SCOTTSDALE HEALTHCARE
OSBORN
SHEA
THOMPSON PEAK

MEDICAL STAFF

RULES AND REGULATIONS

June 28, 2011

MEDICAL STAFF OF SCOTTSDALE HEALTHCARE

GENERAL RULES AND REGULATIONS

1. Disaster Planning

All Medical Staff members agree to participate in medical disaster programs, to accept assignment according to the current disaster plan, and - in the event of an emergency - to relinquish responsibility for their private patients to a physician designated by the disaster plan to assume such responsibility.

2. Special Care Units Response

Medical Staff members attending patients in the special care units shall:

a. respond by phone within twenty (20) minutes,
b. see a patient admitted to the SCU within twelve (12) hours, unless patient's condition changes or warrants physicians should see the patient sooner,
c. provide orders for patients admitted to SCU within twenty (20) minutes,
d. respond as requested at the discretion of the Medical Directors of SCU.

3. Treatment of Family Members

Physicians generally should not treat themselves or members of their immediate families within the Scottsdale Healthcare Hospitals and Ambulatory Surgical Facilities. Exceptions need to be approved by the Chair of the Department or the Division President of the Executive Committee for settings where there is no other qualified physician available. In emergent settings where there is no other qualified physician available, physician should not hesitate to treat themselves or family members until another physician becomes available.

4. Pharmacy & Therapeutics

Medical Staff members shall adhere to the P&T Committee's policies regarding the use of drugs and compliance with the Hospital Formulary. The use of non-formulary drugs shall follow the procedure as approved by the P&T Committee.

5. Alternative Coverage

Medical Staff members must provide appropriate alternative coverage by another physician member of the Medical Staff qualified to manage the care/treatment needs of the patient. An attending physician away for more than twenty-four hours must put in writing on the chart that the care of the patient shall be transferred to another physician. In cases where a physician or alternate cannot be located, the Administrator or the Chair of the appropriate Department shall have the authority to call any member of the Medical Staff to attend a patient.

6. On-Call Obligations

Medical staff members shall adhere to the Protocol for On-Call Schedules and shall participate in primary care and/or specialty consultations and on-call schedules as deemed necessary by the Executive Committee and/or department committee to assure appropriate and timely care of all patients.

Physicians serving emergency on-call responsibilities shall:

a. Respond by phone to calls within twenty (20) minutes.
b. Present to the Emergency Department within thirty (30) minutes when requested by the Emergency physician.
c. Accept all patients requiring admission who do not have a private physician on staff, when so requested by an Emergency physician.

d. Sign out only to physicians who are on the staff at Scottsdale Healthcare.
e. Accept referrals to their office for at least one visit following discharge from the Emergency Department. If patient has not called the office to schedule a visit within 14 days of discharge, physician obligation ceases at that time.
f. The preferences of the patient or the primary care physician take precedence over the on-call schedule.
g. Cover from 7:00 a.m. to 7:00 a.m. the following day (24 hrs) unless otherwise specified.
h. Once the emergency room call schedule has been published, and if a medical staff member is unable to cover the assigned call day(s), it is the medical staff member's responsibility to find appropriate coverage and to notify the medical staff services department and the emergency department.
i. Resigning medical staff members shall be responsible to find appropriate coverage for thirty (30) days following their notification of resignation.

7. Federal Regulations (EMTALA)

Medical Staff members shall adhere to EMTALA regulations as it applies to the treatment and transfer of patients in the Emergency Department. Physicians may perform medical screening examinations. The following other classes of practitioners may also perform medical screening examinations if qualified by training, experience and competency:

a. Physician Assistants (P.A.s);
b. Nurse Practitioners (N.P.s); and
c. Registered Nurses (R.N.s) in the Department of Obstetrics.

MEDICAL RECORDS RULES AND REGULATIONS
GENERAL RULES

8. Abbreviations

a. Only acceptable abbreviations, which have been approved by the medical staff, may be used in the patient records. Unacceptable abbreviations for medication orders are not to be used in the patient records.
b. All acceptable abbreviations and the list of unacceptable abbreviations for medication orders shall be on record and available at each nursing station and in the Health Information Management Department.
c. All final diagnoses and procedures are recorded, without use of symbols or abbreviations, in the discharge summary, discharge note, or on the coding summary sheet.

9. Signatures

d. All signatures are to be legible. Electronic signatures are acceptable. Signature stamps are not acceptable.
e. Physicians may sign medical record documents for another Medical Staff member, if both are involved in the care of the patient. The documentation they are signing must pertain to an area in which both physicians are privileged.
f. All medical staff members approved after June 1, 2001 shall participate in and utilize the hospital's electronic signature authentication (ESA) program.

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10. Consents

a. Appropriate informed consent is documented in the medical record for procedures specified in the Informed Consent Policy.

b. Accomplishment of informed consent ultimately rests/resides on the qualified professional performing the procedure. The elements of informed consent may be delivered by ancillary staff utilizing educational material developed by Quality Resource Management (QRM) and approved by Scottsdale Healthcare and the medical staff.

11. Consultations

Consultations are obtained at the request of the attending physician. The consulting physician dictates a report, including the findings, opinions, recommendations and authenticates the consultation. The consultant shall write a brief note in the progress notes to indicate the patient was seen and the consult was dictated.

12. Release of Information/Access to Medical Records

a. All medical records are the property of Scottsdale Healthcare. Original medical records are only removed from Scottsdale Healthcare's jurisdiction in accordance with a valid subpoena or court order.
b. Access to medical records, whether paper or electronic, will only be done for treatment, payment or healthcare operation reasons.
c. Access to and the processing of health care information shall also be compliant with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).
d. In addition to individual penalties authorized under the Acts, violations of HIPAA or HITECH regulations will be referred to the Medical Staff Peer Review Process.

13. Documentation

a. All written entries and transcribed reports must be timed, dated and authenticated by the responsible health care provider:
   1) History and physical
   2) Orders
   3) Progress notes
   4) Consultations
   5) Operative reports
   6) Pathology reports
   7) ED reports
   8) Discharge and/or expiration summaries
   9) All clinical notes of outpatients seen at Scottsdale Healthcare
b. **All documentation shall meet requirements of CMS core measures.**
c. All written entries contained in the medical record shall be legible. All entries shall be written in black or blue colored ink pen. No pencil entries are allowed within the medical record.
d. Any changes or corrections to entries in the medical record shall be initialed and dated. No portion of the medical record shall be destroyed or deleted. Revisions to transcribed reports must be completed by the Medical Transcription Department.
e. Documentation by residents, medical students, physician assistants, or nurse practitioners shows evidence of supervision through the countersignature of the responsible supervising physician where applicable.

14. Admission/Admitting Note

a. At the time of admission, there shall be an admitting note documenting assessment, necessity for acute care admission, a treatment plan and a provisional diagnosis documented within the medical record as soon as possible.

b. All admission orders require an order designating a level of care (intensive care unit, medical floor, telemetry, etc.).
c. All patients require an order indicating either an admitting status (inpatient, observation, outpatient bed) or the use of an approved protocol to determine the admitting status.

15. Re-Admissions

An interval note completed within twenty-four (24) hours by the admitting physician, resident physician, NP or PA is acceptable when the patient is readmitted within thirty (30) days for the same or related problem, provided that a legible copy of the original history and physical is available in the medical record. The interval note shall contain:

a. Present complaint,
b. Pertinent changes in general and/or physical condition of the patient.

MEDICAL RECORD REPORTS

16. History and Physical

a. Medical Staff members shall be responsible for the documentation of the history and physical examination. Dictated consultations may be used as a substitute for, or augmentation to, the history and physical examination.
b. A legible or transcribed history and physical examination (H&P) is documented within twenty-four (24) hours of admission for all inpatients. The history and physical, including a pre-operative diagnosis, MUST be documented prior to non-emergent surgery. For surgical patients, the documentation of the history and physical may be postponed if the operating surgeon determines that a life-threatening situation exists. Such a case is documented in the medical record, and the history and physical is available within twenty-four (24) hours.
c. The physician shall use his/her clinical judgment based on his/her assessment of the patient's condition and any co-morbidities in relation to the reason the patient was admitted or to the surgery to be performed when deciding what depth of assessment needs to be performed and what information needs to be included in the update note. The elements of an appropriate history and physical examination include:
   1) Chief complaint
   2) Reason for admission/admitting diagnosis
   3) Details of the present illness and any pertinent co-morbid conditions
   4) A list of known current medications or documentation if unavailable
   5) Allergies including past medication reactions, if known
   6) Appropriate physical examination which includes pulmonary status, cardiovascular status, blood pressure, and vital signs.
   7) The course of action planned for the patient's episode of care.
d. An H&P performed within thirty (30) days prior to admission may also be used for the hospital medical record if it is accompanied by an update note. An update note must be written at the time of admission or within twenty-four (24) hours of admission and/or prior to the procedure. The update note should identify any changes in the patient's medical condition that has occurred since the prior H&P and should reaffirm the necessity for the planned care. History and Physicals older than thirty (30) days are not acceptable.
e. Handwritten History and Physicals are permissible; short stay records can be used for same day surgery patients and patients whose stay is less than forty-eight (48) hours.

f. A history and physical is not required for non-surgical outpatients undergoing diagnostic procedures or elective minor procedures without sedation.
g. All outpatient endoscopy patients will have a History & Physical documented on the Endoscopy Physician Record prior to the procedure. This form will be accepted as the History & Physical report.

18. Orders

a. All telephone and verbal orders must be signed within 48 hours.
b. Orders given verbally or over the telephone may be accepted and transcribed by the following clinical staff:
   1) Registered Nurses
   2) Licensed Practical Nurses
   3) Registered Pharmacists
   4) Respiratory Care Technicians for respiratory orders
   5) Radiology Technicians for radiology orders
   6) Physical Therapists for physical therapy orders
   7) Occupational Therapists for occupational therapy orders
   8) Speech Pathologists for speech pathology orders
   9) Registered Dietitians for medical nutrition therapy orders
   10) Case Managers.

c. Standing orders may be used by individual physicians, after approval by their clinical committee. These standing orders must be reviewed and approved annually.
d. Patient care orders may be written by the resident physicians, PA's, NP's when authorized by the attending physician.
e. All orders on any patient shall be automatically canceled by a surgical operation. New orders shall be written post-operatively. Orders for "no code" status shall be exempt from this rule.
f. Orders to withdraw life-sustaining treatment or withhold resuscitative services must be written by the physician providing care to the patient.
g. Restraint and/or seclusion orders will be followed per Hospital policy.
h. Facsimile transmissions of orders to Scottsdale Healthcare from another facility are accepted only when the orders contain the signature of the ordering health care provider or designee.
i. A patient shall be discharged only on written or verbal order of the attending physician. At the time of discharge the medical record shall contain the principal discharge diagnosis in writing.

19. Progress Notes

a. Attending physician or covering physician must see the patients daily. Consulting physicians shall see the patients as appropriate. All physician visits are documented in a progress note. All notes must be timed, dated and authenticated. The note describes the patient's course, documents any significant changes in the patient's condition, and permits continuity of patient care.
b. Progress notes written by Nurse Practitioners or Physician's Assistants in lieu of the physician's progress notes documents that the patient was seen by the supervising physician.
c. Progress notes written by Residents are countersigned by the responsible supervising physicians.
d. On the day of discharge, patients do not need to be seen by the physician. Nurse Practitioners or Physician's Assistants may discharge patients in collaboration with the sponsoring physician.
e. Clinical staff may handwrite in the progress notes. These notes may also be accomplished with the use of a stamp and/or sticker.

20. Discharge Summary

a. A discharge summary is dictated for inpatients by the attending physician as soon as possible after discharge, not to exceed twenty-one (21) days. Discharge summaries completed by resident physicians, nurse practitioners, and/or physician assistants are countersigned by the responsible supervising physician where applicable.

b. The discharge summary includes:
   1) Reason for hospitalization
   2) Course of care (Treatment and services provided)
   3) Significant findings
   4) Procedures/surgeries performed
   5) Patient condition on discharge
   6) Discharge instructions including activity, diet, medications, and follow-up to the patient and family
   7) Final diagnosis.

c. A handwritten discharge note is acceptable for patients discharged within forty-eight (48) hours of their elective surgery The handwritten note includes patient condition on discharge, follow-up instructions, discharged instructions, and medications.

d. A final progress note may be substituted for a dictated Discharge Summary, for patients with problems of a minor nature and/or who requires less that forty-eight (48) hours of hospitalization which include:
   1) Normal newborns,
   2) Uncomplicated obstetrical deliveries, including caesarean sections,
   3) Hourly Observation Patients (HOPS) admissions not converted to Acute Care stay. This final Progress Note shall include instructions given to the patient or to the patient's family.

e. In the event of a transfer, the attending physician must dictate a discharge summary at the time of the transfer regardless of length of stay.

21. Expiration Summary

a. In the event of death, a transcribed expiration summary will be dictated by the attending physician, PA's, NP's and/or resident physician as soon as possible after discharge, not to exceed twenty-one)21) days.. An expiration summary is required for all deaths, regardless of the length of the hospitalization or the patient type. Summaries completed by resident physicians, PA's, or NP's are countersigned by the responsible supervising physician where applicable.

b. The expiration summary includes:
   1) Reason for hospitalization
   2) Course of care
   3) Significant findings
   4) Procedures/surgeries performed
   5) Events leading to death
   6) Documentation of whether or not an autopsy was requested.

22. Ancillary Reports

All Diagnostic (EEG, EKG, and other special procedure reports), Pathology and Radiology reports are authenticated, signed and dated by the responsible interpreter and added to the record.

23. Operative Reports (INPATIENT)
    a. A complete operative report shall be dictated or documented immediately after surgery, or within twenty-four (24) hours. A brief handwritten progress note is documented immediately following surgery.
    b. The transcribed operative report includes:
        1) Pre-operative diagnosis
        2) Anesthesia used
        3) Name of primary surgeon and assistants
        4) Findings
        5) Description of technical procedure
        6) Estimated blood loss
        7) Specimens removed
        8) Post-operative diagnosis
    c. Authentication/signature of transcribed operative reports is the responsibility of the surgeon.

24. Operative Reports (OUTPATIENT)
    Operative Reports are to be dictated or written immediately after surgery. Exceptions include ophthalmic laser procedures, endoscopies, and minor procedures performed in the procedure room. In these cases, respective procedure forms will be completed for minor procedures, endoscopies, and laser photocoagulation procedure record.

25. Autopsy Reports
    Documentation of consent for the autopsy shall be included in the medical record. The provisional anatomic diagnoses shall be recorded in the medical record within three (3) days of completion of the autopsy. The complete autopsy report shall be recorded in the medical record within ninety (90) days of the date of autopsy.

DEPARTMENT RULES

ANESTHESIA RECORDS

26. Anesthesia Notes
    a. A pre-anesthesia evaluation is documented in the medical record on the "Anesthesia Record" form and includes:
        1) Documentation of patient interview,
        2) Review of past and present drug and medical history,
        3) Physical status assessment,
        4) Results of any relevant diagnostic tests,
        5) Anesthesia risk,
        6) Planned choice of anesthesia.
    b. Evidence of both the patient's re-evaluation immediately prior to induction and the monitoring of the patient's physiological status during anesthesia administration are documented on the "Anesthesia Record".
    c. The post-anesthesia notes include:
        1) Release of patient from post-anesthesia care unit (PACU) to the floor according to established criteria;
        2) Documentation of complete recovery with date and time notation was made, describing presence or absence of anesthesia-related complications;
        3) Documentation of patient's status upon admission to and discharge from PACU;

4) Documentation of patient's discharge from PACU by a licensed practitioner or in accordance with established discharge criteria.

EMERGENCY DEPARTMENT RECORDS

27. Emergency Department Record

a. Emergency Department Evaluation and Treatment Record shall be dictated or written within 24 hours following examination of the patient and include the following:
   1) pertinent history of the illness/injury,
   2) physical findings,
   3) documentation of clinical observations, tests and results,
   4) procedures performed,
   5) conclusions at the termination of evaluation/treatment, including the final disposition, condition on discharge or transfer, and instructions for follow-up care,
   6) documentation of a patient leaving against medical advice, if appropriate.
b. For patients being transferred from the ED to another healthcare facility, the ED report will include:
   1) Reason for transfer
   2) Stability of the patient at the time of transfer
   3) Documentation of acceptance by receiving organization.
c. The attending physician's order for admission must be documented on the physician's order sheet if admitted to the hospital from the Emergency Department.
d. The Emergency Department Evaluation and Treatment Record shall not be used in lieu of the history and physical examination when the patient is a direct hospital admission
e. The Emergency Department evaluation and Treatment Record must document the following for patients treated in the Emergency Department for possible abuse or neglect:
   1) examinations;
   2) treatment given;
   3) any referrals made to other care providers and to community agencies; and
   4) any required reporting to the proper authorities.

OBSTETRICAL RECORDS

28. Obstetrical Records

a. There shall be a prenatal history and physical examination on every obstetrical patient. A durable, legible original or reproduction of the office or clinical prenatal record is acceptable. A copy of the prenatal record shall be sent to the Obstetrical Department prior to delivery.
b. If the time period between the last office visit and the time of delivery exceeds thirty (30) days, an interval note or update of the prenatal record is required.
c. If the patient is to have a Cesarean section, tubal ligation or any other type of surgery, a complete History and Physical is required.
d. The History and Physical on an incomplete abortion should be standard and recorded on a prenatal record.
e. Obstetrical patients having Caesarean sections, tubal ligation or other gynecological surgery require a Discharge Summary.
f. Fetal monitor strips will be kept and stored electronically through optical disk.

SURGERY DEPARTMENT RECORDS

29. Tissue Reports

All tissues removed or obtained from the patient must be submitted to Pathology with the following exceptions:

1) Bones from hammertoes
2) Cataracts
3) Tissue for grafting
4) Ribs removed for exposure
5) Teeth
6) Skin and subcutaneous fat removed for cosmesis (e.g., facelift, blepharoplasty, liposuction, scar revisions; mastopexy specimens without breast tissue)
7) Foreskin from children
8) Clinically normal placentas
9) Skin and soft tissue removed in repair of trauma
10) Orthopedic repair of shoulder, knee, etc. (i.e., arthroscopic shavings, acromion, rotator cuff, fascia, meniscus, ligament, bunion)
11) Varicose veins
12) Vaginal mucosa removed from prolapse
13) Joints removed for degenerative joint disease (osteoarthritis)
14) Intervertebral disc
15) Extraocular muscle from corrective surgical procedures
16) Nasal bone and cartilage from rhinoplasty or septoplasty
17) Tonsils/Adenoids (Children under the age of 18)
18) Decubitus Ulcers
19) Hernia Sacs
20) Loose bodies from joints
21) Arteriosclerotic plaque
22) Breast capsules in patients without previous breast cancer and without adherent breast tissue.

a. At the discretion of the physician, any of these tissues or non-tissue items may be sent to Pathology for examination.

b. Non-Tissue items, such as the following, need not be sent to Pathology unless there is a clinical indication affecting patient care:

1) Foreign bodies such as glass shards, thorns and splinters, sutures, coins
2) Orthopedic appliances, hardware, wires
3) Prostheses such as hips, knee, TMJ, breasts, penile and vascular
4) Pacemaker generators and leads
5) Stents, drains, and shunts
6) Therapeutic radioactive sources

c. Foreign bodies removed after crimes of violence shall be submitted to Pathology, unless taken by law enforcement officials. Pathology can help to preserve the chain of evidence and provide security for the specimen.

d. Certain specimens (i.e., breast implants & capsules) given to Pathology for temporary storage and/or eventual return to the patient will be accessioned and a report issued.

30. TNM [Tumor Nodular Metastases] Staging Forms

a. In accordance with the American College of Surgeon's guidelines, the TNM Staging form will become a permanent part of the medical record for all newly diagnosed cancer cases.

b. 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.

TIMELY COMPLETION OF THE MEDICAL RECORD

31. Ongoing Chart Review/Timeliness Review of Documentation

a. Medical records will be reviewed for completeness, accuracy and timely completion of information.
b. Results of ongoing chart reviews/timeliness reviews and medical record completion statistics will be reported quarterly to the Quality Resource Management (QRM) Committee.
c. The QRM Committee will take action, as necessary, to improve this process.

32. Absence from the Hospital (Practitioner)

When a practitioner will be away from the hospital for any time longer than fourteen (14) calendar days and completion of records will be delayed, it is the practitioner's responsibility to assure that charts are completed prior to departure and to notify the Health Information Management Department of his/her prolonged absence and approximate date of return.

33. Timely Completion of the Medical Record

a. A patient's medical record shall be considered delinquent if the history and physical examination is not completed within twenty-four (24) hours of admission or prior to surgery; if operative reports or procedure notes are not completed within twenty-four (24) hours; and if all other record deficiencies are not completed twenty-one (21) days post-discharge.
b. Medical or Allied staff members who are on suspension for delinquent medical records may not admit to the hospital, schedule surgery, see patients in consultation, or administer anesthesia. Medical or Allied staff members shall remain on suspension until all delinquent charts are completed and fines are paid to the Medical Staff.
c. When a suspended physician attempts to admit patients, the Admitting Department will advise the physician that admitting privileges have been suspended due to delinquent medical records. The Admitting Department shall not allow the physician to admit. If the physician seeks an exception to the suspension of admitting privileges, the physician must contact his/her appropriate Department Chair.
d. Patients may be seen and orders written in the Emergency Department by a suspended practitioner. However, patients requiring admission from the Emergency Department will not be admitted by a physician on the suspension list. It shall be the responsibility of the physician to inform the patient regarding admission under another physician. The suspended physician can indicate the physician of his/her choice to handle the patient, or the patient will be admitted by the physician on call. Exceptions can be made by the appropriate Department Chair.

e. If Medical Staff members on suspension admit patients under a group member, or other staff physician's name, and the suspended member cares for the hospitalized patient, the suspended member may be subject to disciplinary action set forth in the Medical Staff Bylaws.
f. Upon completion of delinquent records and payment of fines, the practitioner's name shall be removed from the suspension list. If the practitioner fails to fully complete the delinquent records, the practitioner's name will be placed back on the suspension list. The practitioner will be notified by telephone immediately.
g. A practitioner planning to leave the medical/allied staff must complete his/her delinquent records within twenty-one (21) days after notice of resignation providing the charts are available within that 21 day period.
h. The Quality Resource Management Committee (QRM) shall be allowed to declare any medical record complete for the purposes of filing when a practitioner is deceased or unavailable permanently or protractedly for other reasons. The Chair of the QRM Committee shall review and sign a statement that explains the reason the practitioner was unable to complete the record. This statement shall be made a part of the permanent medical record.
i. If a Medical/Allied Staff member remains on suspension of admitting privileges for more than thirty (21) days consecutively, he/she will be fined $100 (frequency to be determined by QRM Committee).
j. If a Medical/Allied Staff member remains on suspension for more than forty-five (45) days, with more than five (5) deficiencies, he/she shall be sent a certified letter requesting his/her appearance before the Medical Executive Committee within 45 days to address why the Medical Executive Committee should not terminate the practitioner's medical/allied staff privileges for failure to complete medical records. The Medical Executive Committee has the option to automatically terminate the practitioner's privileges if he/she fails to attend.

FINING PROCESS

34. Fines

a. All History and Physicals must be completed prior to non-emergent surgery and/or within twenty-four (24) hours of admission and all operative reports must be completed immediately after the procedure. If a history and physical, or an operative report is not completed at the time of discharge, the medical/allied staff member shall be considered delinquent and will be notified by facsimile, telephone and certified mail by the Health Information Management Department. Medical/Allied staff members who are delinquent on more than one occasion per quarter will be fined $100 and placed on suspension of privileges. After the medical record is completed and the fine paid, the delinquency and suspension of privileges will be revoked. The credentialing committee will be notified of all medical/allied staff members who are fined and placed on suspension for future reappointment considerations.
b. If a practitioner is on suspension of privileges over twenty-one (21) days consecutively per each calendar year, he/she will be fined $100 for every business day (Monday-Friday). For every twenty-four (24) hours that a practitioner remains on suspension of privileges following the levying of the fine, the practitioner shall incur additional fines of $100. Medical/Allied staff members shall remain on suspension of privileges until delinquent records are completed and fines are paid to the Medical Staff Office. The credentialing committee will be notified of all medical/allied staff members who are fined for being on suspension of privileges for future reappointment considerations.

CLASSES OF PRACTITIONERS

35. Medical Students / Residents / Fellows (Military physicians on rotations at SHC will be included under the resident/fellow class of practitioner)

    a. Third and fourth year medical students on an approved rotation may dictate histories & physicals and discharge summaries, and write progress notes, which must be countersigned. They may write orders, which must be immediately countersigned by the attending physician or resident prior to institution of those orders.
    b. Residents/Fellows who are participants in a professional graduate education program, which has been approved by the Medical Staff and are not members of the Medical Staff, are authorized to document in the medical record. The respective supervising physician shall countersign documentation/dictation. Countersignature shall be documented at the end of a dictated report. A separate daily attending progress note or countersignature is required. Residents/Fellows shall abide by the Medical Staff Bylaws, Rules and Regulations.
    c. Medical staff members who supervise residents/fellows or medical students shall write progress notes including the date, which documents evidence of supervision. Such documentation may consist of a progress note written by the attending physician or a counter signature on the same day of the resident's progress note. Such documentation shall occur within twenty-four hours and may consist of a progress note or counter signature.
    d. Attending/supervising medical staff members may change a statement made in the record by the resident/fellow/medical student and shall initial and date the change.
    e. All entries must be complete and shall include the hospital assigned dictation number.
    f. The attending/supervising medical staff members are responsible for all incomplete and/or delinquent records assigned to the residents/fellows he/she supervises.

36. Medical Students
    a. 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 patient
    b. Medical students are permitted to perform histories and physical examinations for evaluation by the house and attending staff. These are acceptable as part of the medical record. The history and physical shall be reviewed and countersigned by the supervising physician.
    c. Medical students are permitted to write orders in the medical record provided they are countersigned, or given telephone approval, by the appropriate physician at the time of writing. Such orders will be written with both the student's and the physician's names attached, e.g., "J. Smith, M.D., per M. Jones, MS III."
    d. Medical Students are permitted to dictate Discharge Summaries, which must be reviewed and countersigned by the attending staff. These are acceptable as part of the medical record.

ALLIED HEALTH PRACTITIONERS (AHP)

37. Nurse Practitioners
    a. Nurse practitioners may evaluate and treat patients under the supervision/collaboration of their sponsoring physician/agent.
    b. Nurse practitioners may participate in the care of patients only under direct supervision/collaboration of an attending physician.
    c. Nurse practitioners may write progress notes, history and physical examinations, and consultations in the medical records; and dictate these reports.

d. Nurse practitioners may write orders and prescribe medication on behalf of the supervising/collaborating physician/agent within the limits for which they have been approved by the Arizona State Board of Nursing and the Medical Staff.
e. Nurse practitioners may discharge patients in collaboration with the supervising/collaborating physician.

38. Physician Assistants
a. Physician Assistants may write progress notes, history and physical examinations, and consultations in the medical record.
b. The history and physical shall be reviewed and countersigned on the day of admission by the attending or sponsoring physician. The sponsoring physician shall endorse the findings, conclusions and assessment of risk prior to major diagnostic or therapeutic intervention or within 24 hours of admission, whichever occurs first.
c. Physician Assistants may transcribe verbal orders in the presence of the attending physician, which must be reviewed and co-signed by the sponsoring physician. Physician assistants may phone in orders only at the direction of their supervising physician. All orders must be co-signed by the supervising physician within 24 hours.
d. Physician Assistants may discharge patients in collaboration with the supervising physician. The Physician Assistants may dictate the discharge summary with the co-signature of the attending physician.

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