenatal record is required if the time period from the last office or clinic visit and the time of delivery exceeds seven days. Cesarean Section and post-delivery procedures require an updated comprehensive History and Physical Examination Report.

4.0.4 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.

4.1 Orders

4.1.1 Diagnostic and Therapeutic Orders

Orders must be written only within the authority scope of clinical privileges granted to the practitioner giving the orders. All orders must be legible, dated, timed and signed. Orders for diagnostic and therapeutic tests must include sufficient detail to facilitate interpreters review.

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.

It is the responsibility of the ordering physician to review and sign such 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.

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.

Special treatment orders, such as use of restraints, will be documented to include type of restraint, justification and time limits. Restraint orders will be documented to include type of restraint, justification and time limits, **NOT TO EXCEED 24 HOURS**. Subsequent restraint orders must be written 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)

4.1.2 Routine Orders

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.

4.1.3 Automatic Cancellation of Orders

All previous orders are automatically discontinued when the patient goes to surgery or is transferred.

4.1.3-1 No Code 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 writing 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.

4.1.3-2 Countersignatures

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

Countersignatures 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 Countersignature.

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.

4.1.4 Consultation Reports

Each consultation report shall contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and a review of the patient's medical record. 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:

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

4.1.5 Clinical Observations (Progress Notes)

Patients will be seen and a progress note will be written daily for all inpatients by the attending physician at 24-hour intervals and no less than daily. Additional progress notes will be written 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 written only by those authorized by the Medical Staff.

4.1.6 Discharge Summary

A discharge summary shall be completed immediately and no longer than five (5) 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.

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.

4.1.7 Informed Consent

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

1) All inpatient or surgical and invasive procedures;
2) All procedures where anesthesia of any type is administered;
3) All endoscopic procedures;
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) All HIV testing; or
6) All administration of investigational medications or devices.

It shall be the responsibility of the physician to inform the patient about any and all proposed procedures and therapies and to secure the patient's informed consent prior to the initiation of any procedure or therapy. The risk/benefits and alternatives associated with the procedure(s)or therapy(s) are to be discussed by the physician with the patient or authorizing party before documenting the informed consent.

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). 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. Exceptions are as provided in accordance with hospital policy #Q-605 Consents.

4.1.8 Surgery Requirements

4.1.8-1 Preoperative Diagnosis

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

4.1.8-2 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.

4.1.8-3 Post-Anesthesia

All patients are evaluated on admission to and prior to discharge from the post-anesthesia recovery area by the individual performing the post-anesthesia evaluation based on discharge criteria.

4.1.8-4 Tissue

All tissue and foreign objects removed during any operation (except items specifically exempted by the Surgery Committee) 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 make a written report. All tissue obtained in this manner shall remain the property of the Hospital.

4.1.8-5 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.

4.1.8-6 Orders

Orders for patient care will be canceled at the time of surgery. 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.

4.1.8-7 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.

5.0 Delinquency and Termination Policies for Incomplete Medical Records

5.1 Medical Record Delinquent Days

The Medical Records Department will notify physicians about incomplete records weekly by mail or fax, informing them that records must be completed within fifteen (15) days following discharge. Once records remain incomplete for thirty (30) days following discharge, delinquent days shall begin to accumulate. No more than sixty (60) days of delinquency may be accumulated in a calendar year. The Medical Records Department shall notify a physician by certified mail, after thirty (30) days of incomplete records that the counting of delinquent days is underway.

Medical and surgical care of patients shall not be disrupted during the accumulation of delinquent days or while a physician's medical records remain incomplete during this delinquency. However, termination of membership and privileges will become automatic if more than sixty (60) delinquent days are accumulated in a calendar year. A physician shall be assessed a $25 per day delinquency fee for each day over thirty (30) delinquent days, and the accumulation of this fee shall continue until all delinquent records are completed. As the days accumulate, delinquency fees will become due on a monthly billing cycle and payable to the Desert Mission Food Bank.

5.2 Termination for Incomplete Records

A physician shall be allowed no more than sixty (60) delinquent days per calendar year. A staff member who accumulates more than sixty (60) delinquent days shall be notified by the Chief Executive Officer (or his designee), as the agent of the Board of Directors, of the termination of his/her staff appointment.

Pursuant to Arizona Revised Statutes, the Hospital shall report the physician to his/her appropriate licensing board. In order to obtain staff privileges following such action, the physician shall follow the required process:

5.2.1 First Occurrence:

(1) Wait a minimum of thirty (30) days after receipt of notification by the Chief Executive Officer (or his designee), or thirty (30) days after completion of all incomplete medical records, whichever date occurs later, before requesting an application for reinstatement; and

(2) Remit a reinstatement fee of $500 payable to the Hospital, plus any outstanding delinquency fee, to be donated to the Desert Mission Food Bank.

5.2.2 Subsequent Occurrence:

(1) Wait a minimum of six (6) months after receipt of notification by the Chief Executive Officer (or his designee), or six (6) months after

completion of all incomplete medical records, whichever date occurs later, before requesting an application for reinstatement;

(2) Remit a reinstatement fee of $1,000, plus any outstanding delinquency fee, to be evenly divided between the Hospital and the Medical Staff.

The application for reinstatement shall require processing and verification of information since the physician's last reappointment to the Medical Staff. Review and approval of the completed application for reinstatement shall be required by the applicable clinical department, the Medical Executive Committee and the Board of Directors. There shall be no expedited process to reinstate a physician following revocation of membership and privileges for incomplete medical records.

5.2.3 Procedure:

The following steps shall be taken in accordance with the above provision:

(1) A physician shall be notified by mail that medical records are to be completed fifteen (15) days following discharge;

(2) After thirty (30) days of incomplete medical records, a physician shall be notified by the Medical Records Department by certified mail that the counting of delinquent days is underway;

(3) If greater than sixty (60) delinquent days are accumulated in a calendar year, the Chief Executive Officer (or his designee) shall notify the physician, by certified mail, that his/her Medical Staff membership and privileges have been terminated;

(4) Pursuant to Arizona Revised Statutes, the Hospital shall, in accordance with law, file a report with the appropriate State licensing board.

5.3 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.

6.0 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.

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-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. 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. The attending physician, however, is ultimately responsible for patient care.

7.0 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.

7.1 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.

7.2 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.

7.3 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.

7.4 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.

8.0 CONTINUING EDUCATION

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

9.0 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.

10.0 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.

11.0 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.

12.0 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. Unified medical command under the direction of the Emergency Department physician(s) on duty;
4. Conversion of all usable space into clearly defined areas for efficient triage for patient observation and for immediate care;
5. A special disaster medical record, such as an appropriately designated tag that accompanies the casualty at all times and contains specific required information;
6. Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy;
7. Maintaining security in order to keep relatives and unauthorized personnel out of the triage area;
8. Establishment of a centralized public information center with designated spokesman;
9. A pre-established radio communication for use when telephone communications are unavailable;
10. 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

11. The Disaster Plan will be reviewed to ensure conformance with the Hospital's Disaster Plan Policies and Procedures.

13.0 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.

14.0 ADOPTION

14.1 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.

14.2 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:

September 1990
September 1995
June 1997
January 1998
April 1998
December 1999
December 2000
March 2001
October 2001
January 2003
October 2004
January 2007
January 2008
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