ARIZONA SPINE & JOINT HOSPITAL
Proudly Owned & Operated by Physicians

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# Medical Staff Rules & Regulations

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# INTRODUCTION

Pursuant to Section 15.1 of the Medical Staff Bylaws of Arizona Spine & Joint Hospital ("Hospital"), the following are adopted by the Medical Staff as the Rules and Regulations replacing all previous such Rules and

Regulations as approved by the Governing Board of the Hospital. Medical Staff Bylaws, Rules and Regulations will be reviewed and as appropriate revised at least every other year.

# SECTION 1: CREDENTIALING PROCESS

1. It is a requirement that all Medical Staff Members adhere to the credentialing process outlined in the Medical Staff Bylaws of the Hospital. All Members must be fully compliant with the Medical Staff Bylaws and are bound by the application, notice, hearing and appeal processes outlined.
2. The Medical Executive Committee ("MEC") and the Credentials Committee will take the following into consideration when making a reappointment to the Medical Staff Members or re-privileging allied health professionals:
    a. An infection rate below three percent (3%);
    b. A complication rate below two percent (2%);
    c. Less than three (3) medical records suspensions from the Medical Staff during the current period of appointment; and
    d. Less than a delinquent medical record rate of twenty (20) medical records per month.

# SECTION 2: DELINEATION OF CLINICAL PRIVILEGES

1. Lists of the most commonly requested Privileges have been developed for the specialties practicing at the Hospital and reflect the Hospital's capacity, equipment and personnel capabilities.
2. The Chief Executive Officer and the office of the Medical Staff will keep the lists of Privileges, by specialty.
3. Concurrent with an applicant's appraisal by the MEC for appointment or reappointment to the Medical Staff, the MEC shall review the applicant's qualifications for the specific procedures the applicant desires to perform. The MEC shall include a specific list of procedures that the applicant is qualified to perform at the Hospital with each recommendation for appointment and/or reappointment that is submitted to the Governing Board.
4. Granting and Renewing privileges will be based on criteria defined in Medical Staff Bylaws and will be based on current competency, an applicant's ability to provide patient care, treatment and services within the scope of the privileges requested, available quality information and peer recommendations..
5. All Delineation of Privileges will be reviewed and approved by the Medical Staff

# SECTION 3: CREDENTIALING OF ALLIED HEALTH PROFESSIONALS

1. All non-physician health personnel providing services at the Hospital that are not Hospital employees and/or not under contract to the Hospital shall be credentialed by the Medical Staff in accordance with the Medical Staff Bylaws.
2. Certified registered nurse anesthetists ("CRNAs") may be credentialed as defined by the State Board of Nurse Examiners, R4-19-516, scope of practice. CRNAs may be credentialed to perform general anesthesia, spinal anesthesia, epidural anesthesia, IV sedation, or administer local anesthesia. CRNAs

are not eligible to be Members of the Medical Staff.

3. Licensed/certified Surgical first assistants may be credentialed to perform within this role, allowed to manipulate tissue, suture, and assist the Member. Non-licensed/certified surgical first assistants may only perform services under the personal supervision of the surgeon or AHP. Surgical first assistants are not eligible to be Members of the Medical Staff.
4. Registered nurses, physician assistants, and nurse practitioners may be credentialed to perform in their respective role based on demonstrated competency and as defined by the appropriate licensing body. Each is required to maintain current licensure, demonstrate clinical competency, maintain personal health status, BLS Certification and professional liability insurance at the specified levels, and other requirements as required by the Bylaws and Rules and Regulations. Registered nurses, physician assistants, and nurse practitioners are not eligible to be Members of the Medical Staff.
5. The Medical Staff may consider other health professionals for Privileges by following the Medical Staff Bylaws in regard to allied health professionals.

# SECTION 4: INFORMED CONSENT

1. Every patient, or legally authorized person acting on behalf of a patient, shall be given procedure information, explanations, consequences, options, and the opportunity to question the surgeon and anesthesia provider in order to grant informed consent to a procedure or treatment.
2. It is the surgeon's responsibility to obtain a written informed consent. Surgical operations are permitted only with the consent of the patient, or legally authorized person acting on behalf of a patient, except in emergencies. A properly executed informed consent form for the operation must be in the patient's chart before surgery. The patient must be informed of the nature of the treatment, the risk, and possible complications, together with alternative forms of treatment. It is the physician's responsibility to convey the necessary information to the patient in language that the patient can understand. Arizona Spine and Joint Hospital shall assure itself that the physician has informed the patient of the nature and probable result of the contemplated course of treatment or procedures. This assurance shall be obtained utilizing the consent forms. The consent must contain the signature of patient, or legally authorized person acting on behalf of a patient, date and time consent was obtained, statement that the procedures was explained to the patient or legally authorized person acting on behalf of a patient, signature of professional person witnessing the consent, and the name/signature of the Member who explained the procedure to the patient or legally authorized person.
3. Additional consent forms may be necessary for special procedures, or for specific payers such as Medicaid.
4. Other consent forms designed by or from individual Members may be used, but use of such a form will supplement, but not replace, the need for informed consent consistent with the requirements of the Hospital. A copy of the additional consent form will be given to ASJH by the Member as a permanent part of the medical record.
5. Erasure or other obliterating marks, including any type of "white-out" may not be used on an informed consent.
6. The patient, or legally authorized person acting on behalf of a patient, must sign the informed consent form.
7. If, in a rare event, the legally authorized person is not present, then a telephone consent witnessed by two (2) Hospital staff members and fully documented in the medical record as to the reason for the telephone

consent is acceptable. Witnesses shall determine that the person on the phone is truly the legally authorized person acting on behalf of the patient and authorized to provide informed consent.

8. A patient cannot sign a permit after receiving sedatives and/or narcotics unless a four (4) hour time frame has elapsed and the patient is deemed able to provide an informed consent.

# SECTION 5: NON-DISCRIMINATION

1. Members and AHPs shall comply with Hospital's policies regarding the admission, transfer and discharge of patients. All services in the Hospital shall be provided in a non-discriminatory manner, without regard to race, color, national origin, handicap or other protected classification.

# SECTION 6: ADMISSION OF PATIENTS

1. Patients shall be admitted to the Hospital for treatment upon the order of a physician Member in good standing that holds admitting privileges.
2. All scheduled pediatric cases should be first in the lineup while those cases scheduled as urgent/same day cases can be added on later in the lineup, but close to a 2 pm start time. Pediatric NPO instructions should be NPO at midnight and water until 2 hours before reporting to the hospital.
3. Members shall avoid treating members of immediate family.
4. The admitting physician Member shall be responsible for declaring an admitting diagnosis or impression, admitting orders, admitting note, and complete history and physical examination ("H&P"), which must be entered into the inpatient record within twenty-four (24) hours of admission and must meet the currency requirements defined in Section 11. The physician Member shall be responsible for the total care of the patient, for obtaining proper consultation whenever indicated, for completion of all medical records as required.
5. It is the responsibility of the admitting physician Member to obtain informed consent from the patient, parent, or legally authorized person for any procedure to be performed at the Hospital.
6. A written H&P, which contains a chief complaint, present illness, inventory of symptoms, past history, family history, social history, record of results of physical examination, provisional diagnosis, and current medications shall be recorded in the patient's medical record and signed by the admitting physician Member or allied health professional, with these privileges, **prior to surgery** on all patients. The H&P must meet currency requirements as detailed in these Rules and Regulations. A dictated H&P prior to surgery is acceptable in an emergency situation. For, patients having podiatric or dental surgery, an admitting physician Member must complete the medical portion of the H&P unless otherwise stipulated and allowed by the Medical Staff. An AHP may be granted privileges to complete portions or all of the H&P with the appropriate supervision as allowed by law.
7. All patients admitted to the Hospital shall be under the care of a physician Member privileged to do so. An order is required for each patient admitted to the Hospital on an inpatient or outpatient basis. Each patient will have laboratory test results, previously ordered by the surgeon and/or anesthesia provider, recorded on the medical record prior to surgery.

   There shall be no joint admissions. The admitting Physician member shall be known as the attending physician and shall be responsible for history, physical, and discharge summary. Patients admitted for dental or podiatric services shall be under the general care of a physician Member of the Active Staff.
8. It is the attending physician Member's responsibility to obtain consultations when:

a. The patient is not a good medical or surgical risk;

b. The diagnosis is inconclusive or obscure;

c. The need is outside the clinical scope of the physician Member's practice;

d. There is doubt as to the best therapeutic measures to be utilized;

e. When the patient, or legally authorized person acting on behalf of a patient, requests such consultation;

f. The patient has failed to respond to therapeutic measures over an extended period of time.

The consultation must be included in the medical record and, if obtained prior to surgery, it shall be recorded prior to the operation.

9. It is the attending physician Member's responsibility to provide competent coverage for patient care in the event that the Member is out of town or unavailable to provide coverage.
10. Each attending physician Member will visit his/her patients at least once every twenty-four (24) hours except on the day patient is discharged.

# SECTION 7: CONSULTATIONS

1. A Consultation is a service provided by a Member whose opinion or advice regarding evaluation and/or management ("E/M") of a specific problem is requested by another Member or other appropriate source.
2. A request and need for a consultation shall be documented by the consultant in the patient's medical record and included in the requesting Member's plan of care in the patient's medical record.
3. Consultations shall be answered within twenty-four (24) hours of the request. In the event of an urgent or emergent consult need, it shall be the responsibility of the requesting physician to call the consult physician directly.
4. After the consultation is provided, the consultant shall prepare a written report of his findings and recommendations, which shall be provided to the referring Member.
5. A consultation shall not be performed as a split/shared E/M visit.
6. A consulting Member may initiate diagnostic services and treatment at the initial consultation or subsequent visit.
7. A transfer of care occurs when a Member requests that another Member take over the responsibility for managing the patient's complete care for the condition and does not expect to continue treating or caring for the patient for that condition.
    a. When this transfer is arranged, the requesting Member is not asking for an opinion or advice to personally treat this patient and is not expecting to continue treating the patient for the condition; and
    b. The receiving Member shall document the transfer of the patient's care, to his/her service, in the patient's medical record or plan of care.
8. A second opinion E/M service is a request by the patient, or legally authorized person acting on behalf of the patient, or mandated (e.g., by a third-party payer or State law) and is not requested by a Member.
    a. A written report is not required to be sent to a Member when an evaluation for a second opinion has been requested by the patient or legally authorized person acting on behalf of a patient;
    b. A second opinion is generally performed as a request for a second or third opinion of a previously

recommended medical treatment or surgical procedure; and

c. In the inpatient hospital setting, a request for a second opinion shall be made through the attending physician.

9. A written request for a consultation from an appropriate source and the need for a consultation must be documented in the patient's medical record.
    a. The initial request may be a verbal interaction between the requesting physician and the consulting Member; however, the verbal conversation shall be documented in the patient's medical record, indicating a request for a consultation service was made by the requesting Member;
    b. The reason for the consultation shall be documented by the consulting Member in the patient's medical record and included in the requesting Member's plan of care. The consultation request may be written on an order form by the requestor in a shared medical record, as part of a plan written in the requesting Member's progress note, an order in the medical record, or a specific written request for consultation; and
    c. A written consultation report shall be furnished to the requesting Member.
10. Examples that do not meet the criteria for consultation services:
    a. Standing orders in the medical record for consultations;
    b. No order for a consultation; and
    c. No written report of a consultation.

# SECTION 8: ANESTHESIA

1. Administration of local and/or topical anesthesia shall be the responsibility of the surgeon(s).
2. Administration of conscious sedation will be under the supervision of a Member or AHP credentialed to do so.
3. Administration of general anesthesia, block, spinal, or epidural anesthesia shall be the responsibility of an anesthesiologist Member or CRNA*(with the exception of block, CRNAs are not privileged for block anesthesia)* approved by the surgeon and credentialed to perform the type of anesthesia being utilized.
4. When the use of sedation is planned, the attending physician Member, anesthesia provider, or allied health professional with appropriate Privileges must evaluate the heart, lungs, oral airway and ASA Classification of the patient.
5. The Member or AHP administering anesthesia will ensure that the medical record for each patient receiving anesthesia contains:
    a. A pre-anesthesia evaluation by a Member or AHP privileged to administer anesthesia within twenty-four (24) hours prior to surgery; The delivery of the first dose of medication(s) for the purpose of inducing anesthesia marks the end of the 24 hour timeframe.
    b. An intra-operative anesthesia record;
    c. With respect to inpatients, a post-anesthesia follow-up report by the individual who administers the anesthesia that is written within twenty-four (24) hours after surgery or prior to discharge, whichever occurs first; and
    d. With respect to outpatients, a post-anesthesia evaluation for proper anesthesia recovery performed in accordance with Medical Staff Policies and Procedures.

6. Anesthesia will not be started until the surgeon is present in the surgical suite.
7. If anesthesia is administered by a Certified Registered Nurse Anesthetist (CRNA), the anesthesiologist must provide medical direction.
    a. Medical "direction" is CRNA's, working directly with an anesthesiologist, under his/her license, not the surgeon's. The Anesthesiologist must physically perform the pre-operative anesthesia evaluation, develop the anesthesia plan, be physically present in the OR suite for both induction and emergence (the critical aspects of the anesthetic), remain immediately available throughout the procedure (within the facility) and participate/direct post-op care in PACU. The ratio for this model should not exceed 1:3.
    b. CRNAs are not allowed to perform block anesthesia.
    c. Medical Directing Physician must use ASJH approved stamp for co-signing documentation.. Az Statue 32-1634.04. "Certified registered nurse anesthetist; scope of practice A certified registered nurse anesthetist may administer anesthetics under the direction of and in the presence of a physician or surgeon in connection with the preoperative, intraoperative or postoperative care of a patient or as part of a procedure performed by a physician or surgeon"
8. Az Statue 32-1634.04. "A certified registered nurse anesthetist's authority to administer anesthetics or to issue a medication order as prescribed by this section does not constitute prescribing authority."
9. Pediatric Anesthesia Providers are required to maintain Pediatric Advance Life Support (PALS) Certification.
10. No explosive anesthesia agents will be available at the Hospital.
11. After the administration of an anesthetic, patients shall be constantly attended until reactive and able to summon aid in accordance with established standards of care in the post-anesthesia care unit.
12. The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:
    - Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
    - Cardiovascular function, including pulse rate and blood pressure;
    - Mental Status;
    - Temperature;
    - Pain;
    - Nausea and vomiting; and
    - Postoperative hydration.
13. All waste is to be immediately completed in the pyxis with a witness. Paper waste will no longer be a valid form of waste. In addition, the waste should be completed in the unit of measure that the drug is available in. All narcotic wastes will be resolved within 7 business days. Once there are 3 unwitnessed wastes that haven't been resolved in 7 working days, the provider will be locked out of the pyxis. If the provider has been locked out of the pyxis twice, they will be suspended for 30 days. All subsequent suspensions related to this issue will be reported to the Medical Board.

# SECTION 9: POST ANESTHESIA CARE UNIT

1. The Post Anesthesia Care Unit ("PACU") care of a patient will function under the direction of the anesthesia provider.

2. Attending physicians and anesthesia providers must adhere to the admission and discharge criteria established for the recovery of patients reviewed and approved by the MEC.
3. A Member or AHP with training and experience in cardiopulmonary resuscitation shall be on the Hospital premises and immediately available until all patients are discharged from the PACU.
4. The medical directing physician will ensure all documentation is completed prior to the CRNA leaving the facility.

# SECTION 10: DISCHARGE OF PATIENTS

1. A Member or AHP must discharge either inpatients or outpatients from the PACU **OR** discharge can be accomplished under the direction of the Member or AHP based on criteria approved by the Medical Staff.
2. Outpatients:
    a. Discharge from the Hospital is based on the patient's ability to leave safely when accompanied by a responsible adult. The patient may not drive himself or herself home unless the attending physician Member approves by written order.
    b. Upon discharge each patient will be provided discharge instructions with the phone number of his/her attending physician Member for emergency use and after hours information.
3. If following surgery the attending physician Member determines that an outpatient requires observation status for up to seventy-two (72) hours, an order must appear in the record and the record must reflect the clinical reason for observation.
4. If a physician admits a patient for observation, it is required that the surgeon write at least one progress note prior to the patient being discharged, in addition to the required immediate post-op note.
5. If following surgery the attending physician Member determines that the patient requires Hospital admission, Hospital admission criteria must be followed and the attending physician Member must comply with the medical record requirements for inpatient stays.
6. The attending physician Member shall complete a discharge summary for all inpatients with final diagnosis within twenty-four (24) hours of discharge, unless there are extenuating circumstances.
7. If the attending physician Member determines that transfer to another hospital is required, the procedures outlined in Section 18 of these Rules and Regulations will be followed.

# SECTION 11: MEDICAL RECORDS

1. The attending physician Member shall be responsible for the preparation of a complete medical record for each patient.
2. All entries in the medical records by Hospital staff Members and AHPs shall be legible, permanently recorded, dated, timed, and authenticated by the name and title of the person making the entry. Documentation of the attending physician Member's participation in the care of the patient shall be evidenced by:
    a. The Member's signature on the patient's history and physical examination;
    b. Periodic progress notes or countersignatures;
    c. If surgery was performed, the Member's signature on the progress report; and
    d. The Member's signature on the discharge summary for inpatients.

e. All entries made by a nurse practitioner or physician assistant require countersignatures by the attending physician.

3. History and Physical Examination: There must be documentation of a complete H&P in the medical record **prior to surgery**. A complete H&P is defined in Section 6 of these Rules and Regulations.
    a. The H & P must meet currency requirements as defined by law based on the following rules:
        i. The H&P was performed within thirty (30) days prior to the surgery; **AND**
        ii. An appropriate assessment is performed by the physician Member within twenty-four (24) hours prior to surgery or within twenty-four (24) hours of admission to the Hospital, whichever occurs first, which should include:

            A physical examination of the patient to update any components of the patient's current medical status that may have changed since the actual performance of the H&P or to address any areas where more current data is needed;
            Confirmation that the necessity for the procedure is still present and that the H&P is still current; **AND**
        iii. The physician or other individual qualified to perform the H&P writes an update note addressing the patient's current status and/or changes in status; and
        iv. The updated note must be on or attached to the H&P **AND** the H&P and updates must be included in the medical record prior to surgery. If upon examination, the physician finds no change in the patient's condition since the H&P was completed, he/she must indicate in the patient's medical records that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed.
    b. An H&P performed more than thirty (30) days prior to surgery does not meet the currency criteria and a new H&P must be completed.
    c. All or part of the H&P may be delegated to other practitioners in accordance with State law and with approved Privileges. The physician Member must sign the H&P as applicable and required by State law.
    d. If a patient is readmitted within thirty (30) days for the same or related condition there shall be a reference made to the previous history with an interval note and any pertinent changes in physical findings shall be recorded.
4. For non-surgical procedures, the attending physician Member with appropriate privileges will document the diagnosis and clinical indications for the intended procedure in the medical record prior to the procedure.
5. An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed, dated and timed by the surgeon.
6. Discharge Summary: The inpatient medical record shall also contain a discharge summary and a discharge order initiated by the attending physician Member.
7. The Medical Record shall include:
    a. All orders, nursing notes, reports of treatment, medication records, radiology, laboratory reports, vital signs, and other information necessary to monitor the patient's condition;
    b. A full description of all surgical procedures performed, completed by the operating surgeon;

c. A copy of the discharge instructions, which are given to all patients;

d. A pathology report, radiology reports, and/or other consultative reports when appropriate;

e. Documentation of complications, Hospital acquired infections, and unfavorable reactions to drugs and anesthesia, if any;

f. Final diagnosis; and

g. The attending physician Member shall see that the record is complete and signed.

8. All orders shall be given by Members or AHPs privileged to do so. All orders for treatment shall be in writing.

   a. An order shall be considered to be in writing if dictated to a registered nurse, registered dietitian, registered pharmacist, registered or certified respiratory therapist, or registered physical therapist, and signed, dated and timed by the Member or AHP.

   b. Verbal and telephone orders shall contain the name of the Member or AHP giving the order, the first initial and last name and professional designation of the health care practitioner receiving the order.

   c. Verbal orders are discouraged, all telephone and verbal orders will be read back to the Member or AHP and this read back will be documented in the medical record.

   d. All verbal and telephone orders will be signed, dated and timed upon the practitioner's next visit to the facility but no later than 30 days.

   e. All approved verbal orders authentication must be completed within 30 days from the time the physician placed order.

9. It is required that the attending physician Member complete medical records in a timely manner not to exceed thirty (30) days after discharge.

10. An automatic suspension shall be imposed for the failure of a Member or AHP to complete the records in the required time period and shall remain in effect until the incomplete medical records are complete.

    a. Upon the decision to impose an automatic suspension, the physician shall be given a seven (7) day written notice before the automatic suspension is imposed.

    b. An automatic suspension shall result in the withdrawal of the Member's admitting and surgical scheduling privileges or the AHP's privileges. This rule may be waived for a maximum time of twenty-four (24) hours at the sole discretion of the Chief of Staff or his/her designee in accordance with the Bylaws. The Chief of Staff may not waive his/her own suspension.

    c. Any automatic suspension for incomplete medical records, no matter its duration, shall be considered administrative only and shall not be construed to be a professional review action within the meaning of the Health Care Quality Improvement Act of 1986 for purposes of reporting to the National Practitioner Data Bank.

    d. For the purpose of enforcing an automatic suspension, justified reason for delay in completing medical records shall include:

       i. That the Member, AHP or any other individual contributing to the record is ill, on vacation or otherwise unavailable for a period of time;

       ii. That the Member is awaiting results necessary for completion of the discharge summary and final diagnosis;

       iii. That the Member has dictated reports and is waiting for Hospital personnel to transcribe them or

the medical record has not been made available to the Member. If so, the Member shall be given thirty (30) days to complete the chart from the time of dictation or availability.

11. All medical records shall remain the property of the Hospital and shall not be taken from the Hospital without the express written permission of the Chief Executive Officer.
12. HIPAA violations by Members or AHPs are investigated by the Hospital with recommendation to the MEC for disciplinary action, if any.
13. In the case of readmission of a patient, all previous medical records shall be made available for use of the attending physician Member or anesthesiologist.
14. Free access to medical records of patients shall be afforded to Members and AHPs, involved in treatment decisions for the patient, who are in good standing. Upon written permission of the Chief Executive Officer, the Chief of Staff, and the MEC, and written consent of the patient, medical records may be used for study and research, consistent with preserving the confidentiality of personal information concerning individual patients.
15. All persons are restricted from using abbreviations which appear on the "Do Not Use Abbreviations List".
16. Correction of errors in the course of documentation within the medical record shall be done in the proper manner. The method utilized shall include:
    a. Single line through the error to be corrected;
    b. Initials of person correcting; and
    c. Printed name at bottom of medical record page representing identity of initials
17. The release of medical information shall be by written consent of the patient or legally authorized person acting on behalf of the patient, except as otherwise required or permitted by law. The release shall become a part of the medical record.
18. Standing orders may be used. Standing orders must be approved by the MEC and reviewed annually.

# SECTION 12: LABORATORY & PATHOLOGY SERVICES

1. The Hospital shall provide laboratory services under the direction of a qualified medical director approved by the MEC. The Hospital will maintain the laboratory or will maintain a contractual relationship with a CLIA-certified laboratory for pathology services, and provide stat and routine laboratory testing either directly or under contractual arrangement.
2. The laboratory medical director will review and approve policy and procedures, assure the competency of the staff, review performance improvement initiatives and provide medical staff liaison or problem resolution and review of medical care.
3. The MEC approves the Laboratory Policy and Procedures Manual.
4. All tissue removed which is not exempted per policy will be sent to the laboratory for examination per established policy and procedure. A report will be completed, returned to the Hospital and entered as part of the permanent record.
5. All pre-operative laboratory tests associated with the intended procedure ordered by the surgeon, anesthesiologist, or attending physician Member will be obtained and entered into the medical records.
6. Blood or blood products will be ordered and administered according to established policy and procedures.

7. All personnel will follow established policy and procedure for the ordering, labeling, drawing, and transport of laboratory specimens for testing ordered by a Member or AHP.
8. All tissue specimens and appliances removed during surgical procedures must be submitted for pathology examination unless specifically exempted. The following tissues/specimens may be exempted from pathology examination when specifically authorized by the surgeon and documentation of such is made in the medical record. Such tissues/specimens generally do not lend to the diagnosis of the patient and include:

   Scars
   Lens of the Eye
   Menisci
   Foreskin
   Cartilage
   Skin Tags
   Plica
   Bursa
   Labrum
   Nails
   Intact Hardware|
   Prosthetics
   Liposuction  Fat
   Excess Skin
   Bone Fragments
9. When requested by the attending physician Member, some specimens may be returned to the attending physician Member or patient. Examples of such items often returned to the patient are teeth and intact orthopedic appliances and hardware, which are not broken or damaged.

# SECTION 13: PHARMACY SERVICES

1. The Hospital operates a pharmacy for the purposes of providing pharmaceuticals for patients receiving care in the Hospital.
2. Policies and procedures have been developed to manage the operation of the pharmacy and to meet the Hospital's responsibility for safeguarding the use of drugs in the Hospital. The complete Pharmacy Policy and Procedure Manual can be obtained from the CEO or pharmacist-in-charge.
3. The MEC approves Pharmacy Policies and Procedures.
4. A registered pharmacist will be responsible for the supervision of the pharmacy, twenty-four (24) hour call, and monitoring of compliance with all applicable laws and regulations outlined by the State Board of Pharmacy and will be designated pharmacist-in-charge.
5. Pharmacy Policies and Procedures that apply to the Medical Staff include:
   a. Authority to order medications is restricted to Members and AHPs who are licensed in the State and authorized to prescribe medications. All orders must be signed.
   b. Prescription of controlled or scheduled medications is restricted to Members or AHPs who are properly certified and registered by the Drug Enforcement Agency. The Member or AHP may prescribe only those schedules of drugs for which he/she is authorized.

c. Documentation of medication use must meet legal requirements. The Member or AHP must complete and sign all necessary records to comply with proper inventory control and accountability of controlled drugs.

d. Members and AHPs are prohibited from using any medications not approved by the U.S. Food and Drug Administration ("FDA").

e. Use of medications in a manner not approved by the FDA, i.e., off-label use, must be reviewed and approved by the MEC.

f. All Members and AHPs must make reports of adverse drug reactions.

6. The MEC will review and approve the Hospital formulary and develop criteria for the selection of medications to the formulary.

# SECTION 14: RADIOLOGY SERVICES

1. Members and AHPs educated and certified in the provision of radiology services may provide radiology services at the Hospital if so credentialed.
2. The MEC approves Radiology Services Policies and Procedures.
3. Radiation safety of personnel, patients, and visitors will be established, maintained and reviewed.
4. A Board Certified radiologist will have overall supervision of the radiology service and shall be contracted to provide x-ray interpretation and medical direction for the department.

# SECTION 15: RESPIRATORY THERAPY

1. The Hospital shall provide organized respiratory therapy services. The services will be under the direction of a qualified medical director approved by the MEC.
2. The medical director and will review and approve policy and procedures, assure the competency of the staff, review performance improvement initiative, and provide medical staff liaison or problem resolution and review of medical care.
3. The MEC approves Respiratory Therapy Services Policies and Procedures.

# SECTION 16: PHYSICAL THERAPY

1. The Hospital shall provide physical therapy services. The services are provided to patients upon appropriate physician order.
2. The MEC will review and approve policies and procedures, review performance improvement initiative and provide Medical Staff liaison or problem resolution, and review of medical care.
3. The MEC approves Physical Therapy Services Policies and Procedures.

# SECTION 17: APPROVED ABBREVIATIONS

1. All persons who make entry into the medical record are restricted from using abbreviations which appear on the "do not use" abbreviation list.

# SECTION 18: HOSPITAL TRANSFER

1. The Hospital will maintain transfer agreements with local hospital(s) to facilitate emergency transfer of a

patient and acute hospital admission for continued care when services are not available at the Hospital.

2. The Medical Staff will follow established policy and procedure for emergency transfer and transfer for acute hospital admission.
3. The Hospital will utilize the appropriate transport and/or emergency ambulance services during a emergency transfer. EMS services will not be used as a substitute to respond to emergencies which occur on the property or present to the Hospital.
4. The Hospital will maintain under contract an ambulance/transportation service for transfer for acute Hospital admission for continued care and non-emergency transfer.
5. The Hospital will comply with COBRA regulations, EMTALA rules, and any State, local, or federal regulation in the transfer of all patients for emergency and acute Hospital admission.
6. When the patient is transferred to another hospital, a copy of the medical record and descriptive narrative of the events leading to the need for hospitalization must accompany the patient to the other hospital. In the event of a declared emergency or ambulance transfer for continued care, a memorandum of transfer will also accompany the patient. The attending physician Member must sign the memorandum of transfer and is responsible for arranging the transfer, to include finding an accepting physician for transfer of care and writing orders inclusive of equipment, transportation and personnel required for the safe transfer of the patient..

# SECTION 19: INSTITUTIONAL REVIEW COMMITTEE

1. The MEC will review, approve, and provide oversight of research, use of investigational drugs, clinical investigation, or institutional review activities either provided directly or under agreement with an authorized Institutional Review Board for the purpose to assure compliance with FDA requirements, adherence to medical ethics, to assure the rights of patients while involved in research protocol, and assure safe medical practice during research and integrity of investigative methods.
2. The MEC will consider and approve each investigator based on the documentation provided to the committee supporting the investigator's competency to provide services within the scope of the study/ proposed research and experience/ability to conduct research and serve as an authorized investigator.
3. The MEC supports the rights of patients or participants in studies to withdraw from a study at any time. The delivery or withholding of care at the Hospital is not dependent on participation in a study or conditional on funding provided as a part of a study.

# SECTION 20: INFECTION CONTROL

1. The Hospital will maintain a system for education, surveillance, and prevention of infections, including nosocomial infections.
2. An established infection control plan will be maintained and polices and procedures established to support implementation. The plan, policies and procedures will be approved by the MEC and reviewed annually.
3. Infection control reports will be included as part of the performance improvement program and reported to the MEC.

# SECTION 21: UTILIZATION MANAGEMENT

1. The Medical Staff will participate with the Hospital to maintain a system for utilization management to ensure the appropriateness and medical necessity for patient care.
2. The Medical Staff will participate with the Hospital to have a written utilization management plan designed to ensure that quality patient care is provided in the most appropriate manner. This plan will be approved by the MEC and reviewed annually.
3. Utilization management reports will be incorporated into the performance improvement reports and will be reported to the performance improvement committee and MEC.

# SECTION 22: RESIDENT, MEDICAL STUDENTS, FELLOWS AND NON-LICENSED SURGICAL ASSISTANTS GUIDELINES

1. REQUIREMENTS FOR ROTATION OF MEDICAL STUDENTS
    a. Medical students may observe and assist at the discretion of the surgeon while surgeon is in attendance.
    b. The surgeon takes full responsibility for the medical student.
    c. The Hospital must have a fully executed affiliation agreement with the sponsoring school for medical students and the contract must define their role and limitations when on clinical rotation at the Hospital.
    d. The school must provide proof of professional liability coverage.
2. REQUIREMENTS FOR ROTATION OF RESIDENTS
    a. Program Director
        i. Each academic year a letter from the program director requesting specific residents to be allowed to assist and perform surgery under the direct supervision of specified Members will be provided to the MEC.
        ii. Documentation that activities of the residents are covered by program's professional liability insurance must be provided.
        iii. Copy of the Medical License of each resident must be entered into an established Medical Staff file.
        iv. An affiliation agreement must be on file in the contracts book, with written description of the roles, responsibilities, and patient care provided to the Medical Staff and Hospital staff within the agreement. Specific privileges will be requested by the resident and reviewed and acted upon by the MEC.
    b. Supervising Member
        i. Must co-sign, date and time all resident orders and notes.
        ii. Will maintain a method to communicate issues of quality to the graduate medical education committee of the resident program.
        iii. Will assure compliance with residency review committee citations from the sponsoring residency

program.

c. Resident
    i. Must act within the supervised medical confines of the supervising Member.
    ii. May write orders and progress notes but must have them co-signed, dated and timed by the supervising Member within twenty-four (24) hours.
    iii. May dictate the history, physical or operative note but must identify that such is on behalf of the supervising Member.

d. Hospital
    i. Establish and maintain a fellow file with privilege list on each fellow. For residents there privileges are based off the assigned precepting provider.

3. REQUIREMENTS FOR FELLOWS
    a. Must apply for Staff privileges at the Hospital as defined in the Bylaws;
    b. Must be currently specialty board eligible or certified or completed approved residency; and
    c. Requested privileges must be approved by the MEC.
4. REQUIREMENTS FOR NON-LICENSED SURGICAL ASSISTANTS
    a. A Non-Licensed Physician Surgical Assistant is a highly skilled individual, providing quality perioperative care to patients, who has received specialty training in surgical assisting from any of the following:
        i. Formal surgical assisting from universities, hospitals, private schools, allied health organizations;
        ii. Military training in specialty programs, operation rooms and in the field;
        iii. Foreign medical school graduates participating in additional training seminars or working in the United States;
        iv. Hospital operating room staff members training by surgeons in the operating room
    b. Assists in performance of any surgical procedures, working under the surgeon's direction
    c. Physicians and students in training and physicians non-licensed in Arizona who do not meet the above criteria may assist under the direction of the primary physician
    d. Qualifications:
        i. A non-licensed physician in the state of Arizona who has proof of medical training and is sponsored by an attending surgeon.
        ii. A Registered Nurse or Physician Assistant licensed by the state of Arizona and sponsored by an attending physician.
        iii. A surgical technician who has proof of education and is sponsored by an attending physician.
    e. REQUIRED DOCUMENTATION FOR NON-LICENSED SURGICAL ASSISTANTS:
        i. A copy of Passport or Government Issued ID or Driver's License
        ii. A copy of Valid Medical License
        iii. Documentation of course certifications / training
        iv. Malpractice coverage letter or certificate

v. A copy of Immunization Records (TB)

vi. Authorization and Consent for Release of Professional Information (Signed)

vii. Practitioner Disclosure & Authorization Form for Basic Background Check (Signed)

f. TIME FRAME FOR NON-LICENSED SURGICAL ASSISTANTS
Appointment not to exceed 120 days without additional approval from Chief of Medical Staff. CEO or Appointed Designee

g. Supervision shall be continuous, and shall require that the delegating physician be physically present and immediately available in the operating room to personally respond to any emergency until the patient is released from the operating room and care has been transferred to another physician. Telecommunication is insufficient for supervision purposes.

# SECTION 23: ADOPTION AND AMENDMENT

1. Upon the request of (a) a Member of the MEC, (b) the Chief of Staff, or (c) upon written petition signed by at least thirty-three percent (33%) of the Members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Rules and Regulations. Such action shall be taken at a regular meeting of the MEC.
2. Rules and Regulation changes adopted by the MEC shall become effective following approval by the Governing Board, which approval shall not be withheld unreasonably or automatically within ninety (90) days if the Governing Board takes no action. If approval is withheld, the reasons for doing so shall be specified by the Governing Board in writing and shall be forwarded to the Chief of Staff and the MEC.
3. Medical Staff Members shall be provided with copies of the revisions in the Rules and Regulations and related Medical Staff policies.
4. These Rules and Regulations when adopted by the MEC shall replace any previous Rules and Regulations and shall become effective when approved by the Governing Board of the Hospital.

# SECTION 24: PERFORMANCE IMPROVEMENT

## Summary

The Governing Board and Medical Staff of the Arizona Spine and Joint Hospital are committed to providing and maintaining the highest standard of patient care. Essential to this commitment is an ongoing mechanism to detect, review and correct any variances from the highest standards of patient care. This process is Performance Improvement, and this document outlines the organization of Performance Improvement at Arizona Spine and Joint Hospital.

## Authority

The Governing Board of the Arizona Spine and Joint Hospital and the Medical Staff Bylaws require that the Medical Executive Committee and the Medical Staff establish mechanisms designed to assure the achievement and maintenance of high standards of medical practice and patient care. The Performance Improvement activities are reported to and monitored by Medical Executive Committee at each meeting.

## Performance Improvement Committee

The Performance Improvement Committee, with members appointed in accordance with section 12.5-1 of the

MSB, is authorized to develop a Performance Improvement Plan and coordinate all quality monitoring functions of the Medical Staff including, but not limited to: Surgical Case Review, Medical records, and Infection Surveillance and Control, patient satisfaction, autopsy criteria, blood and blood components, operative and other procedures, use of information about adverse privileging decisions, appropriateness of clinical practice patterns, medical assessment and treatment of patients, patient safety, sentinel event data. In the absence of a committee the Medical Executive Committee will serve as the Performance Improvement Committee until one is appointed. The Chief Nursing Officer will be responsible to coordinate all hospital performance improvement initiatives.

# Appointment

The following persons are Ex-Officio members of the Performance Improvement Committee:

1. Medical Director
2. Chief Executive Officer and/or Administrator
3. Chief Nursing Officer
4. Inpatient Manager
5. CFO
6. Surgical Services Manager
7. Pharmacist-in-charge
8. Infection Control Practitioner
9. Selected staff members

Other members may be appointed at any time to permit consultation as needed.

# Meetings

The Performance Improvement Committee will meet as often as needed, but not less than quarterly.

# Reporting

The Performance Improvement Committee functions to support the Medical Executive Committee's quality assurance and peer review functions. As such, all Performance Improvement Committee activities are reported to the Medical Executive Committee at each regular meeting.
In turn, the Medical Executive makes a report of all Performance Improvement activities including the activities of the Performance Improvement Committee at each regular meeting of the Governing Board.

# The Improvement Program

A. A**ppointment and Reappointment**

As detailed in the Medical Staff Bylaws and Rules and Regulations, the Medical Executive Committee is responsible for reviewing the credentials of every member of the Medical Staff. All information available, including information collected from the Performance Improvement functions shall be used by the Medical Executive Committee to make recommendations to the Governing Board for the granting of privileges, appointment and reappointment to the Medical Staff.

B. **Monitoring**

The Performance Improvement Committee and the Medical Executive Committee will review and approve the Performance Improvement Plan and Calendar and monitor the results on a regular basis.

# SECTION 25: CONFLICT OF INTEREST

1. Arizona Spine & Joint Hospital is committed to ensuring its Medical Staff functions in an environment that supports ethical standards and quality care. A conflict of interest can occur when a Licensed Independent Practitioner has an interest that might compromise his or her decision-making objectivity. Licensed Independent Practitioners of the Medical Staff have an obligation to address both the substance and the appearance of conflict of interest that affect or has the potential to affect the safety or quality of care, treatment and services provided to the patient, and to disclose outside activities or affiliations that might lead to a conflict of interest or commitment. Each medical staff member has a duty to place the interests of the patient foremost and has a continuing responsibility to comply with the requirements of this policy.
2. It is the policy of Arizona Spine and Joint Hospital, that:
    - Medical Staff members have an obligation to avoid unacceptable ethical, legal, financial or other conflicts of interest and to ensure that their activities and interests do not conflict with their obligations to the safety, quality of care, treatment and services of patients within the hospital.
    - any member engaging in an outside activity or possessing a personal interest that could lead to a conflict of interest must inform the Chief of Staff;
3. The disclosure by a member or the determination by the Chief of Staff of a conflict of interest or potential conflict of interest will require that the Chief of Staff investigate the conflict, following the process outlined in the medical staff bylaws, Articles VIII and IX.

## Attachments:

No Attachments

## Approval Signatures

| Approver | Date |
|---|---|
| Deborah Parke: Exec Admin Coordinator - E | 11/2018 |
| Elizabeth Kearney: CNO | 11/2018 |
| Angela Ervin: Quality/Risk Manager - E | 09/2018 |