

PHOENIX CHILDREN'S HOSPITAL
Medical Staff Rules and Regulations
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PHOENIX CHILDREN'S HOSPITAL
Medical Staff Rules and Regulations

1. ADMISSIONS POLICIES

- a) The authority for admission of patients to the Hospital has been vested in the Chief Executive Officer by the Board of Directors. Requests for admission are made by the physician staff member, but the final approval rests with the Chief Executive Officer or designee. The Hospital shall admit patients, provided that facilities are available for care of the patient and protection of Hospital personnel. Only physicians who are members of the Honorary, Active, Associate, Courtesy, or Senior Medical Staff shall have privileges to admit patients to the hospital.
- b) Management of a patient's general medical condition is the responsibility of a qualified physician member of the medical staff, who has been granted the appropriate clinical privileges. Medical Staff members are responsible for seeing their patients within a reasonable period of time following admission, and in no case later than 24 hours after admission.
- c) Except in an emergency, informed consent is obtained from the patient's representative before or at the time of admission, and is documented in the patient's medical record.
- d) In the management of any admission, it is the attending physician's responsibility to utilize medical resources efficiently, and to initiate timely discharge planning.
- e) Members of the Medical Staff shall participate in the process of educating patients and families, and in the coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient.
- f) Members of the Medical Staff are responsible for ensuring that the same standard of care exists for all patients in the hospital.
- g) Private patients shall be attended by their own physicians. Private patients applying for admission who have no attending physician shall be assigned to members of the Medical Staff on duty in the general pediatric service.
- h) Whenever responsibility for care is transferred to another staff member, a statement covering the transfer of responsibility shall be entered on the physician order page of the medical record.
- i) Medically indigent and charity patients shall be attended by members of the Medical Staff and shall be assigned to the appropriate Department.

- j) Except in an emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been recorded. In case of emergency, the provisional diagnosis shall be recorded as soon after admission as possible. (For the purpose of these Rules and Regulations, the term "emergency" may be applied to any patient whose condition is such that any delay caused by compliance with these Rules and Regulations might affect the physical welfare of the patient.) Physicians admitting private patients are responsible for providing information necessary to protect other patients and Hospital personnel from potential risk.
- k) Physicians admitting emergency cases shall be prepared to justify to the Medical Executive Committee and the Chief Executive Officer that the admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.
- l) Each staff member shall name a member of the staff who is to be called to attend his patient in an emergency. In case of failure to name such an associate, or if neither the attending practitioner nor the named associate, nor the chairman of the respective division can be located, the Chief Executive Officer shall have the authority to call any member of the staff to render interim treatment, should this be considered necessary.
- m) All physicians on the Medical Staff of the Hospital specifically agree to relinquish direction of providing care of their patients, private or charity, to the Chairmen of the Medical, Surgical and Anesthesia Departments in the event of a natural or other disaster resulting in mass casualties.
- n) The admitting office will admit patients based on the following order of priorities:
 - i) Emergency Admissions: Those patients who are designated by the attending physician as patients who need immediate hospital care and whose condition would suffer if admission is delayed. Willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee for appropriate action.
 - ii) Reservation Admissions: Those patients already scheduled for surgery as well as other patients who have previously made reservations in advance of being admitted on a particular day.
 - iii) Urgent Admissions: Those patients who warrant hospitalization within 24 to 48 hours and whose conditions would suffer if admissions were delayed beyond that period of time.
 - iv) Routine Admissions: Those patients who are elective admissions.

- o) Re-Admissions
 - i) If a patient is re-admitted within thirty (30) days for the same condition, the previous History and Physical Examination, with an Interval Note by the physician will suffice.
 - ii) The Interval Note shall contain:
 - a) Present complaint;
 - b) Pertinent changes in general condition of the patient; and
 - c) Any changes in physical condition.
 - iii) Pertinent previous health records shall be ordered when appropriate.

2. ORDERS

- a) All orders, including verbal orders, must be dated, timed and authenticated promptly by the ordering practitioner. Written orders are to be dated and timed for when the order is being written. Verbal and telephone orders must be dated and timed for the time the practitioner is authenticating the order.

- b) Routine Orders

Routine laboratory procedures performed on admission of a patient shall be determined by the Medical Executive Committee. A professional interpretation is to be included automatically with orders for the following studies: (87207) Smear, any source with interpretation, special stains for inclusion bodies or intracellular parasites; (89060) Crystal Identification, by light microscopy with or without polarizing lens analysis, any body fluid. A urine HCG pregnancy test will be performed on all post-menarchal females who are scheduled for any procedure requiring the administration of general anesthesia.

Routine orders may be formulated by joint action of the voting membership for the Medical Staff and the Chief Executive Officer and may be changed only in the same manner. These routine orders shall be followed insofar as proper treatment of the patient will allow and shall constitute the orders for treatment until specific orders are written and signed by the attending physician.

- c) Pre-Printed and Faxed Orders

Preprinted orders may be used by the medical staff after review and approval of the Pharmacy & Therapeutics (P&T) Committee (applies to orders with medications only) and Medical Records Committee. These orders will be individualized for each patient by the ordering physician by drawing a line through the unwanted items and adding any additional orders as indicated. The physician must sign and date these orders.

If faxed orders are transmitted to PCH by the attending physician, his/her orders will be transmitted on the attending physician's letterhead or on the PCH physician order sheet. The order will be dated, signed and placed in the patient's medical record.

- d) Verbal and Telephone Orders
Verbal orders shall not be accepted except in emergency situations.

Telephone orders are only acceptable if the physician or practitioner giving the order is not immediately available, e.g., in surgery.

Only physicians and nurse practitioners or physician assistants, credentialed by the hospital, are permitted to give telephone orders for inpatient services. Verbal or telephone orders are not acceptable for designating patient status as DNR (Do Not Resuscitate).

When telephone orders or emergency verbal orders must be used, the receiver of the order will enter the order electronically into SCM or enter the order on the physician order sheet, sign, date, and time the order. The receiver will “read back” the complete order (includes ALL orders, not just medication orders) to the physician or practitioner and receive verbal confirmation of the correct order. In emergency situations, if it is not feasible to formally “read-back” the order, “repeat-back” is acceptable. In addition, physicians and practitioners should “read back” critical lab values or test results communicated verbally by staff.

Telephone orders and emergency verbal orders shall be legibly and promptly authenticated by the responsible physician or designated covering physician. Authentication must be dated and timed, and may include signature, written initials, or computer entry. Authentication should be completed as soon as possible, but always within forty-eight (48) hours of the order. Telephone orders and emergency verbal orders must be taken by personnel most qualified, by scope of practice, to accept them. Imaging technologists, licensed respiratory care practitioners and registered pharmacists may accept telephone orders provided the orders are directly related to their specialized discipline. Registered pharmacists are permitted to give telephone orders under physician ordered pharmacotherapy consultation. RNs or LPNs are permitted to accept telephone orders on nursing units.

3. PATIENT TRANSFERS

- a) Emergency room to appropriate patient bed.
- b) From intensive care unit to general care unit.
- c) From temporary placement in an inappropriate geographic or clinical service area to appropriate geographic or clinical service area for the patient.

No patient will be transferred without such transfer being approved by the responsible practitioner. All orders shall be rewritten when a patient is transferred from one level of patient care to another. All previous orders are canceled when patients go to surgery.

The process for assignment and notification of Attending Physician after PCCU Admission or Transfer to Floor is that the intensivist shall personally contact the attending floor physician who is accepting the patient. Documentation of this event must be recorded in the medical record and on the order sheet, and must be communicated to the business associate, who will make necessary changes in the patient information system.

4. VISITS BY ATTENDING PHYSICIANS

a) Initial Hospital Visit

The initial visit and attending physician's admission note should be performed in a timely fashion. If the patient's condition deteriorates, or if the nursing staff feels it is necessary to ask for physician help and the attending physician does not respond in a timely manner, the hospital reserves the right to have the patient evaluated by another physician on staff.

- i) The timeliness of the initial visit by the attending physician in the hospital should be commensurate with the severity and seriousness of the illness, as well as when the patient was last seen as an outpatient.
- ii) Intensive care patients should be seen sooner unless there is delegation of care to a consulting physician.
- iii) Only under very unusual circumstances should the initial visit by an attending physician occur after 24 hours of admission.

b) Follow-Up Visits

Daily visits by an attending physician are required. Progress notes shall be written by the attending physician for each visit. Discharge may be facilitated by a qualified physician or nurse practitioner designated by the Attending Physician to perform the discharge evaluation. A discharge order will be documented by the attending physician or his/her designee before discharge.

Nurse practitioner/physician assistant and/or resident physician daily visits and progress notes do not substitute for the attending physician visit except for the facilitation of the discharge process. An Attending Physician must see the patient on discharge except for stable post-op patients that meet discharge criteria.

In the Biobehavioral Unit, visits by the attending psychiatry physician will occur a minimum of five (5) times a week for patients designated as acute status. Progress notes shall be written by the attending physician for each visit.

c) PNT (Physician Non-Teaching) Service

The Physician Non-Teaching (PNT) Service offers in-hospital consultation to attending physicians on a 24-hour basis. A medical staff physician should recognize that since PCH is an academic institution, patients may be used as teaching patients in the residency program. As a requisite to receiving PNT coverage for patients, physicians must agree to permit patients to be assigned, in most cases, to the resident teaching service. Physicians who uniformly do not allow assignment to the teaching service will not be afforded PNT coverage, except in emergency situations.

5. CONSULTATIONS

Except in an emergency, consultations with another qualified physician should be obtained for cases on all services in which, according to the judgment of the physician: 1) the patient

is not a good medical or surgical risk, 2) the diagnosis is obscure, and/or 3) there is uncertainty as to the best therapeutic measures to be utilized. All consultations shall be requested by specifying the individual physician or physician group name. The attending physician is responsible for requesting the consultation in writing.

A satisfactory consultation includes examination of the patient as well as the health record. When operative procedures are involved, the pre-operative assessment shall be recorded prior to the operation (except in an emergency).

Each Clinical Department of the Medical Staff may develop its own consultation requirements with approval of the Medical Executive Committee.

A written opinion signed by the consultant must be included in the medical record. A 24 hour response time is expected; however, physician to physician communication is essential in order to individualize the response time according to the patient's needs. It is the duty of the Medical Staff through its Departmental Chairmen and Executive Committee to make certain that members of the staff do not fail in the matter of calling consultants as needed. In the absence of action by the Medical Staff, the Chief Executive Officer shall undertake such responsibility.

A psychologist may write orders in the medical record for psychiatric consultations, social worker consultations, child life consultations, and sitters.

6. MEDICAL MANAGEMENT OF PEDIATRIC CRITICAL CARE PATIENTS

All patients who require pediatric critical care services at PCH shall have a mandatory consult by a physician credentialed by the Section of Pediatric Critical Care. At the time these services are initially provided, the attending physician may indicate whether the pediatric intensivist is to:

- Assume primary management of the patient or
- Co-manage the patient along with the primary attending physician and other consultants

In the event that the role of the intensivist is not specified, it will be assumed that the primary attending physician desires the pediatric intensivist to co-manage the patient.

In special circumstances, following initial consultation, the pediatric intensivist may elect to have the management of the patient continue under the direction of the child's primary attending physician. In those cases, the Pediatric Intensivist shall continue to be readily available to assist with management issues when requested by the primary attending physician.

The pediatric intensivist shall have the authority to assume management of any child within the Hospital who is in immediate and impending danger. Every effort will be made to contact and update the child's primary attending physician as rapidly as possible once the child's clinical status allows.

7. CONSULTATIONS IN THE INTENSIVE CARE NURSERIES

Consultation of appropriate Intensive Care Physicians is required for all seriously ill patients in the Intensive Care Nursery. This includes medical as well as surgical patients. In order to clarify this policy, the following is a suggested list of conditions for which consultation by a neonatologist or appropriate pediatric subspecialist seems appropriate:

- Shock/Septic Shock
- Complicated Meningitis/Sepsis
- Ventilated Patients, Impending Respiratory Failure
- Impending or Overt Organ System Failure (consultation is required for ventilated CPAP patients)

It is the responsibility of the patient's attending physician to order such consultation. Hospital policy **STRONGLY** suggests personal communication by the referring physician with the consulting physician to outline the reasons for the consult.

Noting that consultation of appropriate intensive care physician is required, the performance of these procedures within the Intensive Care Nursery shall be under the supervision of the neonatologist or appropriate pediatric subspecialist:

- ECMO-HFJV
- Ventilator Management
- Management of Invasive Monitoring Lines (CVP, Arterial Lines, Swan Ganz Catheters, etc., excluding umbilical catheters)
- Administration of Vasoactive Drugs

At certain other times automatic consultation of the neonatologist or appropriate subspecialist may be necessary. The neonatologist shall have the authority to assume temporary management of any patient within the Hospital in immediate and impending danger. Every effort must be made to simultaneously contact the attending physician as rapidly as possible. It will still be the responsibility of the attending physician to give the official order even if after the fact.

It is to be understood by the attending physicians that the neonatologist is NOT consulted automatically except as above. An actual **ORDER** should be given in order to officially consult the neonatologist in difficult cases especially when the diagnosis remains obscure or as outlined above.

- a) In the absence of a consultation of a neonatologist, supervision of House Staff and NNPs shall be the responsibility of the attending physician.
- b) If after discussion with the attending physician there is still a discrepancy and the neonatologist feels his consultation may be in the best interest of the patient, then he may request a review of the case by the Chairman of the appropriate Department.

8. HEALTH RECORDS

- a) Hybrid Health Record
The health record comprises individually identifiable data, in any medium, that are collected, processed, stored, displayed, and used by healthcare professionals. The information in the health record is collected and/or directly used to document healthcare delivery or healthcare status. A hybrid record is a system with functional components that: 1) include both paper and electronic documents 2) use both manual and electronic processes. Other health information is maintained on various other media types such as film, video, or an imaging system.
- b) Release of Information
Please see the Hospital Policy and Procedure, “PCH Patient Request for Records”. Health records are the property of the Hospital and shall not be removed except by court order, statute or subpoena.
- c) Unit Record
To assure information about a patient is available to the professional staff rendering patient care, a unit record system is used. All components of the inpatient and ambulatory medical record can be located using an automated chart tracking system. The health records of patients treated in the ambulatory clinics are not incorporated into the inpatient unit record. Providers may request the inpatient and/or ambulatory clinic records at the point of patient care in the hospital or ambulatory clinics.
- d) Content of Health Record
All significant clinical information is incorporated into the patient’s health record in order to provide sufficient information to identify the patient, support the diagnosis, justify the treatment and document the results. The health record is sufficiently detailed and organized to enable:
- i) The responsible practitioner and the health care team to provide continuing care, determine later what the patient’s condition was at a specified time, and review diagnostic/therapeutic procedures performed and the patient’s response to treatment.
 - ii) A consultant to render an opinion after an examination of the patient and review of the health record.
 - iii) Another practitioner to assume care of the patient at any time.
 - iv) Retrieval of pertinent information required for utilization review and/or continuous quality improvement activities.

Although the format and forms used to document in the health record may vary, all health records contain at least the following:

- Patient identification
- Medical history
- Physical examination
- Diagnostic and therapeutic orders
- Evidence of informed consent (documentation of the reason when consent is not obtainable)

- Clinical observations
- Procedures, reports and test results
- Conclusions at the end of hospitalization, evaluation or treatment
- Final Diagnosis
- Health Care Directives as indicated
- Conditions of Admission
- Discharge Instructions
- Autopsy results, if performed

e) Documentation In The Health Record

i) Abbreviations

The use of abbreviations is discouraged, but may be necessary due to time or writing/printing space constraints. Abbreviations on the Unapproved Abbreviations and Symbols List (available at each nursing station and in Health Information Management) are not allowed for use in medical record documentation due to their increased potential for medication errors. Abbreviations shall not be used in final diagnoses, in summaries and typewritten reports, on consent forms, or for medication names.

ii) Absence from the Hospital (Physician)

When a physician will be away from the hospital for any length of time and completion of records will be delayed, (vacation, out of town, seminars, etc.) it is the physician's responsibility to assure that charts are completed prior to departure and to notify Health Information Management with the dates of departure and approximate date of return. The physician shall have 72 hours upon their return to complete records to avoid suspension status. Physicians who plan to resign or take a leave of absence from the medical staff must notify Health Information Management and make arrangements to complete his/her delinquent records within thirty (30) days.

iii) Anesthesia Evaluation

Except in an emergency, a pre-anesthesia evaluation, performed within 48 hours before anesthesia is administered, shall be documented on the Anesthesia Record, and includes:

1. Pre-anesthesia documentation of the evaluation of the patient;
2. Information relative to the choice of anesthesia;
3. Surgical procedure anticipated;
4. Indication of use of general, spinal or regional anesthesia;
5. Previous drug history; and
6. Review of patient's condition immediately prior to induction

Anesthesia administration is documented in a patient's medical record and includes an intra-operative anesthesia record and the post-operative status of the patient upon leaving the operating room. The post-anesthesia evaluation is completed in the post anesthesia care unit by PACU staff. This

documentation includes the patient's level of consciousness upon entering and leaving the area, vital signs, status of infusions, drains, tubes, catheters and surgical dressings (when used), and unusual events or post-operative complications and management. Inpatients must have a postanesthesia evaluation completed and documented by an anesthesiologist within forty-eight (48) hours after surgery.

iv) Autopsy findings must be documented in the medical record (refer to section on Autopsy).

v) Authentication of Entries

All entries in health records must be legible, complete, dated and timed and authenticated in written or electronic form and a method is established to identify the authors of entries. Records are to be authenticated by the person responsible for providing or evaluating the service in accordance with hospital policy and procedure. The Medical Staff is responsible for ensuring accurate, timely, and legible completion of patients' medical records. To correct an error in the health record, the practitioner must line through the incorrect information, write "error," his/her name and date. Write in the correct information. The incorrect information should not be obliterated or removed. Late entries must be clearly timed, dated, signed and labeled as a late entry.

f) History and Physical

A complete history and physical examination in all cases shall be recorded within 24 hours of admission. A patient admitted for inpatient care has a medical history taken and an appropriate physical examination performed by a qualified member of the Medical Staff. Licensed nurse practitioners may perform all or part of the medical history and physical examination, if granted such privileges. A signed, handwritten note, placed in the medical record within 24 hours of admission is acceptable. The note must contain pertinent findings or sufficient information to manage the patient and guide the plan of care.

The H&P must be a durable and legible copy. The H&P may be conducted up to thirty (30) days prior to admission but in all cases within twenty-four (24) hours of admission by the responsible physician, or another practitioner who has the privilege to perform an H&P in accordance with State law and Medical Staff Bylaws. When the medical history and examination are completed within thirty (30) days before admission, there must be an interval note. The interval note can be documented on the H&P or in the admission note, upon the patient's admission; which includes documentation that an examination was performed for any changes in the patient's condition from when the H&P was performed and confirming that the necessity for the procedure or care is still present. This updated exam must be in the patient's medical record within 24 hours after admission.

Inpatients

A complete history and physical examination shall in all cases be recorded within 24 hours after admission of the patient. This includes all patients converted to an inpatient status from 24 hours observation or any other outpatient status. A complete H&P shall include the following components:

- Chief complaint
- History of present illness or condition
- Relevant past medical, emotional, social and family history
- Inventory of body systems
- Evaluation of patient's developmental age
- Comprehensive physical exam and diagnosis or problem list
- Consideration of educational needs and daily activities, as appropriate
- Parents report or other documentation of the patient's immunization status
- Family's and/or guardian's expectation for, and involvement in, the assessment, treatment, and continuous care of the patient
- Conclusions or impressions drawn from the admission history & physical
- Plan of action – course of action planned for the patient while in the hospital

Outpatients (excludes *recurring ambulatory patients)

For patients having outpatient operative/invasive procedures done, the following components of an H&P shall be performed:

- Relevant medical and surgical history
- Focused H&P specific to the body part/system upon which the procedure is being performed
- Assessment of the heart & lungs
- Mental status
- Any system with which the patient has significant problems

Noninvasive Procedures With Sedation or Anesthesia

In all noninvasive procedure cases with sedation or anesthesia, a focused history/physical examination relevant to the specific to the body part/system for which the patient is seeking treatment/procedure is being performed must be on the record prior to procedure. Prior to procedure is defined as "prior to commencement of the procedure and before induction of sedation or anesthesia." An office history and physical performed within (30) days prior to admission is acceptable. An interval note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded.

Surgical Patients

In all surgical cases and other invasive procedures that place the patient at risk, a history/physical examination or a concise note indicating the nature of the patient's illnesses must be on the record prior to surgery. Prior to surgery is defined as "when the patient enters the operating suite. An office history and physical performed within thirty (30) days prior to admission is acceptable. An interval admission note

that includes documentation that an examination was performed for any changes in the patient's condition from when the H&P was performed and confirming that the necessity for the procedure or care is recorded.

***Recurring Ambulatory Patients**

(Includes patients having same/repeated invasive procedures):

- A complete history and physical done within 30 days prior to the first visit shall be on the chart prior to the treatment/procedure
- Repeat treatment/procedures within 30 days of the full history and physical being performed are required to have only an interval physical examination report reflecting any subsequent changes, provided the original history and physical is readily available in the medical record
- The interval exam shall include the following:
 - Focal examination of area/system being treated or upon which procedure is being done
 - Documentation of relevant medical/surgical history since last treatment/procedure
- A new complete history and physical must be performed at least every 30 days.

An oral surgeon who admits a patient without medical conditions may complete an admission history and physical examination, if he/she has such privileges, in order to assess the medical, surgical, and anesthetic risks of the procedure to the patient. Patients with medical conditions admitted to the Hospital by an oral surgeon and patients admitted for dental care by individuals, who are not qualified oral surgeons, shall receive the same basic medical appraisal as patients admitted for other services. This includes having a physician who either is a member of the medical staff, or is approved by the medical staff to perform an admission history/physical examination and an evaluation of the overall medical risk, and record the findings in the health record.

Each dentist will be responsible for the part of the history/physical that is related to dentistry. A physician member of the medical staff will be responsible for the care of any medical conditions that may be present on admission or arise during hospitalization.

Patients with medical problems admitted to the biobehavioral unit shall receive the same basic medical appraisal as patients admitted for other services. This includes having a physician who either is a member of the medical staff or is approved by the medical staff to perform an admission pediatric history, physical examination and evaluation of overall medical risk and record the findings in the medical record. The psychologist shall be responsible for that part of the pediatric history related to psychology. A physician member of the medical staff shall be responsible for the care of any medical problems that may be present on admission or that may arise during hospitalization.

A physical exam must reflect a comprehensive physical assessment and be authenticated by the responsible practitioner. A statement of the conclusion or impression drawn from the history/physical and a course of action planned for the patient must be documented. The findings, conclusions, and assessment of risk are confirmed or endorsed by a qualified member of the medical staff prior to major high-risk (as defined by the medical staff) diagnostic or therapeutic interventions. Handwritten history and physicals are permissible and can be documented in the progress notes or on the History and Physical form. A postponement of the required history and physical or note on the chart at time of surgery can be made in the event of emergency surgeries or life-threatening situations; a note on the pre-operative diagnosis must be recorded before surgery.

g) Emergency Department Record

The Emergency Department record should be completed after the evaluation of the patient and include the following:

- i) Pertinent history of the illness/injury, physical findings, including the patient's vital signs;
- ii) Emergency care provided to the patient prior to arrival;
- iii) Diagnostic and therapeutic orders;
- iv) Clinical observations, including results of treatment;
- v) Reports of procedures, tests, and results;
- vi) Diagnostic impressions;
- vii) Conclusion at the termination of evaluation/treatment, including the final disposition, of the patient's condition on discharge or transfer.

The Emergency Department Record shall not be used in lieu of the history and physical examination when the patient is a direct hospital admission. Documentation in the Medical Record is required for patients treated in the Emergency Department for possible abuse or neglect and must include:

- Examinations;
- Treatment given;
- Any referrals made to other care providers and to community agencies; and any required reporting to the proper authorities.

Admission from the Emergency Department:

Attending physician's order for admission must be documented on the physician's order sheet. Admit to observation in the Emergency Department must be written on the physician order sheet.

Patients who leave against Medical Advice

All pertinent patient information (reference i-vii) should be included in the ED record as well as documentation of the circumstances related to the patient leaving prior to the completion of services/care.

h) Operative Reports

It is the responsibility of the operating surgeon to enter an operative progress note

in the medical record immediately after surgery to provide pertinent information to the next care provider. Written or dictated operative reports must be completed within twenty-four (24) hours. The report will contain names of primary surgeon and assistants, a description of the findings, technical procedures used, specimens removed, and postoperative diagnosis as well as estimated blood loss. Immediately after surgery is defined as "upon completion of surgery, before the patient is transferred to the next level of care." If the surgeon accompanies the patient from the operating room to the next unit or area of care, the operative note or progress note can be written in that unit or area of care.

i) Procedures and Tests Performed

Reports of all procedures and tests performed in diagnostic and therapeutic departments should be completed promptly and filed into the health record within 24 hours of completion. Clinical Laboratory results or status of pending reports shall be entered in the patient's record within 24 hours. Cumulative laboratory reports shall be placed in the record daily. EEG, EKG, and Other Special Procedure Reports shall be signed and dated by the responsible interpreter and shall be part of the health record. Radiology/ neurodiagnostic reports shall be the original radiologist's report, dated and signed electronically by the radiologist and filed in the health record.

j) Progress Notes

Pertinent progress notes shall be made by, but not limited to those persons who are authorized to do so by the Medical Staff, including: physicians, residents, fellows, dentists, nurse practitioners, physician assistants, dietitians, speech therapists, occupational therapists, physical therapists, clergy, affiliate staff, hospital-based social workers, and audiologists. Progress notes by a Medical Staff member should give a pertinent chronological report of the patient's course in the hospital.

Daily progress notes shall be written on all patient records, including patients admitted to Observation and Same Day Care, and sufficient in content to describe changes in the patient's course in the hospital. If there is a change in the patient's admission status, the reason for this change shall be documented in the progress notes or dictated into the medical record. Progress notes are updated to reflect the treatment plan, document the diagnosis(es) related to the treatment plan and document all procedures performed.

If a patient is transferred to a unit or service providing a different level of care, progress note shall be completed.

Medical Staff members who supervise residents or medical students shall write daily progress notes that document evidence of supervision. Such documentation may consist of a progress note written by the attending physician or a countersignature of the resident's progress note. Countersignature does not suffice for billing purposes.

k) Discharge Summary

A discharge summary (clinical summary) shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours. A final progress note is acceptable in lieu of a discharge summary in cases where the hospitalization was less than 48 hours providing the hospitalization was of a minor nature and non-complicated, which includes same day care and observation patients.

The Discharge/Transfer Summary must include: the reason for the hospitalization, significant findings, procedures or operations performed, treatment rendered, condition of the patient upon discharge and any specific instructions given to the patient and/or family (i.e. medications, activities, diet, etc.) for continuity of care. It is expected the discharge summary will be completed by the attending physician or designee as soon as possible; preferably on the day of discharge, not to exceed 15 days beyond discharge.

A detailed death summary shall be dictated, or written, for all inpatient deaths and should include: reason for admission, findings, course in the hospital and events leading to death.

l) Documentation by House Staff (Residents and Fellows)

When a teaching service is involved in patient care, sufficient evidence is documented in the progress notes of the health record to substantiate active participation and supervision of the patient's care by the attending physician. Regarding histories, physicals, and resident notes in the medical record, the teaching physician must personally document his/her participation in three (3) key components of the service by house staff, i.e. history, exam, and medical decision making.

House staff is responsible for completing the history and physical examination for the teaching service. House staff is responsible for operative reports of surgeries performed by teaching staff whom they have assisted. Attending/supervising medical staff members may change a statement made in the record by house staff and initial the change. An end-of-service note should be written by residents/fellows to document the transfer of care of a patient to another resident. The attending/supervising physician will receive notification of all incomplete and/or delinquent records assigned to house staff/residents/fellows he supervises.

m) Medical Students

Medical students are not licensed physicians and, therefore, all their work with patients must be approved and countersigned by a physician legally entitled to care for the patient. Medical students are permitted to write orders in the health record provided the orders are countersigned by a house staff or attending physician before they are transcribed.

n) Signatures

All clinical entries in the health record should be authenticated. Electronic signature authentication of dictated reports is acceptable when it conforms to medical staff rules and regulations, federal, state and accrediting agency requirements. All members of the medical staff participating in the electronic signature authentication must have an electronic statement of participation in the electronic signature program that he/she is the only individual using and in possession of the confidential pin and password and will not manually sign transcribed reports which are available via electronic means. Existing policies and procedures on confidentiality of patient information will continue to be adhered to at all times. Termination of the electronic privilege will be carried out if misused, at which time the authentication process will revert to manual signatures for all transcribed reports.

Signature stamps are not acceptable and should not be used in lieu of signatures. A name stamp may be used to identify and legibly document the name of a physician on orders and progress notes, and must include a signature and identification number.

Medical staff involved in patient care who provide written/verbal/telephone orders shall sign their name and include their hospital assigned dictation number on the Practitioner Signature Index form to ensure legibility and identification of author and entries.

o) Completion of Health Records

- **Incomplete Medical Record:** a medical record requiring signatures and/or dictations that is outstanding less than 30 days from the date of discharge or from the date of encounter.
- **Delinquent Medical Record:** a medical record will be considered delinquent when the record is incomplete for greater than thirty (30) days from discharge.
- **Delinquent Physician:** a physician who does not complete all his/her available medical records that are greater than thirty (30) days from the patient's discharge. Prior to being placed on suspension status, all providers will be properly notified by fax, telephone call, and certified mail.

According to regulatory bodies, the following definitions apply:

- **Delinquent operative report:** an operative report that has not been dictated or written 24 hours after surgery.
- **Delinquent history and physical report:** a history and physical report that has not been dictated or written within 48 hours of admission or prior to performing any surgical procedures.
- **Delinquent discharge summary:** a discharge summary that has not been dictated or written 5 days from discharge.

- **Post operative note:** a note that is completed on the same day of surgery by the surgeon and fully address all the required elements. This note must be documented immediately after the patient leaves the operating room.
- **Verbal or telephone orders:** all verbal orders are to be signed within 48 hours of being entered into SCM. All ordering Physicians are required to sign these orders within the Sunrise Clinical Management (SCM) system.

Delinquent Medical Record Notification

Physicians that are placed on the Medical Records Suspension List will be notified via a telephone call, certified letter, and a faxed letter notifying them of this status change.

If the physician has not completed his/her medical records greater than thirty (30) days after a patient's discharge and this same physician has not presented to complete their medical records in over thirty (30) days, then this physician will be placed on suspension for loss of admitting privileges.

If a medical staff member remains on suspension for more than thirty (30) consecutive days, he/she may be fined according to the Medical Staff Policy on Timely Completion of Medical Records.

If a medical staff member remains on suspension for more than sixty (60) days, he/she will be sent a certified letter requesting them to appear before the Medical Executive Committee. The Medical Executive Committee will discuss the appropriate actions that will be taken with these offenders.

Medical Staff members who are on suspension for medical records delinquencies may not admit to the hospital, schedule surgery, see patients in consultation, or administer anesthesia. Providers may continue to maintain their obligations to take ER/Trauma Call. Medical Staff members shall remain on suspension of admitting privileges until delinquent records are completed.

- p) **Filing of Incomplete Medical Records**
Upon resignation from staff or a Leave of Absence, the physician will notify Health Information Management and make arrangements to complete all medical records for which he/she is responsible. Medical records left in an incomplete status may be referred to the appropriate Section Chief/Department Chair or closed administratively by the Chair of HIM committee.

Medical record completion statistics are reported to the HIM Committee on a quarterly basis. Quarterly reports are sent to the Medical Staff committees. Individual physician record completion history data is provided to Medical Staff Services for use in the physician reappointment process.

- q) **Review of Records**

Members of the medical staff are entitled to review records of patients for whom they provided care. Access to other patient's records, whether on-line or in paper form, will require a written authorization from the patient, unless the physician is now providing care and needs historical data for the continuum of care. A medical staff member may review any patient record without the patient's consent if he/she is acting in an official capacity as a member of a peer review or medical staff committee.

r) Protected Health Information

All members of the Medical Staff, Allied Health Staff, and House Staff shall maintain the confidentiality, privacy, security and availability of all protected health information in records maintained by the Hospital in accordance with health information privacy policies adopted by the Hospital. Protected health information may only be used or disclosed in accordance with such health information privacy policies of the Hospital and applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Members of the PCH Medical Staff, Allied Health Staff, and House Staff, when treating patients in the hospital, will be covered under the hospital's Notice of Privacy Practices and will be required to observe the requirements of HIPAA, related to the care of hospitalized patients.

s) TNM Staging Forms

In accordance with the American College of Surgeons' guidelines, the TNM Staging form will become a permanent part of the health record for all newly diagnosed cancer cases. Completion of the TNM Staging form will be the responsibility of the surgeon performing the initial biopsy or definitive surgical procedure. In the event that the diagnosis is made prior to admission or non-surgically, the attending physician shall be responsible for completion of the staging form.

t) Transplants/Implants

Health record documentation on donor and recipients of transplants will be consistent with state reporting law A.R.S. 36-849. Information regarding implants should be documented in the health record.

9. INFECTION CONTROL

The Infection Control Committee has the authority to institute appropriate control or study measures including isolation procedures within the Hospital when there is reasonably considered to be a danger to any patient or personnel. The Committee also has the authority to report any actual or suspect infections and to initiate non-invasive culture and sensitivity testing.

The Committee will report its findings and recommendations, including recommendations for appropriate isolation procedures, to the President of the Medical Staff, the Chief Executive Officer and Nursing Administration.

10. SUPERVISION OF HOUSE STAFF

Final responsibility for patient care and House Staff supervision belongs to the attending physician or his/her designee. House Staff may write patient orders under the attending physician's supervision. Members of the House Staff may render emergency treatment pending notification of the attending physician. Medical care provided by the House Staff in ambulatory care areas is under the supervision of the Medical Staff.

All members of the House Staff participating in Graduate Medical Education must be approved for staff privileges in accordance with Article III, Section 3.10 of the Medical Staff Bylaws. Patient care provided by the House Staff is reviewed in accordance with the PCH Performance Improvement Plan. Variations will be reported to the appropriate Department Chairman for evaluation in accordance with the Medical Staff Bylaws. All decisions relative to the quality of care are made by the Medical Staff.

Whenever the medical care plan of the patient is significantly altered, there should be communication between the attending physician and House Officer.

11. PHARMACY & THERAPEUTICS

General Information

a) All medications administered to patients at PCH will be supplied by the Department of Pharmacy Services unless otherwise defined by policy or by pharmacy approval. The Department of Pharmacy Services maintains a formulary as authorized by the P&T Committee. The formulary is an established compendium of approved medications available at PCH for diagnostic, prophylactic, therapeutic or empiric treatment of patients. The pharmacy is not required to stock more than one brand of an individual medication as approved by the P&T Committee. Medications ordered by trade name may not necessarily be filled by that name unless the physician states "do not substitute" on the order. The pharmacy will be permitted to make therapeutic substitutions of medications only within clearly defined parameters established by the P&T Committee and approved by the Executive Committee.

b) Medication Orders

Hand-written (as opposed to CPOE) orders for medications must be written clearly and accurately, including date, time and signature. All orders for medications must be complete including medication name, dosage form, dose, strength, route (if medications can be administered by more than one route), frequency, rate, method, and site of administration. Medications ordered as "PRN" must specify frequency and indication. The use of abbreviations should be minimized and abbreviations on the Hospital's Unapproved Abbreviations and Symbols List are not permitted in medical record documentation. Medication dosages should be expressed in the metric system and the use of unnecessary decimal points or zeros after a decimal point should be eliminated. A zero should be placed in front of a leading decimal point.

c) Requirement to Write Medication Orders in Mg/Kg

That the weight of the child in kilograms be recorded on the first sheet of the doctor's orders (or be available in Sunrise Clinical Manager), and

That the drug dosage be given both in milligrams and in milligrams/kilogram or milligrams/kilogram/dose.

d) Authorization to Order Medications

Medical practitioners, licensed by the State of Arizona to prescribe medications, may write orders for medications, diagnostic procedures and treatments if they satisfy the requirements for membership on the medical staff as set forth by Article II of the Medical Staff Bylaws and have clinical privileges at Phoenix Children's Hospital. Appropriately licensed interns, residents and fellows, in the teaching program at Phoenix Children's Hospital may write orders for inpatients. They may also write orders for patients seen in the emergency center and the outpatient clinics as part of their teaching program. Nurse practitioners and Physician Assistants may write orders within the definition of their approved scope of practice. Registered pharmacists are permitted to order medications under physician ordered pharmacotherapy consults.

e) House Staff Orders

House staff in the teaching program at PCH, appropriately registered with the Arizona Medical Board, may write all orders for diagnostic procedures, diets, activity status, treatments, medications and all other physician-ordered procedures for inpatients, outpatients, and emergency center patients.

Individual departments and teaching programs may modify these responsibilities as needed.

Residents and fellows may write controlled substance orders for inpatients and outpatients. Each resident and fellow will be given a designated identifying number by the Medical Education department as required by Federal and State laws. This number is valid only when the house staff is working for the Medical Center in the usual course of his/her hospital practice. With this number, controlled substance orders written by the house staff need not be countersigned by the attending physician.

All house staff, before ordering any medications, will check the patient's record. Before ordering a drug that would alter the therapy prescribed by the attending physician, the patient will be checked personally by the house staff and the attending physician will be notified.

All medical students will have all orders cosigned by a house staff or attending physician before the orders are transcribed.

f) Authorization to Administer Medications

It is required that only appropriately licensed personnel or approved personnel working directly under the supervision of a licensed medical practitioner be allowed to administer medications and diagnostic contrast media. Administration

of medications shall be only in response to an order by an authorized individual, as set forth above.

The following categories of personnel may administer medications at Phoenix Children's Hospital under the order of a qualified and licensed medical practitioner:

1. Physician, including house staff officers.
2. Registered Nurse and Nurse Practitioner.
3. (Administration of chemotherapeutic agents can only be performed by nurses certified in chemotherapy.)
4. Physician Assistant
5. Respiratory Care Practitioners: Clinical Resource RCPs, Clinical Specialist RCPs, and Professional Practice RCPs (medications related to respiratory therapy treatments only).
6. Radiology Technologist and Nuclear Medicine Technologist (medications related to radiology/nuclear procedures only).
7. EEG Technician and Cardiovascular Technician (oral medications only) and Anesthesia Technicians.
8. Physical therapist (topical medications only)
9. Nursing and respiratory students under direct supervision of a preceptor.

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

- g) Automatic Stop Orders
(Per current ISMP recommendations, pharmacy has deleted automatic stops. Medications are only discontinued when ordered discontinued.)
- h) Drug Usage Evaluation
Drug Usage Evaluation is performed as a criteria-based, ongoing, planned, and systematic process designed to continuously improve the appropriate and effective use of drugs. This process includes the routine collection and assessment of information in order to identify opportunities to improve the use of drugs and to resolve problems in their use. The Drug Usage Evaluation function is the responsibility of the Pharmacy & Therapeutics Committee.

12. GENERAL PERIOPERATIVE INFORMATION

Except in an emergency, the following are documented in a patient's medical record before a surgical and/or invasive procedure:

- a. Consent for Procedure. Permit for operation/procedure and/or invasive procedure must be properly executed and consent given by the patient, parent or legal guardian by signing the permit. The surgeon/proceduralist is responsible for providing informed consent including the risks, benefits and alternatives to the surgical and/or invasive

procedure. A consent or refusal for blood or blood products signed by the patient or patient's representative, if applicable, is documented.

- b. Provisional Diagnosis. In surgical cases, the provisional diagnosis shall be recorded by the surgeon before operation.
- c. Pre-Surgical History and Physical. When history and physical examination are not recorded or stated in writing to have been dictated before the time stated for operation, the operation shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient. An interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded.
- d. Diagnostic Tests performed in the hospital are documented in the patient's medical record prior to the surgical procedure.
- e. Operative Dictation. All operations performed in the Hospital shall be dictated and fully described by the operating surgeon immediately following surgery. All orders for patient care will be canceled at the time of surgery. It is the responsibility of the attending surgeon to document in the medical record postoperative orders relevant to the surgery. Other services will be responsible for post-operative orders, as appropriate, for continuation of the patient's care.
- f. Procedures Permitted in Treatment Rooms and/or Patient Rooms. Minor surgical or other procedures not requiring general anesthesia and not requiring surgical assistance may be performed in an intensive care unit, a treatment room, or the emergency room when, if in the judgment of the operating surgeon, the use of the operating room is unnecessary. When such procedures are performed out of the operating room, the physician must assure that all the prerequisites for the procedure exist, including necessary instruments, equipment, supplies, nursing support, lighting, and achievement of a sterile field. It is ultimately the responsibility of the physician performing any operative procedure to determine the proper location (O.R., Endoscopy Suite, Patient's room, treatment room, etc.) in which to perform the procedure. Hickmans, Broviacs, or implanted venous device is not placed on pediatric floors.

13. PATHOLOGY

All specimens, as defined by the current Department of Pathology Guidelines, that are removed at operation or in the course of any other procedure (including those done in patient rooms, outpatient clinics, or satellites) shall be sent to the Department of Pathology. In keeping with Departmental guidelines, gross examinations will be performed and, whenever indicated, microscopic slides will be prepared and examined. In all cases a Pathology report will be generated.

A current list of items exempted from being sent to the Department of Pathology may be obtained from the Department of Pathology.

When surgical and/or invasive procedures or medical therapy are to be performed based on tissue examination and interpretation performed at an outside institution, the diagnostic slides

or other materials from the outside institution shall be reviewed by a PCH pathologist or appropriate specialist and a report generated for the medical record. When such slides or materials are not available for review, the physician performing the procedure or therapy will so note in the chart and also identify a copy of the outside report to be retained in the hospital chart.

14. AUTOPSIES

All medical staff members are expected to attempt to secure permission for autopsy examination of deceased patients. It is the intent that each family shall be afforded the opportunity for clarification of cause of death **in all** cases. It is particularly important that autopsies be performed in the following circumstances:

1. In cases in which new modalities of treatment are being developed, such as organ/tissue transplantation and all research protocols (Phase I and Phase II studies).
2. In children with suspected malignancy.
3. In instances where an autopsy could contribute to family genetic counseling.

No autopsy shall be performed without proper written consent from the family. The request for approval or denial of permission to perform an autopsy will be documented in the final progress note or dictated in the Death Summary.

When an autopsy is scheduled, the attending physician caring for the patient is notified prior to the autopsy of the time that the autopsy will be performed. This notification is documented in the autopsy Preliminary Anatomic Diagnoses report, which is placed in the patient's chart.

All autopsies shall be supervised by a Phoenix Children's Hospital Staff Pathologist or by a physician to whom this responsibility is delegated.

Preliminary reports of all autopsies shall be finalized within seventy-two (72) hours after completion of the autopsy. All final reports shall be finalized within thirty (30) days after completion of the autopsy. In the event that the report cannot be finalized because tests are outstanding, the pathologist shall make a notation in the patient chart on day 30 that the report is pending, with the reason given. The report will then be finalized as soon as is practical after the pending test result or results become available.

All divisions of the medical staff shall review autopsy data from patients on their service at a subsequent Morbidity and Mortality Conference.

The attending physician shall relay information derived from the autopsy to the patient's family. It is recommended the primary care physician be involved in this process.

15. COST-EFFECTIVE MEDICAL CARE

Cost-effective medical care is care that achieves an optimal result within reasonable and appropriate financial limits. The Medical Staff of Phoenix Children's Hospital will strive to maintain a leading standard of excellence for cost-effective pediatric health care with no lessening of quality or accessibility of care.

16. MEDICAL RESEARCH

Any experimental or research procedure involving the use of the facilities of the Hospital must first be approved by the Scientific Review Committee, the Medical Executive Committee, and the Institutional Review Board (IRB).

17. MEDICAL STAFF MEETINGS

The meetings of the Medical Staff shall be held as provided in Article XI of the Medical Staff Bylaws. General Staff meetings will be held quarterly during the months of February, May, September and November, but may be rescheduled if conflicts arise. Programs for these meetings will be the responsibility of the President of the Medical Staff. Members of the Active Staff are encouraged to attend.

Department Committees shall meet monthly or as scheduled by the Department Chairman. Each Department Committee Chairman may appoint a secretary from the Medical Staff who will assume the responsibility for the content of these meetings. The Chairman or secretary shall have the following duties:

- a) To record attendance at meetings.
- b) To organize the agenda for meetings, which should include section reports or recommendations and performance improvement activities.
- c) To record the minutes of the meeting.

18. APPOINTMENT AND REAPPOINTMENT OF MEDICAL STAFF MEMBERS; GRANTING AND RENEWAL OR REVISION OF CLINICAL PRIVILEGES

(Specific policies/procedures concerning appointment, reappointment, delineation of clinical privileges, and provisional requirements are located in the Medical Staff Bylaws and/or Credentialing Manual.)

- a) Applicants shall complete, sign and file with the CEO, the application form prescribed by the Medical Executive Committee and Board of Directors. The application form requires full and complete disclosure by the applicant of all information requested.
- b) Applicants must request specific privileges when submitting an application.
- c) The applicant shall have the burden of producing adequate information for a proper evaluation of competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. In the event that the applicant fails to meet this burden, the application will be deemed incomplete and voluntarily withdrawn.
- d) The application shall require detailed information concerning the applicant's professional qualifications including evidence of appropriate state professional licensure, DEA registration, health status and other information as deemed necessary, including but not limited to peer references who have had direct experience working with the applicant and who can attest to the applicant's professional competence and ethical character.

- e) Once an application is submitted, the applicant will be provided access to a copy of the Medical Staff Bylaws, Rules and Regulations and the appropriate criteria for clinical privileges requested. Action on an individual's application for appointment or initial clinical privileges shall be withheld until complete information is available and verified by primary sources whenever feasible.
- f) A completed application shall include the following information:
- g) Medical school and postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended and written verification from the program director attesting to the applicant's competence to perform the privileges requested.
- h) All currently valid medical, dental, or other professional licensures or certifications, and Drug Enforcement Administration (DEA) registration when applicable, with the number, and expiration date for each.
- i) Previously successful or currently pending challenges to a license or registration (State or District, DEA) or voluntary or involuntary relinquishment of such license or registration.
- j) Health Status: Applicants, when requesting clinical privileges, are required to submit any reasonable evidence of current competency upon the request of the Credentials Committee, Department Committee or Medical Executive Committee. Between routine reappointment dates practitioners shall immediately furnish to the Medical Executive Committee and Governing Body, whenever applicable: information about significant change in health status that would impede the practitioner's ability to exercise the privileges requested; and/or any information requested by the Medical Executive Committee or Governing Body to reasonably accommodate the staff member.
- k) Peer Recommendations: Physicians, or individuals having similar training and background, who are familiar with the applicant's professional performance, competence, judgment, clinical and/or technical skills and ethical character.
- l) Specialty or Subspecialty Board Certification, status: An applicant requesting membership/privileges in the Departments of Medicine, Surgery and Anesthesia must be American Board Certified, have equivalent foreign certification, or have completed necessary training and other requirements to be admissible to certification examination by the American Board at the time of completion of training. Specific Board Certification requirements are included in the privileging criteria for each clinical department or section.
- m) Request for specific clinical privileges in accordance with criteria established by the clinical section in which the applicant is applying.
- n) Professional Liability Insurance coverage, in the amount acceptable to the Board. A minimum of \$1,000,000 professional liability insurance is a condition of staff membership at Phoenix Children's Hospital.

- o) Names of present and past insurance carriers with complete information on malpractice claims history including: currently pending malpractice claims, suits, settlements, judgments, arbitration proceedings, or complaints filed within the previous ten(10) years.
- p) Any current felony criminal charges pending against the applicant and any past charges including their resolution.
- q) Names and addresses of all hospitals or health care organizations where the applicant has or had association, employment, privileges or practice within the previous ten (10) years, with the inclusive dates of each affiliation.
- r) Evidence of the applicant's agreement to abide by the provisions of the Medical Staff Bylaws, Rules and Regulations.
- s) Application fee in the amount established by the Executive Committee must be submitted by the applicant prior to processing of the application.
- t) Information Contained on National Practitioner Data Bank Report.
- u) Voluntary or Involuntary Termination of Medical Staff Membership or Voluntary or Involuntary Limitation, Reduction, or Loss of Clinical Privileges at another Hospital or health care facility.
- v) Continuing Medical Education, as required for licensure in the State of Arizona, completed within the previous two (2) years, that is pertinent to the privileges requested. Five (5) hours of Category I CME per year must be in the physician's specialty or sub-specialty if applicable (To be enforced January 1, 2008.).
- w) Medicare/Medicaid Sanctions Report issued by the Office of the Inspector General of the Department of Health and Human Services.
- x) Completed TB Attestation Form.
- y) A government issued form of identification.

19. REQUIREMENTS FOR ACTIVE/ASSOCIATE STAFF CATEGORIES

- a) Utilization for achieving/maintaining Active Staff category: ten (10) patient contacts within a two (2) year period, i.e. admissions, consults, surgical procedures. Failure to maintain the required number of patient contacts may result in reduction of staff category to Associate Staff.
- b) Utilization for achieving/maintaining Associate Staff category: five (5) patient contacts within a two (2) year period, i.e. admissions, consults, surgical procedures. Failure to maintain the required number of patient contacts may result in reduction of staff category to Courtesy Staff.

- c) Medical Staff Members with provisional status are not eligible for advancement in staff category. This requirement may be waived by the Board upon recommendation of the Executive Committee in accordance with the Medical Staff Bylaws.

20. APPOINTMENT AND REAPPOINTMENT OF ALLIED HEALTH STAFF;
GRANTING AND RENEWAL OR REVISION OF CLINICAL PRIVILEGES

- a) Applicants shall complete, sign and file with the CEO, the application form prescribed by the Medical Executive Committee and Board of Directors. The application form requires full and complete disclosure by the applicant of all information requested.
- b) Applicants must request specific privileges when submitting an application.
- c) The applicant shall have the burden of producing adequate information for a proper evaluation of education, training, competence, character, licensure, certification, continuing education, ethics and other qualifications, and for resolving any doubts about such qualifications. In the event that the applicant fails to meet this burden, the application will be deemed incomplete and voluntarily withdrawn.
- d) Credentials Committee Action. Following receipt of the complete and verified file, the Credentials Committee shall review the file and shall submit a report and recommendation to the applicant's Department and the MEC regarding the application (new application's only). The report and recommendation shall specify the scope of Clinical Privileges which it recommends be granted and shall specify whether the granting of Clinical Privileges should be conditioned upon the supervision of the Practitioner by a particular Medical Staff appointee.
- e) Department Review. The applicant's Department will review the file and determine whether or not the applicant has, to the satisfaction of the Department, demonstrated appropriate education, training, current competency and recent experience for the privileges requested. The Department will forward the file to the MEC outlining the Clinical Privileges which it recommends be granted and shall specify whether the granting of Clinical Privileges should be conditioned upon the supervision of the Practitioner by a particular Medical Staff appointee.
- f) MEC Action. Following receipt of a file from the credentials committee, the MEC shall review the file and shall submit a report and recommendation to the Board of Directors regarding the application. The report and recommendation shall specify the scope of Clinical Privileges which it recommends be granted and shall specify whether the granting of Clinical Privileges should be conditioned upon the supervision of the Practitioner by a particular Medical Staff appointee.
- g) Board of Directors Action. Following receipt of the file from the MEC, the Board of Trustees shall review the file and shall make a decision whether to grant the application in whole or in part. If the application is granted in whole or in part, the Board of Directors shall specify the scope of Clinical Privileges granted to the Practitioner and

shall specify whether the granting of Clinical Privileges is conditioned upon the supervision the Practitioner. The decision of the Board of Directors shall be final, and the practitioner shall not have any right to a hearing or other review.

- h) Duration of appointment. All appointments, reappointments and modifications of appointments to the AHP staff shall be for a period not to exceed two years. Upon the expiration of such term of appointment, the appointment together with all Clinical Privileges of the Practitioner shall lapse.
- i) Loss of Sponsorship. The AHPs appointment and clinical privileges shall automatically terminate upon the termination of the supervisory relationship with the Medical Staff appointee or upon termination , resignation, or reduction of the Medical Staff appointee's Medical Staff appointment or clinical privileges necessary to supervise the Practitioner. The Practitioner shall immediately inform the CEO of the change in status.

21. STIPENDS FOR MEDICAL STAFF OFFICERS

The President of the Medical Staff at Phoenix Children's Hospital shall be compensated for the time commitment required of this role during the term of office to a total of \$50,000 on an annual basis. The Vice President/President-Elect shall be compensated at \$5,000 annually or \$25,000 if the individual also serves as Chairman of the Quality Council, Medical Staff Department Chairmen shall be compensated at \$25,000 annually.

Latest Revision Endorsed by Phoenix Children's Hospital
Board of Directors: May 2007

Revisions approved:

- June, 1985
- May/December, 1986
- March, 1987
- April, 1988
- March/December, 1989
- March, 1990
- October, 1991
- June, 1992
- May/June/December, 1993
- February/March/April/November, 1994
- January/February/March/April/December, 1995
- September, 1996
- December, 1997
- August, 1999
- March, 2000
- December, 2001
- May/November, 2002
- April/November, 2003
- February/April/May, 2004
- March/October/November, 2005
- January/May/September/October, 2006

January/February/March/May 2007
July, 2009