

**BAYLOR ALL SAINTS MEDICAL CENTERS
FORT WORTH, TEXAS**

**GENERAL RULES AND REGULATIONS
OF THE MEDICAL STAFF**

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DEFINITIONS

The following definitions apply to the provisions of these General Rules and Regulations of the Medical Staff. The definitions are presented in alphabetical order.

1. **Allied Health Professional** or **AHP** means an individual who is qualified by academic and clinical training and by prior and continuing experience and current competence in a discipline which the Board of Directors has determined to allow to practice in the Hospital. An "independent AHP" is licensed by the state and permitted by the Hospital to provide services in the Hospital without the direction or immediate supervision of a Medical Staff Member. A "Dependent AHP" functions in a medical support role to and under the direction and supervision of a Medical Staff Member. Allied health professionals are not members of the Medical Staff.
2. **AND – Allow Natural Death**
3. **Board of Directors** or **Board** means the governing body of the Hospital, the Board of Directors of Baylor All Saints Medical Center. As appropriate to the context and consistent with the Bylaws of the Hospital and delegations of authority made by the Board, it may also mean any committee of the Board or any individual authorized by the Board to act on its behalf on certain matters.
4. **Chief of Staff** means that member of the Active Staff elected pursuant to the Bylaws to be the principal elected officer of the Staff. The Chief of Staff may designate a representative to perform his responsibilities per the Chain of Command Policy in the MSCS Department.
5. **Southwest Facility** means Baylor Medical Center at Southwest Fort Worth, the assumed name under which the Hospital operates its acute care general hospital located at 7100 Oakmont Boulevard, Fort Worth, Texas.
6. **Clinical Privileges** or **Privileges** mean the permission granted pursuant to the Bylaws and related manuals to a practitioner to provide specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.
7. **Credentials Committee or CC** means the Credentials Committee of the Medical Staff.
8. **Dentist** means an individual with a D.D.S. or D.M.D. degree, or its equivalent, who is licensed to practice dentistry and whose practice is in the area of general dentistry or a specialty thereof.
9. **Ex Officio** means service as a member of a body by virtue of office or position held. Unless otherwise expressly provided, an ex officio member of a body has no voting rights, shall not be counted in determining the existence of a quorum, and shall hold the ex officio position only for so long as he/she holds the position upon which the ex officio status is based.
10. **Facilities** mean Baylor Medical Center at Southwest in Fort Worth and Baylor All Saints Medical Center at Fort Worth collectively.
11. **Facility** means Baylor Medical Center at Southwest in Fort Worth or Baylor All Saints Medical Center at Fort Worth.
12. **Fort Worth Facility** means Baylor All Saints Medical Center at Fort Worth, the assumed name under which the Hospital operates its acute care general hospital located at 1400 Eighth Avenue, Fort Worth, Texas.

13. **Hospital** means any entity affiliated with Baylor All Saints Medical Center.
14. **Hospital President** Baylor All Saints Medical Center President means the individual appointed by the Board of Directors as the President of the Hospital to be responsible for the overall executive supervision and management of the Hospital. The Hospital President may, consistent with his responsibilities under the Bylaws of the Hospital, designate a representative to perform his responsibilities under the Medical Staff Bylaws and related manuals.
15. **Medical Staff Executive Committee or MEC** means the Medical Staff Executive Committee.
16. **Medical Staff** or **Staff** is the organizational component of the Hospital that includes all practitioners who are appointed to it.
17. **Medical Staff Bylaws** or **Bylaws** means the Bylaws of the Medical Staff. The Manuals are:
 - Medical Staff Bylaws Manual
 - General Rules and Regulations of the Medical Staff
 - Allied Health Credentialing Procedures Manual
18. **Medical Staff member in good standing** or **member in good standing** means a practitioner who has been appointed to the Medical Staff and who is not under either a full or partial suspension.
19. **Medical Staff Services or MSS** means the Medical Staff Services Department.
20. **Medical Staff Year** means the 12-month period commencing on March 1 of each year and ending on the last day of February of the next year.
21. **Oral Surgeon** means an individual with a D.D.S. or equivalent degree who is licensed to practice dentistry and who has successfully completed an approved postgraduate program in oral surgery.
22. **Physician** means an individual with a M.D. or D.O. degree, who is licensed to practice medicine.
23. **Podiatrist** means an individual with a D.P.M. degree, who is licensed to practice podiatry.
24. **Practitioner** means, unless otherwise expressly provided, any physician, oral surgeon, dentist, or podiatrist who either: (a) is applying for appointment to the Medical Staff and for clinical privileges; or (b) currently holds appointment to the Medical Staff and has specific delineated clinical privileges; or (c) is applying for or is exercising clinical privileges pursuant to the applicable section of the Credentialing Procedures Manual; or (d) is applying for or is exercising temporary privileges pursuant to the applicable section of the Credentialing Procedures Manual.
25. **Prerogative** means a participatory right granted, by virtue of Staff category or otherwise, to a Staff member or allied health professional.
26. **Joint Clinical Governance Committee** or **JCGC** means the Joint Clinical Governance Committee of the Board. This Committee serves as the communication link between the Medical Staff and the Board.
27. **Special Notice** means written notification sent by certified mail, return receipt requested, or by personal delivery service with signed acknowledgment of receipt.
28. **Specified Services** means the permission granted pursuant to the Policies Governing Allied Health Professionals to an AHP to perform specific clinical functions or activities in the treatment of patients.

CONSTRUCTION OF TERMS AND HEADINGS

Words used in the Bylaws and related manuals will be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in the Bylaws and related manuals are for convenience only and are not intended to limit or define the scope or effect of any provision herein.

PREAMBLE

BECAUSE B Baylor All Saints Medical Center is a not-for-profit corporation organized under the laws of the state of Texas to serve as a health care facility providing patient care, graduate and continuing medical education and research, with all of its activities subject to the ultimate authority of its Board of Directors; and

BECAUSE -- The principal purpose of the Hospital is to provide patient care at a level of quality and efficiency consistent with professionally-accepted standards and otherwise to fulfill professional and institutional obligations to patients, students and the community; and

BECAUSE -- Dedication to this purpose requires the cooperative efforts of the practitioners practicing in the Hospital and the Board and Hospital President, with well-defined lines of communication, responsibility and authority throughout the organizational structure; and

BECAUSE -- The laws, regulations, customs and generally recognized professional standards that govern hospitals require that all practitioners practicing at a hospital (except those granted clinical privileges on a temporary basis or for limited purposes) be appointed to the medical staff and that the board of a hospital delegate to that medical staff certain responsibilities relating to, and exact accountability for, the quality, efficiency and overall appropriateness of practitioner performance;

THEREFORE -- These Rules and Regulations and related manuals are created to set forth the framework, principles and procedures within which the Medical Staff shall function and carry out the responsibilities delegated to it.

SECTION I: ADMISSION OF PATIENTS**1.1 TYPES OF PATIENTS**

The Hospital accepts patients for care and treatment in accordance with the Admission Policy adopted by the Board and these Rules and Regulations.

1.2 ADMITTING PREROGATIVES

Only a member in good standing of the Active-Clinical or Courtesy Staff may admit patients to the Hospital, subject to the conditions and limitations set forth in Medical Staff Bylaws and in and the Rules and Regulations and to such other official admitting policies of the Hospital as may be in effect from time to time. Names of members of the Medical Staff who have been suspended and may not admit, or for other reasons may not admit, will be inactivated in the computer system.

1.3 ADMISSION PRIORITIES

The registrar will admit patients based on the following order of priority:

1.3-1 EMERGENCY ADMISSION

The admitting practitioner may declare a case to be an emergency when the patient needs immediate hospital care and his/her condition would suffer if admission were delayed. Prior to referral of an emergency patient for admission, the admitting practitioner must, when possible, call the registrar's office to determine bed availability.

As soon as possible after admission but at least within 24 hours, the admitting practitioner must document findings from the history and physical examination and any applicable tests which clearly justify the emergency admission. Willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee (MEC) for such action as it deems appropriate.

1.3-2 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.

1.3-3 URGENT ADMISSIONS

Those patients whose conditions warrant hospitalization within 24 to 48 hours and whose conditions would suffer if admissions were delayed beyond that period of time.

1.3-4 TRANSFER PATIENTS

If a request for transfer is received from another acute care facility, sufficient clinical information will be obtained to verify that the patient meets admission criteria for the program/level of care before administrative approval for admission is given. Transfers will be handled according to the Policies and Procedures governing the Memorandum of Transfer. All transfers must have an accepting physician.

1.3-5 BEHAVIORAL HEALTH CENTER ADMISSIONS

All Behavioral Health Center admissions will be coordinated through the Behavioral Health Access Service and will follow the policies/procedures of the Behavioral Health Center. Individuals not meeting established criteria for admission will be evaluated for the need for alternative referrals. Alternative referrals will be coordinated with the referring physician.

1.3-6 REHABILITATION UNIT

All Rehabilitation Unit admissions will follow the policies/procedures of the unit.

1.4 ADMISSION INFORMATION

A patient will not be admitted to the Hospital until a provisional diagnosis or valid reason for admission is provided by the practitioner requesting admission. The admitting practitioner is also responsible for providing the following information concerning a patient to be admitted: preadmission approval where the same is required by the Hospital or a third party payor; information known to the admitting practitioner regarding the presence of an advance directive executed by the patient; any source of communicable or significant infection to the extent allowed by Federal and State law; behavioral characteristics that would disturb or endanger others; need for protecting the patient from self-harm.

Where preadmission approval is required and cannot be obtained and the admitting practitioner still feels admission is necessary, the practitioner shall contact the **Director of Care Coordination** prior to directing the patient to the Hospital.

1.5 TIMELY VISITATION AFTER PATIENT ADMITTED/TRANSFERRED

The attending practitioner or his designee (i.e., another member of the Staff in good standing with the requisite privileges to care for the patient) must see the patient in a timely fashion and certainly within 24 hours after the patient is admitted to the hospital. If a baby has been admitted to the Neonatal Intensive Care Unit, the baby must be seen within 4 hours of admission. If a patient is admitted to the Intensive Care Unit, the patient must be seen within 4 hours of admission.

SECTION II: ATTENDANCE OF PATIENTS

2.1 ATTENDANCE OF PATIENTS

2.1-1 PRIVATE PATIENTS

Each private patient will be attended by the practitioner of his choice provided said practitioner is a member of the Medical Staff and has appropriate clinical privileges. When any patient is attended

by two or more members of the Staff, the name of each attending practitioner must be entered

officially on the Hospital records. A private patient applying for admission, whether on an emergency or non-emergency basis, who has no personal practitioner may request any practitioner who is a member of the Medical Staff and who has appropriate clinical privileges. When no such request is made or when the requested practitioner chooses not to undertake the care of the patient, the patient will be assigned to an appropriate Staff member according to the on-call roster of the applicable Department.

- 2.2** Definition of ER Call: The primary purpose of the ER call list is to provide ER physicians with a list of specialists with knowledge and training beyond that of the ER physician. The on-call physicians are to be available to provide consultation in their areas of expertise when requested by the ER physician and without regard either of payor class or to pre-existing physician patient relationships. If the ER physician believes that a prior physician patient relationship would best facilitate prompt care of a patient, the ER physician may choose to consult that prior physician. This does not remove the responsibility of the on-call physician to provide further expertise if needed. ER call is not intended for the purpose of providing physicians for unassigned patients, though that is a consequence of the above responsibilities.

2.3 PARTICIPATION IN THE ON-CALL ROSTER

Each Department Chief shall be responsible for providing a schedule of Department members for purposes of on-call coverage for the Emergency Room. Each Department Chief and Department shall set forth guidelines as to who will take ER call, subject to review by the MEC. Unless specifically exempted by the Department Chief for good cause shown, each member of the Staff assigned to the on-call roster agrees that, when he is the designated practitioner on call, will accept responsibility during the time specified by the published schedule. If there is a conflict with the published schedule, it is the Staff member's responsibility to locate an appropriate replacement and to notify the Medical Staff Services Department prior to the scheduled rotation.

SECTION III: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

3.1 GENERALLY

A physician, oral surgeon, dentist, or podiatrist member of the Medical Staff shall be responsible for:

- (a) the medical, dental, or podiatric care and treatment of each patient in the Hospital, as applicable;
- (b) the prompt completion and accuracy of those portions of the medical record for which he is responsible;
- (c) necessary special instructions; and
- (d) transmitting reports of the condition of the patient to the referring practitioner.

Primary practitioner responsibility for these matters belongs to the admitting practitioner except when transfer of responsibility is affected pursuant to section 3.2. Each patient's general medical condition is the responsibility of a physician member of the Staff.

3.2 TRANSFER OF RESPONSIBILITY

When primary responsibility for a patient's care is transferred from the current attending practitioner to another Staff member, notes by the respective practitioners covering the transfer of responsibility and acceptance of the same must be entered on the order sheet and progress notes.

The current attending practitioner must continue responsibility for the patient's care until transfer of responsibility is accepted and documented as indicated herein by the second practitioner.

3.3 ALTERNATE COVERAGE

Each practitioner must assure timely, adequate professional care for his patients in the Hospital by being available or designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this Hospital to care for the patient.

Each member of the Staff who will be out of town or unavailable in case of emergency must identify to the Medical Staff Services Department a qualified practitioner, who is a member of the Medical Staff, and who will assume responsibility for the care of the patient during his absence. Upon notification that a physician failed to provide call coverage in his absence, the Chief of the Department will be contacted for appropriate action. Failure of an attending practitioner to meet these requirements may result in loss of Staff appointment or such other disciplinary action as deemed appropriate under the circumstances.

3.4 ORAL SURGEONS

An oral surgeon who has successfully completed an accredited postgraduate/residency program in oral/maxillofacial surgery and who demonstrates current competence in performing a complete history and physical examination may be granted the privileges to do so and to assess the medical risks of the proposed procedure to the patient. Consultations will be obtained when appropriate. In all circumstances, a physician member of the Medical Staff must be consulted for the care of any medical problem that is known or identified at admission or that arises during hospitalization.

3.5 DENTISTS AND PODIATRISTS

By preadmission arrangement, a physician (MD/DO) member of the Medical Staff must perform a basic medical appraisal on a dental/podiatric patient prior to the day of surgery. The physician and the dentist/podiatrist must assess the risk and effect of any proposed procedure on the total health status of the patient. When significant medical abnormality is present, the final decision on whether to proceed must be agreed upon by the dentist/podiatrist and the physician consultant. The Chief of Surgery will decide the issue in case of dispute. In all instances, a physician member of the Medical Staff must be responsible for the care of any medical problem that is present at admission or that arises during hospitalization.

The dentist/podiatrist is responsible for documenting in the medical record, in a timely fashion, a complete and accurate description of the services he provides to the patient. More specifically, the dentist/podiatrist is responsible for the following:

- (a) A detailed dental/podiatric history and description of the dental/podiatric problem documenting the need for hospitalization and any surgery;
- (b) A detailed description of the examination of the oral cavity/foot and a preoperative diagnosis;
- (c) An immediate and complete operative report, describing the findings, technique, specimens

removed, and the postoperative diagnosis.

- (d) Daily progress notes as are pertinent to the dental/podiatric condition;
- (e) Pertinent instructions relative to the dental/podiatric condition for the patient and/or significant other at the time of discharge;
- (f) Making appropriate transfer of responsibility or coverage arrangements for the patient's dental/podiatric care as necessary and required under sections 3.2 and 3.3 of these Rules and Regulations;
- (g) Clinical resume or final discharge summary note; and
- (h) Writing the discharge order for the patient unless the principal attending practitioner on the case has become the physician responsible for the patient's medical problems.

3.6 DOCUMENTING NEED FOR CONTINUED HOSPITALIZATION

Upon request of the Medical Staff Quality Council or a representative thereof charged with conducting utilization review, the attending practitioner must provide written justification of the need for continued hospitalization of any patient. This documentation must include:

- (a) An adequate written record of the reason for continued hospitalization. Simple reconfirmation of the patient's diagnosis is not sufficient.
- (b) Estimated period of time the patient will need to remain in the Hospital.
- (c) Plans for post-hospital care.

The report must be submitted within twenty-four (24) hours of the request.

3.7 POLICY CONCERNING IMMEDIATE QUESTIONS OF CARE

If a nurse or other health care professional involved in the care of a patient has any reason to doubt or question the care provided to that patient by a particular practitioner or feels that appropriate consultation is needed and has not been obtained, such individual shall bring the matter to the attention of the individual's Supervisor. The Supervisor may follow-up directly with the practitioner or AHP involved or may bring the matter to the attention of the Chief of the applicable Department. In the latter instance, the Department Chief shall take such action as is deemed warranted by the circumstances.

3.8 CONSULTATIONS

3.8-1 RESPONSIBILITY

The good conduct of medical practice includes the proper and timely use of consultation. The attending practitioner is primarily responsible for initiating a consult and, in general, responsible for contacting the physician to directly relay relevant patient information when indicated or required pursuant to the guidelines in section 3.8-2 below. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending practitioner.

When a consultation is required under these Rules or when the best interests of the patient will be served, any of the following may direct that a consultation be held and, if necessary, arrange for it: the applicable Department or Section Chief; the physician director of a special unit; the Chief of Staff.

3.8-2 GUIDELINES FOR CALLING CONSULTATIONS

Guidelines for calling consultations are as follows:

- (a) If an intensive care patient regardless of which intensive care unit the patient resides, has not already been seen by a critical care physician upon admission, then the attending physician must request a consult from an approved critical care physician within 24 hours. The consulting physician must see the patient within four (4) hours. (Single organ hearts are excluded from this consultation)
- (b) When the rules of any clinical unit, including any intensive or special care units, or the Staff require it.
- (c) When required by state law.
- (d) When requested by the patient or family.
- (e) Problems of critical illness when doubt exists as to the appropriate diagnostic or therapeutic measures to be utilized.
- (f) When additional expertise is needed for appropriate patient care.

3.8-3 QUALIFICATIONS OF CONSULTANT

Any qualified practitioner may be called as a consultant regardless of his Staff category assignment. A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty board or by appropriate clinical privileges at the Hospital. If a consultant who is not a member of the Medical Staff is to provide direct treatment or orders, he must apply for and receive temporary privileges. If a consultant who is not a member of the Medical Staff is desired for the purpose of providing a written opinion on a patient's care but not for direct treatment or orders, a written request must be sent to and permission must be obtained from the Chief of the applicable Department or Section.

3.8-4 DOCUMENTATION

- (a) Consultation Request: When requesting consultation, the attending practitioner must indicate in writing on the record the reason for the request. The attending practitioner must initiate, by personal communication, the request by calling the consulting physician. It shall otherwise be assumed that requests for orders and follow-up on the particular problem have been initiated. If consultation and opinion only is desired, it should be documented in the progress notes.
- (b) Consultant's Report: The consultant shall see the patient within 24 hours (unless extenuating circumstances make early consultation not reasonable)

after receiving the request or sooner if circumstances so dictate. Immediately after seeing the patient, the consultant must make, date and sign a report of his findings, opinions and recommendations that reflects an actual examination of the patient and the medical record. Such report shall become part of the patient's medical record. When operative procedures are involved, a consultation note shall, except in emergency situations as verified on the record, be recorded prior to the operation.

- (c) Attending Practitioner's Response to Consultant's Opinion: In cases of elective consultation when the attending practitioner elects not to substantially follow the advice of the consultant, he shall record in the progress notes his reasons for electing not to follow the consultant's advice and/or seek the opinion of a second consultant. If the consultant physician has strong concerns about the potential consequence of the attending physician's failure to follow advice, he may refer relevant information to the Department or Section Chief. In cases of required consultation when the attending practitioner does not agree with the consultant, he shall either seek the opinion of a second consultant or refer the matter to the applicable Department or Section Chief for final advice.

3.9 ASSISTANTS AT SURGERY

When major surgery is being performed, there shall always be a qualified assistant scrubbed and present throughout the procedure that is capable of protecting the patient in the event of incapacity of the surgeon until a qualified surgeon can be summoned to complete the case. The primary operating surgeon shall determine the level and number of assistants required (e.g., qualified nurse or surgical technician/assistant, qualified surgeon, other qualified physician) commensurate with the following parameters:

- (a) Gravity and complexity of the procedure being undertaken.
- (b) Generally recognized professional standards of care for the performance of the procedure.
- (c) Particular medical conditions which the patient may have which require active care during surgery.
- (d) Any other exceptional circumstances present.

3.10 PERSONS PERMITTED IN OPERATING ROOMS

3.10-1 RELATIVE/FRIEND

When a patient is being prepared for surgery and is in the surgical suite, no relative or friend of the patient will be permitted to visit or stay in the surgical suite. This rule shall apply to all types of cases with the exception of Obstetrics (up to 2 relatives or friends may be permitted in the surgical suite at the discretion of the Obstetrician). This rule does not apply to the Recovery Room.

3.10-2 OBSERVATION

By invitation of the operating surgeon, a non-staff person will be permitted to observe surgical procedures under the direct sponsorship of the operating surgeon. The

applicant and physician must complete the Observation Application, and consent of the patient must be obtained. The completed application will be reviewed by the Department Chief and Director of Surgery.

3.11 MASS CASUALTY ASSIGNMENTS

All Staff members shall be assigned to posts in the Hospital, in an auxiliary hospital, or in mobile casualty stations as provided in the Hospital Emergency Preparedness Plan. All Staff members specifically relinquish triage of the professional care of their patients in case of such an emergency.

3.12 SPECIAL TREATMENT PROCEDURES

Justification for the following special treatment procedures must be documented in the medical record prior to the initiation of the treatment. A physician's order is required for the use of all restraints. If a restraint order is given by a physician other than the attending physician, the attending physician should be notified as soon as possible. Emergency use of restraints may be initiated before obtaining a physician's order when the assessment by a qualified R.N. determines the need for immediate intervention. The physician's order will be obtained within one (1) hour for all restraints except those used in Special Care Areas under protocol. In those cases, an order will be obtained within twelve (12) hours. Verbal orders will be followed by written order within twenty-four (24) hours. **PRN orders will not be utilized for restraints of any type at any time.** Restraints will not be continued beyond a twenty-four (24) period without a physician face-to-face examination and a personally signed, dated and timed renewal order. Restraints will not be continued beyond the time the patient meets criteria for discontinuation.

- (a) **Restraint Use in Medical/Surgical Areas For Patient Well Being:** Restraint use will be limited to clinically appropriate and adequately justified situations when less restrictive interventions have been determined to be ineffective. Clinical justification for restraint use for improvement of patient well being include altered mental status secondary to medical condition, disruption of tubes/sutures/dressings/drains, or potential for fall/injury. At the time of initiation of restraint, behavioral criteria for discontinuation are specified.
- (b) **Restraint Use in Medical/Surgical Areas for Patient Behavioral Management:** Restraint use will be limited to clinically appropriate and adequately justified situations for behavioral management of the patient when less restrictive interventions have been determined to be ineffective. Clinical justification for restraint use for behavioral management includes actual or potential intentional self-harm, actual or potential intentional harm to others, intentional destruction/serious disruption of the environment and disruption of care of other patients/infringement on the rights of other patients.
 - **Note:** When restraint is used for behavioral management and the physician is not present at the time of restraint initiation, a physician or authorized behavioral health nurse must do a face-to-face examination of the patient is required within one (1) hour to validate the need for restraint. Such examination/validation will be documented in the Physician Progress Note section of the patient record on the Face to Face Review Form. Restraints for Behavioral Management will not be continued beyond an eight (8) hour period without a physician face-to-face examination and a personally signed, dated, and timed renewal order..
- (c) **Restraint and Seclusion Use in Behavioral Health Units:** Restraint and seclusion use will be limited to clinically appropriate and adequately justified situations for behavioral

management of the patient when less restrictive interventions have been determined to be ineffective. Clinical justification for restraint use for behavioral management includes actual or potential self-harm or actual or potential harm to others.

- **Note:** Each order for restraints or seclusion is limited to four (4) hours).
- **Note:** When restraint or seclusion is used for behavioral management and the physician is not present at the time of restraint initiation, a physician or authorized behavioral health nurse must do a face-to-face examination of the patient is required within one (1) hour to validate the need for restraint. Such examination/validation will be documented in the Physician Progress Note section of the patient record on the Face to Face Review Form. Restraint or Seclusion will not be continued beyond a eight (8) hour period without a physician face-to-face examination and a personally signed, dated, and timed renewal order.

- (d) **Electroconvulsive Therapy:** The major indications for the therapeutic use of ECT are major depressive disorder, bipolar disorder and schizophrenic disorder. Space occupying intracranial pathology is an absolute contraindication. Current pregnancy is an absolute contraindication at this Hospital. Only voluntary treatment is used at this Hospital. The treating physician complies with all State regulations including those related to medical evaluation, consent, consultation, limitations on use, and personnel and equipment.

3.13 MODERATE SEDATION

Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands. The ability to independently and continuously maintain a patent airway and allow protective reflexes will be assured throughout the administration process. (This sedation is not intended to result in the loss of protective reflexes or spontaneous or unassisted ventilation.) Physicians desiring to administer moderate sedation must apply for and be granted the privilege. Physicians may complete the programs and take the exam by going online to <http://www.webinservice.com/BHCS> . **Physicians will not be granted the moderate sedation privilege until the program and test have been completed.**

SECTION IV: TRANSFER OF PATIENTS

4.1 INTERNAL TRANSFER

Internal patient transfer priorities are as follows:

- (a) Emergency patient to an appropriate patient bed
- (b) From obstetric patient care area to general care area
- (c) From intensive care units to general care area
- (d) From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

A patient shall be transferred only upon the order of the attending practitioner.

4.2 TRANSFERS TO ANOTHER FACILITY

4.2-1 GENERAL REQUIREMENTS

Except as provided in this section 4.2-1, a patient shall be transferred to another medical care facility only upon the order of the attending practitioner:

- only after a receiving physician has been obtained;
- only after arrangements have been made for admission with the other facility, including its consent to receiving the patient; and
- only after the patient is considered sufficiently stabilized for transport.

All pertinent medical information necessary to insure continuity of care must accompany the patient. Any such transfer shall also be in compliance with any applicable state or federal laws and regulations. The attending physician will verify the transfer on the MOT and Consent to Transfer.

4.2-2 DEMANDED BY EMERGENCY OR CRITICALLY ILL PATIENT

A transfer demanded by an emergency or critically ill patient or his family or legal guardian is not permitted until a physician has explained to the patient or his family or legal guardian the seriousness of the condition and generally not until a physician, who is physically present, has determined that the condition is sufficiently stabilized for safe transport. In each such case, the appropriate release form is to be executed. If the patient or agent refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

SECTION V: DISCHARGE OF PATIENTS

5.1 DISCHARGE PLANNING

In collaboration with Social Work and Care Coordination personnel and the nursing staff, the attending practitioner shall make arrangements as early as possible after admission for anticipated discharge problems and post-discharge care of patients who may require aftercare.

Discharge planning may include notification of physicians when medical record documentation does not substantiate an admission or continued stay.

5.2 REQUIRED ORDER

A patient may be discharged only on the order of the attending practitioner. Documentation of the order must be in the patient's record.

5.3 DISCHARGE PROCEDURES

The attending practitioner is responsible for discharging his patients in a timely fashion so that new admissions may be accommodated. Whenever possible, patients are requested to arrange to be discharged by 11AM on the day of their discharge.

5.4 LEAVING AGAINST MEDICAL ADVICE

If a patient desires to leave the Hospital against the advice of the attending practitioner or without proper discharge, the attending practitioner shall be notified and the patient will be requested to sign the appropriate release form indicating that he realizes he is leaving against medical advice. If a patient leaves the Hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident must be made in the patient's medical record. The attending physician is expected to explain to the patient in person or via the nurse the risks of leaving against medical advice.

Patients may not be restrained or detained in any way (exception: Behavioral Health Unit) unless the patient has been determined to be incompetent or is immediate harm to himself.

5.5 DISCHARGE OF MINOR OR INCOMPETENT PATIENT

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he shall so state in writing and the statement must be made a part of the patient's medical record.

SECTION VI: ORDERS

6.1 GENERAL REQUIREMENTS

Except as may be expressly specified in the policies specific to a particular category of allied health professionals (AHP) or in an AHP's individual delineation of specified services, only practitioners with delineated clinical privileges may issue orders for treatment or diagnostic procedures. All orders for treatment or diagnostic tests must be written clearly, using abbreviations only as appropriate, legibly and completely signed and dated by the practitioner or AHP responsible for them. Orders which are illegible or improperly written will not be carried out until rewritten or clarified with the individual responsible for carrying them out. Orders for diagnostic tests which necessitate the administration of test substances or medications will be considered to include the order for this administration. **Note: The physician must submit orders for the patient within one (1) hour of admission.**

Orders for patients transferred to a higher or lower level of care must be rewritten. **The use of the terms "renew," "repeat," and "continue", for all hospital initiated orders, is acceptable provided it is clear to which order(s) the term refers. The use of the terms "resume prep orders" is not acceptable.** In all instances in which the Medical Staff or a unit or committee thereof has established a designated form for use when renewing, repeating or continuing orders,

that form must be utilized. Continue home meds will not be an accepted order unless home meds are listed individually.

6.2 STANDARDIZED OR PREPRINTED ORDERS

Standardized orders may be formulated for any Department, Division or other clinical unit by the Department Chief, Division Chief or the medical director of the unit in consultation with other appropriate representatives of the Medical Staff and with appropriate representatives of Nursing Service and other Hospital departments. A member of the Medical Staff may formulate standardized orders for his own use.

All standardized orders shall be listed on a "Physician's Orders" sheet that must be included in the patient's medical record and signed and dated by the attending practitioner. Standardized orders shall be considered as a specific order by the attending practitioner for that patient and shall be followed in the absence of other specific orders by the attending practitioner, insofar as the proper treatment of the patient will allow. All standardized orders and routine procedures within a Department, Section or unit must be regularly reviewed by the originator for confirmation or change with re-issuance of orders indicated by signature and date.

6.3 VERBAL ORDERS

6.3-1 BY WHOM AND CIRCUMSTANCE

Telephone or other verbal orders, including an order to write an order, may be taken only by a duly authorized person functioning within a defined sphere of competence. Such a "duly authorized person" must be a practitioner member of the Medical Staff, an AHP as defined in the policies specific to that category of AHPs, a registered nurse, a licensed vocational nurse, a registered pharmacist, a graduate or certified respiratory therapist technician, a graduate or registered respiratory therapist, a registered cardiopulmonary technologist, a licensed physical therapist, a licensed radiology technician, a registered occupational therapist, social worker, or a certified speech pathologist. CRNA's will be able to issue orders for the purpose of drug administration or ordering medications, with the authority of an authorized representative of the supervising physician. Such orders shall be treated as verbal orders requiring co-signature.

Telephone orders will be accepted only from the responsible practitioner or an authorized representative of the practitioner. The representative of the practitioner must identify himself when transmitting orders.

The hospital requires a verification "read back" of all verbal and telephone orders by the person receiving the order.

Diagnostic or therapeutic verbal orders which may represent a potential hazard to patients include: AND orders. Under extraordinary circumstances a telephone AND order can be taken by two nurse witnesses, but should be countersigned and accompanied by an appropriate progress note within 24 hours.

6.3-2 DOCUMENTATION

All verbal orders shall be transcribed in the proper place in the medical record, shall include the date, time, name and signature of the person transcribing the order and the name of the practitioner giving the order. All verbal orders shall be signed, dated and

6.4 ORDERS BY ALLIED HEALTH PROFESSIONALS

An allied health professional (AHP) may write orders only to the extent, if any, specified in applicable Hospital policies, in the position description developed for that category of AHP, and consistent with the scope of services individually defined for him, and allowed by law.. Orders by an AHP must be countersigned by the attending practitioner within 24 hours of the AHP's order, with the exception of Certified Nurse Midwives for normal deliveries. When medication dosing or therapy is delegated to Pharmacy by order or protocol, a subsequent physician countersignature is not required.

6.5 AUTOMATIC CANCELLATION OF ORDERS

All previous orders are automatically discontinued when the patient is transferred to or from critical care areas or surgery. The medical record shall be flagged to indicate this has occurred. The attending practitioner must indicate on the order sheet that the listing was noted by either so stating, reinstating all or some of the orders, or referring to another practitioner for a decision on whether or not to reinstitute all or particular orders.

6.6 STOP ORDERS

The Pharmacy and Therapeutics Committee will establish policies regarding the regular evaluation and continuation of high risk medications.

6.7 PATIENT'S OWN DRUGS AND SELF-ADMINISTRATION

The Pharmacy and Therapeutics Committee will establish policies regarding the self administration of drugs.

6.8 FORMULARY AND INVESTIGATIONAL DRUGS

6.8-1 FORMULARY

The Hospital Formulary lists drugs available for ordering from stock. Each member of the Medical Staff assents to the use of the Formulary. Drugs used in the Hospital shall be listed in the latest editions of United States Pharmacopeias, National Formulary, American Hospital Formulary Service, AMA Drug Evaluations, and Food and Drug Administration (FDA) approved drugs listed in Facts and Comparisons and Pharm Index.

6.8-2 NON-FORMULARY DRUGS

If the drug is not included in the Formulary, procedures defined by the Pharmacy and Therapeutics Committee, and approved by the MEC, will be followed.

6.8-3 INVESTIGATIONAL DRUGS

Use of any investigational drugs must be approved by the Baylor Research Institute.

6.9 MEDICATION ORDERS

All orders for prn medications require an indication, except for categories of medications determined by the Pharmacy and Therapeutics Committee approved policy where it is understood that there is only one use for the medication.

SECTION VII: MEDICAL RECORDS

7.1 REQUIRED CONTENT

The attending practitioner and other Medical Staff members, as applicable, and House Staff involved in the care of the patient shall be responsible for the preparation of a complete and legible medical record for each patient. The attending physician will be responsible for the medical record requirements. All entries in the medical record (including progress notes) must be legible, completed dated, timed and authenticated (signed) in written or electronic form. All entries by AHP must be co-signed, dated and timed by the covering practitioner on the next visit, with the exception of Certified Nurse Midwives for normal deliveries. The record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the course and results accurately. The record's content shall be pertinent, accurate, legible, timely and current. The record shall include:

- (a) Identification data
- (b) Personal and family medical histories to include allergies to food & medications
- (c) Description and history of present complaint and/or illness
- (d) Summary of psychosocial needs, appropriate to age and diagnosis
- (e) Physical examination report
- (f) Diagnostic and therapeutic orders
- (g) Evidence of appropriate informed consent
- (h) Treatment planned and provided
- (i) Progress notes and other clinical observations, including results of therapy
- (j) Special reports, when applicable (such as, clinical laboratory, radiology, radiotherapy, EEG, EKG, consultation, pre- and post-anesthesia, operative and other diagnostic and therapeutic procedures, etc.)
- (k) Pathological findings
- (l) Final diagnosis without the use of symbols or abbreviations
- (m) Condition on discharge, including instructions, if any, to the patient or significant other on post-hospital care
- (n) Autopsy report, when available
- (o) Advance directive.

7.2 HISTORY AND PHYSICAL EXAMINATION AND ADMISSION NOTE

7.2-1 GENERALLY

Except as provided elsewhere in these rules, a complete history and physical examination must be completed within 24 hours after admission to a hospital unit. If an authorized allied health professional performs the history and physical, the attending physician must approve or correct it and sign it within 24 hours. The H&P may be dictated or written in Progress Notes or on a Short Stay Form (stays up to 48 hours only).

The history and physical examination report must include:

- the chief complaint
- details of the present illness
- all relevant past medical, social and family histories
the patient's emotional, behavioral and social status when appropriate
all pertinent (positive and negative) findings resulting from a comprehensive, current assessment of all body systems
- a statement of the conclusions or impressions drawn from the history and physical
- the goals of treatment and the treatment plan

Pediatric: The pediatric history must include childhood illnesses, development relative to age and immunizations. Pediatric records must evaluate needs relevant to education and daily activities and the family/guardians expectations for involvement in the patient's care as appropriate for the patient's condition and duration of hospitalization.

Behavioral Health: A Behavioral Health evaluation must be completed within 60 hours of admission in addition to the H&P required within 24-hours. The evaluation must include record of mental status, note the onset of illness and the circumstances leading to admission, describe attitudes and behavior; estimate intellectual functioning, memory functioning and orientation; and, an inventory of the patient's assets. For outpatient ECT procedures, a H & P performed within 30 days and the required Interval Note must be placed on the record at the time of the initial procedure. Interval notes shall be entered into the record to denote changes in the patient's condition. The H & P shall be repeated annually for patients receiving ongoing outpatient therapy.

Emergencies: For an emergency admission, a brief description of the patient's condition should be immediately noted in/affixed to the chart pending return of the complete history and physical. (See 7.3-1 of these Rules.)

7.2-2 USE OF REPORTS PREPARED PRIOR TO CURRENT ADMISSION

If a qualified member of the Hospital's Medical Staff has obtained a complete history and has performed a complete physical examination within 30 days prior to the patient's admission to the Hospital, a durable, legible copy of the report may be used in the patient's Hospital medical record provided it has an update to the patient's condition since it was last assessed. Any changes that may have occurred are dated and signed in the medical record at the time of admission or within the first 24 hours. If there are no changes, state "no changes", date, time and sign.

Updates to patient's conditions that places the patient at risk (as defined by the organization) and/or involves the use of sedation or anesthesia pre outpatient surgery will be documented in the Pre and Post Anesthesia documentation or progress notes prior to the procedure.

7.3 PREOPERATIVE DOCUMENTATION

7.3-1 HISTORY AND PHYSICAL EXAMINATION

A relevant history and physical examination is required to be on the chart on each patient prior to having surgery or other procedures or treatment in which general or

regional anesthesia or IV sedation is used. Except in an emergency so certified in writing by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed until after the preoperative diagnosis, history, physical examination, and required laboratory tests have been recorded in the medical record. If not recorded, the preoperative medication shall not be administered and the procedure will be rescheduled.

Preoperative documentation must include a statement that the physician has explained the risks, benefits and alternatives to the patient (can be done on consent form if the physician signs the consent form). The risks, benefits and alternatives and may be documented in the H & P, progress note or on the consent form.

In cases of emergency, the responsible practitioner shall, prior to induction of anesthesia and start of the procedure, make at least a comprehensive note regarding the patient's condition. This note should state the basic nature of the proposed surgery/procedure and the condition for which it is to be done, the condition of the heart and lungs, allergies known to be present, and other pertinent pathology and information relating to the patient. The history and physical examination shall be recorded immediately after the emergency surgery has been completed.

7.3-2 CLINICAL LABORATORY TESTS AND X-RAYS

Appropriate advance lab tests, EKGs, and x-rays must be performed within guidelines developed by the Departments of Surgery and Anesthesiology for elective surgery and for outpatient or same day surgery and the results in the chart prior to induction of anesthesia. Reports from laboratories outside the Hospital may be acceptable provided the laboratory is appropriately accredited, and the test is recent enough to be pertinent. Examinations or procedures (radiologic or pathologic) performed outside the Hospital may be submitted to the appropriate Hospital Department for review at the discretion of the operating surgeon.

7.3-3 ANESTHESIA EVALUATION

The anesthesiologist or nurse anesthetist responsible for the patient's anesthesia care must conduct, document and sign a pre-anesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, ASA patient status classification, and orders for preoperative medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered. The anesthesiologist or nurse anesthetist responsible for the patient's anesthesia care must also conduct, document and sign a post-anesthesia follow-up of the patient's condition. If the anesthesia is administered on an outpatient basis, or, the patient is discharged from the hospital within 72-hours of the procedure, no post-anesthesia follow-up note is required.

7.3-4 SURGICAL SITE VERIFICATION

The patient, nursing staff, Anesthesiology and the physician shall all participate in verifying the correct surgical/procedure side/site using the universal to conduct "time out" and complete the appropriate documentation according to hospital policy.

7.4 PROGRESS NOTES**7.4-1 GENERALLY**

Pertinent progress notes must be recorded at the time of observation must be sufficient to permit continuity of care and transferability of the patient and shall be dated and signed. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders, with reasons for instituting various tests or treatment given and results of tests and treatments recorded. Progress notes by the attending practitioner or alternate must be written at least daily on all general hospital patients. The attending practitioner will document reasons for not addressing any abnormal tests. In all other instances, progress notes must be written on a timely and pertinent basis to provide an accurate chronological report of the patient's condition. Progress notes written by a physician-directed allied health professional must be countersigned within 24 hours by the responsible supervising practitioner, with the exception of Nurse Midwives. Any significant complication will have a physician note on the chart in accordance with our consultation guidelines outlined in the privileges document and our clinical practice guidelines. All patients who have an operative delivery (forceps, cesarean section) will have a physician note in accordance with the standards for surgical patients.

7.4-2 BEHAVIORAL HEALTH PATIENTS

A psychiatric Evaluation must be performed for all patients admitted for Behavioral Health Services within 24 hours for inpatients and by the 2nd treatment day for outpatients. The Evaluation must include:

1. Current complaint, present illness.
2. Post psychiatric chemical dependency history.
3. Relevant past medical history.
4. Current medical illness/issues.
5. Current medications.
6. Allergies.
7. Family/psychosocial history.
8. Mental Status Exam.
9. Risk Assessment.
10. Personal strengths/assets.
11. Provisional diagnosis.
12. Program.
13. Initial treatment plan.
14. Projected LOS.

7.4-3 ADVANCE DIRECTIVE

The medical record must indicate whether or not the patient has a signed advance directive. Healthcare professionals shall honor advanced directives within the limits of the law and the hospitals capabilities. The medical record must contain documentation which justifies the effectuation of an advance directive.

7.5 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS**7.5-1 OPERATIVE AND SPECIAL PROCEDURE REPORTS**

Operative and special procedure reports must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed (if any), the postoperative diagnosis, estimated blood loss, and the name of the primary performing practitioner and any assistants. The operative report must be dictated or otherwise entered into the medical record immediately following surgery for inpatient and outpatient procedures and prior to the patient moving to another level of care. If the report is dictated and not immediately transcribed or not dictated or not written in the record immediately after the procedure, the practitioner must enter a comprehensive operative progress note in the medical record immediately after the procedure. This note must provide sufficient and pertinent information for use by any practitioner who is required to attend the patient, including the indications for the procedure, findings and complications.

7.5-2 TISSUE EXAMINATION AND REPORTS

All tissues removed during a procedure, except term placentas of normal deliveries, and foreskin of newborn, shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the Hospital's Department of Pathology. The specimen(s) must be accompanied by a form completed, signed and dated by the operating practitioner or his designee in the OR indicating any pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. An authenticated report of the pathologist's exam shall be made a part of the medical record. When an autopsy is performed, provisional anatomic findings are recorded in the record within three (3) days, and the complete protocol is documented within ninety (90) days.

7.6 OBSTETRICAL RECORD

The current obstetrical record must include a complete prenatal record. The prenatal record may be a durable, legible photocopy of the attending physician's office or clinic original record transferred to the Hospital before admission. An interval admission note, either handwritten in the progress notes or on the designated form, that includes pertinent additions to the history or any subsequent changes in the physical findings must be prepared, signed and dated by the responsible practitioner.

7.7 ENTRIES AT CONCLUSION OF HOSPITALIZATION/SERVICE**7.7-1 OUTPATIENT PROBLEM LIST**

A Problem List will be maintained for all patients who receive continuing ambulatory services and have more than three visits to the same service. The List will include diagnoses, procedures, allergies and medications with dates of entry for each. The List shall be retained in the front of the medical record for the series of care to which it refers.

- (a) **In General:** A discharge summary, discharge note, or transfer summary must be recorded for all patients. The summary must recapitulate concisely the reason for hospitalization, the significant findings including complications, the procedures performed and treatment rendered, the condition of the patient on discharge stated in a manner allowing specific comparison with the condition on admission, discharge instructions, and principal and secondary diagnoses-
- (b) A final discharge note may be substituted for the discharge summary in the case of the following categories of patients: (1) those with problems of a minor nature and observation patients who require less than 48 hours of hospitalization; (2) normal newborn infants; (3) patients having uncomplicated vaginal deliveries; (4) patients who have outpatient surgery or special procedures (general or local anesthesia, Endoscopy, Cardiac Catheterization, or ECT). Discharge notes may be dictated or written in Progress Notes (provided the note is labeled "Discharge Note") or on a Short Stay Form.
- (c) A transfer summary may be substituted for the Discharge Summary in the case of the transfer of the patient to a different level of hospitalization or residential care within the organization.
- (d) For patients undergoing a series of outpatient treatments, a discharge note shall be documented at the end of the series of treatments.
- (e) The dictated Rehabilitation Discharge Assessment from the Rehabilitation Medical Director will be accepted as the Discharge Summary for Rehabilitation Unit patients provided the report meets JCAHO requirements.

7.7-3 INSTRUCTIONS TO PATIENT

The discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet and follow-up care.

7.8 AUTHENTICATION

Signature stamps are approved for outpatient use only and not for the use in the inpatient medical record. If used in the inpatient medical record, then the signature stamp must be authenticated with an original signature. Acknowledgments for the use of signature stamps will be filed in Medical Staff Services for those physicians who choose to use them. The acknowledgment states that the signature stamp must be in the control of the physician and that they will not allow unauthorized use of the stamp. Signature stamps must include the physician's complete signature. Opinions requiring medical judgment should be written, or authenticated, only by individuals who have been granted appropriate clinical privileges.

The following areas of the medical record require the responsible practitioner's signature. Unless otherwise indicated by appropriate remarks, the signature of the responsible practitioner constitutes approval of the information recorded.

- (a) History and physical examination
- (b) All operative or special procedure reports

- (c) Discharge summary
- (d) All clinical entries, diagnoses, orders, reports and progress notes personally written or faxed by the practitioner
- (e) Consultation reports.

A record shall be considered incomplete until all physician signatures are affixed. The responsible practitioner includes: attending physician, partners of the attending physician, physicians taking call for another physician and Medical Directors of a Department of the Medical Staff.

7.9 MEDICAL RECORD COMPLETION REQUIREMENTS AND ENFORCEMENT POLICIES

7.9-1 COMPLETION REQUIREMENTS AND SUSPENSION PROCESS FOR MEDICAL RECORDS

The requirements and suspension process for: 1) failure to complete medical records; 2) extended leave or vacation; 3) repetitive infractions; and 4) reporting to the Texas Medical Board are stated under Section XIX General Provisions, 19.3 and shall be governed by HIM policies and procedures.

7.10 USE OF SYMBOLS AND ABBREVIATIONS

Certain abbreviations have been designated as unsafe practice. Physicians and staff are expected not to use any abbreviations on the non-approved list.

7.11 FILING

No medical record shall be filed until it is complete and properly signed ***with the exception of 19.3-3 of the General Provisions***. In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the Medical Records Department (following departmental policy) will affix a statement to the front of the medical record and file it as an incomplete medical record.

7.12 OWNERSHIP AND REMOVAL OF RECORDS

All original patient medical records, including x-ray films, pathological specimens and slides, are the property of the Hospital and may be removed only in accordance with a court order, subpoena or statute, or with the permission of the Hospital President. Copies of records, films, slides, etc. may be released for follow-up patient care only upon presentation of appropriate authorization and fees for duplication. Unauthorized removal of a medical record or any portion thereof from the Hospital is grounds for such disciplinary action, including immediate and permanent revocation of Staff appointment and clinical privileges, as determined by the MEC and JCGC.

7.13 ACCESS TO RECORDS

7.13-1 BY PATIENT

A patient may have access to all information contained in his medical record, unless access is specifically restricted by the attending practitioner for medical reasons or is prohibited by law.

7.13-2 BY PHYSICIAN NOT ON CASE

To maintain HIPAA compliance a physician who is not associated with the care of a patient may not view the record without permission from the patient.

7.13-3 FOR STATISTICAL PURPOSES AND REQUIRED ACTIVITIES

Patient medical records shall also be made available to authorized Hospital personnel, Medical Staff members or others with an official, Hospital-approved interest for the following purposes:

- (a) Automated data processing of designated information
- (b) Activities concerned with assessing the quality, appropriateness and efficiency of patient care
- (c) Clinical unit/support service review of work performance
- (d) Official surveys for Hospital compliance with accreditation, regulatory and licensing standards
- (e) Bona fide and approved educational programs and research studies consistent with preserving the confidentiality of personal information concerning the individual patients.

Use of a patient record for any of these purposes shall be such as to protect the patient, insofar as possible, from identification, and confidential personal information extraneous to the purposes for which the data is sought shall not be used.

7.13-4 ON READMISSION

In the case of readmission of a patient, all previous records shall be available for use of the current attending practitioner. This shall apply whether the patient is attended by the same practitioner or another.

7.13-5 TO FORMER MEDICAL STAFF MEMBERS

Subject to the discretion of the Chief Operating Officer, former members of the Medical Staff shall be permitted access to information from the medical records of their patients for all periods during which they attended such patients in the Hospital.

7.13-6 PATIENT CONSENT REQUIRED UNDER OTHER CIRCUMSTANCES

Written consent of the patient or his legally qualified representative is required for release of medical information to persons not otherwise authorized under this section 7.14 or by law to receive this information.

SECTION VIII: CONSENTS**8.1 GENERAL**

Each patient's medical record must contain evidence of the patient's or his legal representative's general consent for treatment during hospitalization. When so notified and except in the case of an emergency, it shall be the admitting practitioner's responsibility to obtain proper consent before the patient is admitted to the Hospital.

8.2 SPECIFIC INFORMED CONSENT**8.2-1 WHEN REQUIRED AND RESPONSIBILITY TO OBTAIN**

In accordance with Texas law, the relevant practitioner is responsible for obtaining the informed consent of the patient or person authorized to consent for the patient for the procedures and treatments set forth in Section 4590i Tex. Rev. Civ. Statute. Ann. (Lists A & B). Hospital staff may only witness the execution of an appropriately completed consent form after the relevant practitioner has imparted and documented the necessary information to obtain an informed consent under Texas Law.

8.2-2 INFORMATION REQUIRED

The information required to obtain an informed consent shall include:

- (a) Specific nature of the procedure or treatment;
- (b) Name(s) of the individual(s) who will perform the procedure or administer the treatment;
- (c) Advantages and disadvantages of the treatment/procedure.
- (d) Chances for a successful outcome.
- (e) Possible result of non treatment.
- (f) Medically accepted alternate treatments and procedures;
- (g) Substantial risks and hazards of the proposed treatment or procedure and those of alternate treatments and procedures.

The responsible practitioner should document in the H & P, progress note or on the informed consent form that the above listed items have been discussed with the patient and/or family representative.

8.3 EMERGENCIES

If circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment specified in 25 TAC 606.1 without first obtaining informed consent as required therein and/or without obtaining the general consent required by section 8.1, such circumstances must be

explained in the patient's medical record. Where possible, two physicians should document that delay in treatment pending execution of the general or an informed consent would endanger the patient's health or life.

SECTION IX: EMERGENCY SERVICES

9.1 EMERGENCY SERVICES

9.1-1 COVERAGE

The Medical Staff shall adopt a method of providing medical coverage in the Emergency Department in accordance with the Hospital's basic plan for the delivery of such services. The method shall include basic coverage (i.e., practitioners who provide the first level of coverage 24 hours a day, 7 days a week) and back-up specialty coverage through on-call schedules of specialists for each Department.

9.1-2 MEDICAL RECORD

An accurate, legible, complete and timely medical record shall be maintained for each patient seen in the Emergency Department. This record shall be incorporated into the patient's permanent Hospital record. All prior, pertinent inpatient, emergency and ambulatory care records shall be available, when requested, to the attending practitioner and other authorized personnel. The record for each Emergency Room visit must include at least:

- (a) Adequate identification data, or if not obtainable, the reason indicated
- (b) Time and means of arrival and by who transported
- (c) Pertinent history of the injury or illness and physical findings, including vital signs
- (d) Allergy history
- (e) Details of first and/or emergency care given the patient prior to arrival at the Hospital
- (f) Evidence of general and appropriate informed consent, or if not obtainable, the reason indicated
- (g) Diagnostic and therapeutic orders
- (h) Description of significant clinical, laboratory and radiological findings
- (i) Treatment given
- (j) Clinical observations, including results of treatment
- (k) Diagnosis or diagnostic impression
- (l) Conclusions at the termination of evaluation/treatment, including final disposition, patient's condition on discharge or transfer, and instructions given to the patient

(m) Whether the patient left against medical advice

9.2 MEDICAL RECORD RULES

The provisions found in Part seven of these Rules and Regulations pertaining to inpatient medical records shall apply to the Emergency Department medical records unless otherwise indicated by the contents of section 9.1-2 above.

9.3 SCREENING AND EXAMINATION

All individuals who present for care in the Emergency Department shall receive an appropriate medical screening examination for the presence of an emergency medical condition, and if so, shall be stabilized or transferred in accordance with available resources and Hospital and Emergency Department policy.

Medical screening may be performed by either:

- A. A licensed physician with clinical privileges granted by the Board; or
- B. A licensed nurse practitioner or physician assistant with appropriate advanced training, certification and clinical privileges granted by the Board; or
- C. A competent Labor and Delivery nurse. The Labor and Delivery nurse is competent to perform the medical screening examination on the obstetrical patient when the Labor and Delivery nurse has satisfactorily completed the clinical competency requirements as required by the Medical Staff.

SECTION X: SPECIAL UNITS AND PROGRAMS

10.1 DESIGNATION

Special units and programs include, but are not limited to, the following:

- (a) Intensive and special care units
- (b) Labor and delivery
- (c) NICU
- (d) Day surgery program
- (e) Surgery
- (f) PACU
- (g) Emergency Department
- (h) Palliative Care Program

- (i) Inpatient renal dialysis program
- (j) Transplant program
- (k) Behavioral Health

10.2 POLICIES

The Medical Staff and its Departments and Sections will develop, in coordination with appropriate officers and/or representatives of the Medical Staff, specific policies for the special units and programs. Said policies shall cover, as applicable, such subjects as the responsibility for care of patients in the unit/program, criteria for patient admission to the unit/program, required tests, consultation requirements, admission/discharge/transfer protocols, direction/ organization of the unit/program, authority of the medical director of the unit/program, special record-keeping requirements, scheduling of patients, particular environmental concerns, etc. The policies of the various units and programs are to be coordinated by the Policy and Procedure Committee of the hospital and some policies/procedures may be subject to the approval of the MEC and Board. Policies which are multidisciplinary in scope and impact shall be reviewed by the applicable Hospital departments and their recommendations forwarded to the Policy and Procedure Committee.

SECTION XI: HOSPITAL DEATHS AND AUTOPSIES

11.1 HOSPITAL DEATHS

In the event of a death, the deceased shall be pronounced dead by the attending physician or his designee within a reasonable period of time, not to exceed two (2) hours. The body may not be released from the Hospital until an entry has been made and signed in the deceased's medical record by a designee of the Medical Staff, as outlined in the Pronouncement of Death Policy and Procedure. All other matters with respect to release of the body, reporting of deaths, and issuance of a death certificate shall be carried out in accordance with current Hospital policy and local law.

11.2 AUTOPSIES

It is the responsibility of every member of the Medical Staff to secure autopsies in accordance with Medical Staff approved criteria and particularly in those cases where the exact cause of the clinical event which led to death is uncertain or where insight into the cause, nature or course of a disease process may be obtained. Proper consent for an autopsy shall be obtained in accordance with Hospital policy and applicable state law. All autopsies shall be performed by a Hospital pathologist, or by his qualified designee. The provisional anatomic diagnoses must be recorded on the medical record within 72 hours; and the complete protocol shall be made a part of the medical record within 60 days. These rules do not apply to cases which according to law must be referred to the Medical Examiner's Office. Such referrals shall be the responsibility of the Nursing Supervisor.

11.3 ORGAN/TISSUE DONATION

When a patient qualifies under Hospital protocol as a potential organ/tissue donor, the attending practitioner or designee shall, in accordance with such protocol, ask the appropriate person at or near the time of notification of death if the decedent is a donor. If not, the family member or other

SECTION XII: INFECTION CONTROL

12.1 REPORTING OF INFECTIONS/COMMUNICABLE DISEASES

The attending practitioner is responsible for recording on the progress notes of the medical record and reporting to the charge nurse on the nursing unit the occurrence of any of the following infections in a patient:

- (a) Infection occurring in a clean wound
- (b) Urinary tract infections following catheterization or any type of instrumentation
- (c) Pneumonia developing in the Hospital
- (d) Mastitis or breast abscess
- (e) Any infection in the nursery
- (f) Bacteremia or septicemia following intravascular instrumentation
- (g) Gastrointestinal infections

The attending practitioner shall promptly communicate to the Hospital's Infection Control Practitioner any patient known or found to have or to be a carrier of Hepatitis B, Non Hepatitis A or B, the AIDS virus (HIV), or any other infectious agent for which reporting is required under the Hospital's Infection Control Policies and Procedures. Every Staff member is also encouraged to report promptly to the Infection Control Practitioner infections which develop after discharge and which may be Hospital-acquired.

12.2 PATIENTS WITH INFECTIOUS/COMMUNICABLE DISEASES

Any patient with a suspected infectious or communicable disease will be treated using appropriate isolation techniques, consistent with the principles outlined in the Hospital's Infection Control Policies and Procedures. The infection control personnel may call cases which may need isolation to the attention of the attending practitioner. If the attending practitioner refuses to order isolation, this information shall be given to the Chairman of the Infection Control Committee who will inform the Chief of the Department or Section involved and makes the final decision concerning isolation of the case for the protection of Hospital employees and other patients.

12.3 GENERAL AUTHORITY

The Infection Control Committee has the authority to institute any appropriate control measure or study when there is reasonably felt to be a danger to patients or personnel from an infectious source.

SECTION XIII: REPORTING OF INCIDENTS AND SENTINEL EVENTS

13.1 Reporting of Incidents and Sentinel Events

Each member of the medical staff has a duty to report timely any variance/incident or sentinel event. Report may be made to the Risk Manager or Director of Health Care Improvement. The report is timely if made as soon as is practical after the occurrence, taking into account the patient's immediate need for care, and the need for intervention to prevent further adverse events.

13.2 Definitions

13.2-1 Incident

A variance/incident or occurrence is defined as any untoward or unanticipated event affecting outcome or function. An incident is an occurrence that has produced an actual, potential or perceived injury to a patient, or any practice, premises condition, or product defect that, in the opinion of a reasonably prudent medical practitioner, may produce an injury or significant risk of injury if left uncorrected, including medication error.

13.2-2 Sentinel Event

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome to patients.

A sentinel event is one that meets one of the following criteria:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition **, or
- The event is one of the following:
 1. Patient suicide of any patient receiving care or treatment and services in a staffed around the clock setting or within 72 hours discharge.
 2. Unanticipated death of a full-term infant.
 3. Infant abduction or discharge to the wrong family.
 4. Rape.
 5. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
 6. Surgery on the wrong patient or wrong body part.
 7. Abduction of any patient receiving care, treatment and services.
 8. Unanticipated retention of a foreign object.
 9. Severe neonatal hyperbilirubinemia (bilirubin > 30 milligrams/deciliter).
 10. Prolonged fluoroscopy with cumulative dose > 1500 rads to a single field, or any delivery or radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose.

** Further definition and clarification of illness and/or underlying condition is available through the Risk Manager or the Director of Health Care Improvement.

SECTION XIV: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

14.1 PURPOSES

The purposes of this Medical Staff are as followed:

- To provide a mechanism for accountability to the Board for the uniformed standard of quality patient care, treatment and services of the professional and ethical conduct of each individual practitioner appointed to the Medical Staff.
- To serve as the body through which individual practitioners may obtain prerogatives and clinical privileges at the Hospital, through which practitioners fulfill the obligations of Staff appointment, and through which appropriate organizational components and positions are created and maintained to provide for the self-governance, direction and coordination of the medical staff activities of the Hospital.
- To provide appropriate educational experiences and opportunities to aid in the advancement of professional knowledge and skill.
- To provide an orderly and systematic means by which practitioners can give input to the Board and the Hospital President on medico-administrative problems and on the Hospital's policy-making and planning processes.

14.2 RESPONSIBILITIES

To effectuate the purposes enumerated above, the responsibilities of the Medical Staff are:

- To provide leadership in the Hospital's continuous quality improvement and patient safety program by conducting required and necessary activities for assessing, maintaining and improving the quality, efficiency, and safety of medical care provided in the Hospital. Such activities include, without limitation:
 - a) Evaluating practitioner and institutional performance.
 - b) Engaging in the ongoing monitoring of patient care practices.
 - c) Evaluating the competency of privileged practitioners and delineating the scope of privileges.
 - d) Promoting the appropriate use of the medical and healthcare resources at the Hospital's Facilities for meeting patients' medical, social and emotional needs, consistent with sound health care resource utilization practices.
- To make recommendations to the Board concerning appointments and reappointments to the Staff, including Staff category, Department assignment, clinical privileges, and disciplinary action.
- Staff Categories
 - a) Active–Clinical: 12 or more patient contacts during a 24 month period.

b) Courtesy: 0-11 patient contacts during a 24 month period.

c) **Active-Community: Is not a category of membership offered at this time at Baylor All Saints Medical Centers.**

- To participate in the development, conduct and monitoring of appropriate medical education and training programs and clinical and laboratory research activities.
- To develop, maintain, and enforce compliance with Bylaws and policies that are consistent with the goals and objectives of the Hospital, with sound professional practices and organizational principles and with external requirements.
- To participate in the Hospital's long-range planning activity, to assist in identifying community health needs, and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.
- To exercise, through the appropriate officers, committees, Departments, and other organizational components as identified in these Bylaws and related manuals, the authority granted in these Bylaws and the related manuals so that the above responsibilities are fulfilled in a timely and proper manner.

SECTION XV: STAFF-WIDE OFFICERS

15.1 ELECTED OFFICERS OF THE STAFF

15.1-1 IDENTIFICATION

The general elected officers of the Staff are:

- a) Chief of Staff
- b) Vice Chief of Staff
- c) Secretary

15.1-2 QUALIFICATIONS

Each officer must:

- a) Be a member of the Active-Clinical Staff at the time of nomination and remain in good standing continuously during the term of office.
- b) The officers of the Medical Staff should have and maintain a minimum of 36 patient contacts per year at Baylor All Saints. Proposed officers must have met this requirement for the 12 month period prior to being elected.
- c) Have been an Active-Clinical Staff member in good standing for at least two years.
- d) Have demonstrated executive and administrative ability through experience and prior constructive participation in Staff activities. Candidates must have served actively and effectively on at least two committees and, preferably, as chairman of a committee or in some other leadership position within this medical staff.

- e) Be recognized as having a high level of clinical competence.
- f) Have demonstrated a high degree of interest in and support of the Medical Staff and Hospital.
- g) Agree to, and in practice, faithfully discharge the duties and exercise the authority of the office held and work with the officers of the Staff, with the Hospital President, his designees and the Board and its committees.

A member of the Medical Staff may not serve simultaneously in two officer positions in any capacity at both BASMC and another hospital.

15.2 TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTION

15.2-1 TERM OF OFFICE

The term of office of Staff officers is two years. Officers assume office on the first day of the Medical Staff year, except that an officer elected or appointed to fill a vacancy assumes office immediately upon election or appointment. Each officer serves until the end of his term and until a successor is elected, unless he sooner resigns or is removed from office.

15.2-2 ELIGIBILITY FOR RE-ELECTION

The Chief of Staff is not eligible for re-nomination or re-election to the office of Vice Chief of Staff until two years have elapsed since he held the office of Chief of Staff. The Vice Chief of Staff, Secretary are eligible to succeed themselves in the same position but for no more than a total of two consecutive two-year terms.

15.3 ATTAINMENT

15.3-1 CHIEF OF STAFF

The Chief of Staff attains office by automatic succession from the office of Vice Chief of Staff, subject to a confirmation vote at the meeting at which election of officers is held.

15.3-2 VICE CHIEF OF STAFF, SECRETARY

- a) **Election:** The Vice Chief of Staff, and Secretary are chosen by majority vote of the Active Staff members in good standing who are present at the Staff's annual meeting at which the election is held. Voting shall be by written ballot, unless a majority of the eligible voters present choose an open ballot. If no candidate for a given office receives a majority vote on the first ballot, a runoff election is held immediately between the two candidates receiving the highest number of votes. The names of the officers elected shall be reported to the Joint Clinical Governance Committee for confirmation.
- b) **Nomination:** The Nominating Committees, as defined in these rules and regulations, shall nominate one or more qualified candidates, respectively, for the offices of Vice Chief of Staff and Secretary. The slate so prepared shall be published at least ten (10) days prior to the election by posting in the Medical Staff Lounges at the Facilities with copies available in the Medical Staff Office and in Administration at Baylor All Saints Medical Center at Southwest.

Additional nominations may be submitted by written petition signed by at least ten (10) Active Staff members of the appropriate constituent group in good standing other than the practitioner being nominated. This petition must be filed with the chairman of the relevant nominating committee at least three (3) days in advance of the election and must be accompanied by evidence of the candidate's qualifications and of his willingness to be nominated. The nominating committees shall then finalize their respective slates and transmit the same for presentation at the meeting at which the election is to be held.

If, before the election, all of the individuals nominated either refuse, are disqualified from, or otherwise are unable to accept nomination, then the appropriate nominating committee may substitute nominees at the meeting. In addition, nominations from the floor offered and seconded by Active Staff members of the appropriate constituent group present and in good standing will be accepted. All nominations made under this circumstance must be presented with evidence of the candidate's qualifications and willingness to be nominated.

15.4 VACANCIES

15.4-1 WHEN CREATED

Vacancies in office occur upon the death, resignation or removal of the officer, transfer from the Active-Clinical Staff category, or the loss of Staff membership.

15.4-2 HOW FILLED IN THE OFFICE OF CHIEF OF STAFF

A vacancy in the office of Chief of Staff is filled by succession of the Vice Chief of Staff, who serves the remainder of the unexpired term and his own full term as Chief of Staff.

15.4-3 HOW FILLED IN THE OFFICES OF VICE CHIEF OF STAFF AND SECRETARY

A vacancy in the office of Vice Chief of Staff and Secretary is filled by appointment of an acting officer by the MEC. The acting officer serves pending the outcome of a special election to be conducted as expeditiously as possible and generally in the same manner as provided in section 16.5-7. The MEC may determine not to call a special election if a regular election for the office is to be held within one-hundred eighty (180) days. In this case the acting officer serves until the regular election results are final and the individual elected assumes office.

15.5 RESIGNATION AND RECALL FROM OFFICE

15.5-1 RESIGNATION

Any elected Staff officer may resign at any time by giving written notice to the MEC. Such resignation may or may not be made contingent on formal acceptance. It takes effect on the date of receipt or at any later time specified in it.

15.5-2 RECALL FROM OFFICE

- a) **Mechanism:** Recall of an elected officer by the Staff may be initiated by the MEC or by a petition signed by at least one-fourth of the members of the Staff in good standing who are eligible to vote for the particular officer position involved. Recall

shall be affected by a two-thirds vote by secret ballot of the Staff members in good standing eligible to vote for the officer position involved who attend and vote at a special meeting called for that purpose.

- b) **Grounds:** Permissible bases for recall of an elected Staff officer include, without limitation:
- 1) Failure to perform the duties of the position held in a timely and appropriate manner from whatever cause.
 - 2) Failure to continuously satisfy the qualifications for the position.
 - 3) Having an automatic or summary suspension or other corrective action imposed pursuant to the provisions in the Credentialing Procedures Manual.
 - 4) Conduct or statements inimical or damaging to the best interests of the Medical Staff or the Hospital or to their goals, programs or public image.

15.6 RESPONSIBILITIES AND AUTHORITY OF THE ELECTED OFFICERS

The responsibilities and authority, including specific functions and duties, of the general Staff officers are set forth in the Rules and Regulations of the Medical Staff.

SECTION XVI: CLINICAL DEPARTMENTS AND SECTIONS THEIR OFFICERS

16.1 DESIGNATION

16.1-1 CURRENT CLINICAL DEPARTMENTS

The current Clinical Departments are:

- a) Anesthesiology
- b) Emergency Medicine
- c) Family Practice
- d) Medicine
 - 1) Division of Cardiovascular Services (Cardiologists)
- e) Obstetrics, Gynecology and Pediatrics
- f) Pathology
- g) Psychiatry
- h) Radiology
- i) Surgery
 - 1) Division of Cardiovascular Services (Cardiovascular/Thoracic Surgeons)

16.1-2 SPECIALTY SECTIONS WITHIN A DEPARTMENT

After consulting with appropriate members of the Department, the MEC shall recommend for approval by the Board the specialty Sections to be created as distinct organizational components within that Department. A current listing of said Sections shall be maintained by

16.1-3 FUTURE CLINICAL DEPARTMENTS AND DIVISIONS

Changes to the Department or Division structure may be made in the manner set forth in section 16.1-2 above. The criteria set forth in section 16.2 below and such others as may be deemed appropriate shall be used in taking action under this section 16.1-3.

16.2 CRITERIA TO QUALIFY AS DEPARTMENT OR DIVISION

16.2-1 CRITERIA TO QUALIFY AS A DEPARTMENT

The following criteria shall apply in making Department designations:

- a) The area of practice represents a major general, distinct field of medical practice at this Hospital.
- b) The level of clinical activity at this Hospital is substantial enough to warrant imposing the responsibility to accomplish the functions assigned to Departments.
- c) The practitioners to be assigned to the Department agree to and, in fact, carry out the activities required of Departments at this Hospital.

16.2-2 CRITERIA TO QUALIFY AS A DIVISION

The following criteria shall apply in making Division designations:

- a) The area of practice is an established, professionally-recognized, discrete specialty/subspecialty field within the general field of the Department.
- b) The specialists practicing in that area at the Hospital devote a substantial portion of their time to that specialty and the numbers and/or activity level in that area at the Hospital are such to require designation of a Chief specifically responsible for quality of services and day-to-day problem resolution.
- c) The level of clinical activity is substantial enough to warrant imposing the responsibility to accomplish the functions assigned to Divisions.
- d) The practitioners to be assigned to the Division agree to and, in fact, carry out the activities required of Divisions at this Hospital.

16.3 REQUIREMENT FOR AFFILIATION WITH DEPARTMENTS AND DIVISIONS

Each Department and Division is a separate organizational component of the Medical Staff. Every Staff member must have a primary affiliation with a Department and, if applicable, Division which most closely reflects his professional training, experience, and current practice. A practitioner may be granted clinical privileges in one or more of the other Departments or Divisions. His exercise of clinical privileges within the jurisdiction of any Department or Division is always subject to the rules and regulations (including contractual obligations) of that Department and Division and the authority of the Department Chief and Division Chief.

16.4 FUNCTIONS OF DEPARTMENTS AND DIVISIONS

The clinical, administrative, quality/risk/utilization review, assessment and improvement activities, and collegial and education functions of the Departments and Divisions are set forth in the Medical Staff Rules & Regulations. Each Department or its constituent Divisions must meet as specified in Section 20.3-1 to receive reports on the findings of review and evaluation of the quality and efficiency of care provided to patients served by the Department/Division and for such other purposes as may be necessary to carry out its assigned functions.

16.5 OFFICERS OF DEPARTMENTS AND DIVISIONS**16.5-1 IDENTIFICATION**

The officer positions in the Departments and Divisions are:

- a) Department/Division Chief
- b) Department/Division Vice Chief

In addition, a Department/Division Vice Chief for Baylor All Saints Medical Center at Southwest may be added at the discretion of the MEC upon recommendation by the Department. Medical directors may be designated for various special units (e.g., intensive care units, special diagnostic units) within a Department or Division.

16.5-2 QUALIFICATIONS

Each Department Chief, Department Vice Chief and Division Chief/Vice Chief must be certified by an appropriate specialty board, or affirmatively establishes, through the privilege delineation process, that the person is possessed of comparable competence. In addition, each must be (or become) a member in good standing of the Department or Division, as applicable, of which he is to be an officer and remain in good standing throughout his term. Each must also be recognized for his current clinical ability in the clinical area covered by the Department or Division, as applicable.

The Department/Division Chiefs and Vice Chiefs should have and maintain a minimum of 36 patient contacts per year at Baylor All Saints. Proposed Department/Division Chiefs must have met this requirement for the 12 month period prior to being elected. A Department Chief or Vice Chief may only hold this title at Baylor All Saints Medical Center and Baylor Medical Center Southwest if the physician practices at more than one facility.

16.5-3 ATTAINMENT OF OFFICE

- a) **Of Department Chiefs:** Except where a Department is directed by a Chief pursuant to a contract with the Hospital, the Department Chief is chosen by majority vote of the Active-Clinical Staff members of the Department in good standing who are present at the regular Department meeting in any year in which the Department Chief is to be elected. The Department nominating committee shall be composed of at least three (3) Department members and shall be appointed by the Department Chief. The Department Chiefs elected shall be presented to the Board for confirmation.
- b) **Of Department Vice Chiefs:** Each Department Vice Chief is elected in the same manner as described above for elected Department Chiefs.

- c) **Of Division Chief/Vice Chief:** Each Division Chief/Vice Chief is appointed by the Department Chief in which the Division is formed, after considering the recommendation of the Division members and subject to confirmation by the MEC and the Board.

16.5-4 TERM OF OFFICE AND ELIGIBILITY FOR REAPPOINTMENT TO POSITION

The term of office of elected Department Chiefs, Department Vice Chiefs and Division Chiefs/Vice Chiefs is two (2) years. A Department Chief, Vice Chief or Division Chief may succeed himself, but generally for no more than two (2) consecutive two-year terms. Each assumes office on the first day of the Medical Staff Year following their election, except that an officer elected or appointed to fill a vacancy assumes office immediately upon election or appointment. Each Chief and Vice Chief serves until the end of his term and until a successor is elected, unless he sooner resigns or is removed from office.

16.5-5 RESIGNATION

An elected Department Chief, Vice Chief or Division Chief/Vice Chief may resign at any time by giving written notice to the MEC and the Board. Resignation may or may not be made contingent on formal acceptance and takes effect on the date of receipt or at any later time specified in it.

16.5-6 REMOVAL

Removal of a Department Chief, Vice Chief or Division Chief /Vice Chief may be effected either: (1) by the Board acting upon its own initiative; or (2) by a two-thirds majority vote of the Active Staff members in good standing of the applicable constituent group if such vote is ratified by the MEC; or, in the case of a Section Chief, (3) by the Department Chief subject to approval by the MEC. Permissible bases for removal of a Chief or Vice Chief are the same as specified in section 15.5-2 for general Staff officers.

When the Board is contemplating action to remove a Chief or Vice Chief, it will refer the matter to a special combined committee composed of an equal number of Board members and Active Staff members appointed, respectively, by the Chairman of the Board and the Chief of Staff. As soon as reasonably practicable after the referral to it, the special committee will submit its written report to the Board. Board action after receiving the special committee's report is the final decision in the matter.

16.5-7 VACANCY

- a) **When Created:** Vacancies in office occur upon the death, resignation or removal of the officer, transfer from the Active-Clinical Staff category, or the loss of Staff membership in the applicable Department or Division.
- b) **In Department Chief or Vice Chief Position:** A vacancy in the office of an elected Department Chief or Vice Chief is filled by appointment of an acting Chief by the MEC, after consultation with the appropriate constituent group and subject to approval by the Board. This acting Chief serves pending the outcome of a special election to be conducted as expeditiously as possible and generally in the same manner as provided in section 16.5-3. The MEC may determine not to call a special election if a regular election for the office is held within one-hundred eighty (180) days.

- c) **In Division Chief/Vice Chief Position:** A vacancy in the office of Division Chief/Vice Chief is filled in the same manner in which the original appointment was made.

16.5-8 RESPONSIBILITY AND AUTHORITY

Each Department Chief and Division Chief shall have the responsibility and authority to carry out the functions delegated to him and to the clinical unit he heads. The Department Chief and Division Chief are responsible for the following:

- a) All clinically related activities of the Department/Division.
- b) All administratively related activities of the Department/Division, unless otherwise provided by the hospital.
- c) Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department.
- d) Recommending to the Medical Staff the criteria for clinical privileges in the Department.
- e) Recommending clinical privileges for each member of the Department.
- f) Assesses and recommends to the relevant hospital authority off-site services for needed patient care services not provided by the Department/Division in the organization.
- g) The development and implementation of policies and procedures that guide and support the provision of care, treatment and services.

The Department Vice Chief shall have and exercise the responsibility and authority of the Department Chief in the latter's temporary absence and shall have such other responsibilities as are assigned by the Department Chief, in these Bylaws and related manuals, in any other policies and rules of the Hospital or Staff, and, where applicable, by contract or job description. Each Section Chief shall designate a qualified member of the Section to assume all the responsibility and authority of the office in his temporary absence.

16.5-9 REPORTING OBLIGATIONS

- a) **Department Chief:** Each Department Chief shall report:
- 1) To regularly scheduled meetings of the MEC and the Department and, as requested, to special meetings of those same groups or to the Medical Staff on the activities of the Department.
 - 2) Whenever necessary or requested to the Chief of Staff on matters involving coordination and monitoring of clinical services to maintain quality or to assure patient safety.
 - 3) To the Chief of Staff and any applicable Staff committee on action taken in response to a suggestion, recommendation or finding from one of the Medical Staff's quality assessment and improvement committees.
 - 4) To the Hospital President, or designee, on issues relating to the Chief's administrative duties, if any, for supervision of Hospital personnel, proper functioning

- 5) To the MEC and Hospital President, or designee, on issues relating to the allocation and acquisition of resources for the various Departments, budgetary items and similar concerns.
 - 6) The Department Chief has reporting obligations to the Department members to report relative policy changes in a timely manner.
- b) **Department Vice Chief:** Each Department Vice Chief shall report to the Department Chief on those specific duties and functions as are detailed in the Medical Staff Organization Manual.
- c) **Division Chief:** Each Division Chief shall report to the Department Chief as may be necessary, to the Department and Division at scheduled meetings on the activities of the Section, and, for the matters indicated in sections 16.5-9(a)(2)-(5) above, to the Department Chief as well as to the authorities specified therein.

SECTION XVII FUNCTIONS AND COMMITTEES

17.1 FUNCTIONS OF THE STAFF

The required functions of the Medical Staff are as specified and described in the Rules & Regulations of the Medical Staff. They are accomplished as indicated in these Bylaws and said manual through assignment to the Staff as a whole, to Departments and Sections, or other clinical units, to Staff committees, to Staff officers or other individual Staff members, or to interdisciplinary Hospital committees with participation of Medical Staff members.

17.2 PRINCIPLES GOVERNING COMMITTEES

The composition, functions, reporting and meeting requirements of the MEC are set forth in section 17.4 of the Medical Staff Rules and Regulations. The composition, functions, reporting and meeting requirements of the other standing Staff-wide committees are also set forth in the Rules & Regulations of the Medical Staff. Any committee that is carrying out all or any portion of a function or activity required by these Bylaws and the related manuals pertaining to the assessment, maintenance or improvement of the quality, appropriateness or efficiency of patient care or to practitioner credentialing is deemed a duly appointed and authorized professional and medical peer review committee of the Medical Staff and Hospital.

17.3 REPORTABLE ACTIONS AND INITIATING FAIR HEARING REQUIREMENTS

17.3-1 REPORTABLE ACTIONS

With the sole exception of a recommendation by the MEC to continue a summary suspension, no recommendation of any committee of the Medical Staff shall be deemed a reportable action under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended.

17.3-2 INITIATING FAIR HEARING REQUIREMENTS

Only those actions and recommendations as set forth in the Medical Staff Bylaws shall give rise to the procedural rights afforded in said Plan. In accordance with said provision, in terms

of Medical Staff committees, only recommendations of the MEC shall be considered as a formal professional review action as that term is used in the Health Care Quality Improvement Act for purposes of initiating the procedural requirements of the Medical Staff Bylaws.

17.4 MEDICAL EXECUTIVE COMMITTEE

17.4-1 COMPOSITION

The MEC consists of the following:

- a) Chief of Staff, as chairman and with vote.
- b) Vice Chief of Staff, with vote.
- c) Secretary, with vote.
- d) Baylor All Saints Medical Center at Baylor Southwest – 2 Representatives, with vote.
- e) Chiefs of the current clinical Departments, each with vote.
- f) Division Chiefs of the current Divisions, each with vote.
- g) Past Chief of Staff, with vote.
- h) Hospital President, without vote.
- i) Other Committee Chairmen will be invited as needed, without vote.
- j) Vice-President/Chief Nursing Officer, without vote.

17.4-2 DUTIES AND AUTHORITY

The duties and authority of the MEC are to:

- a) Act on all matters of Medical Staff business, except for election of general Staff officers, removal of general Staff officers, and adoption and amendment of the Medical Staff Bylaws.
- b) Make recommendations directly to the Board regarding:
 - the structure of the Medical Staff;
 - the mechanism used to review credentials and to delineate individual clinical privileges;
 - recommendations of individuals for Medical Staff membership;
 - recommendations for delineated clinical privileges for each eligible individual;
 - organization of the quality assessment and improvement activities, including utilization review activity, of the Medical Staff as well as the mechanism used to conduct, evaluate and revise such activities;
 - mechanisms by which membership on the Medical Staff may be terminated.
- c) Receive, coordinate and act upon, as necessary, the reports and recommendations of the Departments and committees.
- d) Coordinate, or oversee coordination of, the activities of and policies adopted by the Staff, Departments, Sections, other special clinical units, and committees.

- e) Implement the approved policies of the Medical Staff, or monitor that such policies are implemented by the officers, Departments, Sections, other special units and committees.
- f) Study and report to the Medical Staff on proposals for changes in these Bylaws.
- g) Inform the Medical Staff on JCAHO accreditation requirements and the accreditation status of the Hospital and monitor Staff compliance with accreditation, regulatory and other professional standards or requirements. As necessary, suggest or require changes in the manner in which the Staff or any component thereof is carrying out required functions or in applicable policies, procedures, services, or organizational relationships.
- h) Present recommendations to the JCGC, as required in the Medical Staff Bylaws and Rules and Regulations on matters relating to appointments and reappointments, Staff category assignments, clinical privileges, and disciplinary action.
- i) Make recommendations to the Board, through the JCGC, on dues and fees for the Medical Staff.
- j) Take reasonable steps to secure professionally ethical conduct and competent clinical performance on the part of Staff members, including initiating investigations and initiating and pursuing disciplinary action, when warranted.
- k) Account to the Board, through the JCGC, by written report on the quality and efficiency of medical care provided to patients in the Hospital, including a summary of specific findings, action and follow-up.
- l) Make recommendations to the Hospital President on medico-administrative, Hospital management and planning matters, to include personnel, space and other resources needed by a department/service.

17.4-3 MEETINGS AND REPORTING

The MEC meets monthly. It communicates its discussions and actions that affect or define Staff policies, rules or positions by monthly summary reports made available to all Staff members. Policy changes made at the discretion of the Department Chief should be made immediately available by Department mailings. The MEC's other reporting obligations are as stated in the various sections of the Bylaws and the related manuals. In addition, copies of its minutes and reports are forwarded to the Hospital President, and, as appropriate or required, to the Board and appropriate committees thereof.

17.4-4 EXECUTIVE SESSION

An Executive Session of the MEC is a meeting that is usually closed to employees of Baylor All Saints Medical Centers, with the exception of the Hospital President/Chief Executive Officer. Those in attendance at an Executive Session of the MEC will be the Chief of Staff, Vice Chief of Staff, Secretary of the Staff, Chiefs of the Departments, and the physician representative from Baylor All Saints Medical Center at Southwest. The Executive Session may be called by a physician member of the MEC in coordination with the Chief of Staff.

SECTION XVIII: MEETINGS

Revised/Approved 10/28/2008

18.1 MEDICAL STAFF YEAR

For purposes of the business of the Medical Staff, the Medical Staff Year currently commences on March 1 of each year and ends on the last day of February of the succeeding year.

18.2 MEDICAL STAFF MEETINGS**18.2-1 REGULAR MEETINGS**

The Annual Meeting of the Medical Staff shall be held in the first quarter of each year. Notice thereof shall be sent to members of the Medical Staff. No additional notice shall be required.

18.2-2 SPECIAL MEETINGS

A special meeting of the Medical Staff may be called by the Chief of Staff, and must be called by the Chief of Staff within 30 days of a written request from the Board, the JCGC, the MEC, or twenty-five (25) percent of the members of the Active Staff in good standing.

18.3 DEPARTMENT AND COMMITTEE MEETINGS**18.3-1 REGULAR MEETINGS**

Departments and committees may, by resolution, provide the time for holding regular meetings. No notice other than such resolution is then required. A Department, individual or in combination with other Departments, will meet as called by the Chief. The method for accomplishing this is to be determined by the respective Department Chief, subject to the approval of the MEC. Whatever method is chosen, each Department must meet as a whole at least one (1) time per year. The frequency of standing committee meetings is as required by these Rules & Regulations for each committee, or as established by the resolution creating a committee.

18.3-2 SPECIAL MEETINGS

A special meeting of any Department, Section, or committee may be called by the Chief or chairman thereof. A special meeting must be called by the Chief or chairman on written request from the Board, the JCGC, the Chief of Staff, the MEC, the Department Chief in case of a Section meeting, or one-third of the group's current voting members in good standing but not less than two.

18.4 ATTENDANCE REQUIREMENTS**18.4-1 GENERALLY**

All Staff members and all practitioners exercising clinical privileges must satisfy the special appearance requirements of section 18.4-2. All Medical Staff Members are encouraged to attend the Committee meetings to which he/she is appointed. There are no frequency requirements.

18.4-2 SPECIAL APPEARANCE OR CONFERENCES

- a) A practitioner whose patient's clinical course of treatment is scheduled for special case discussion at a Staff, Department or Section meeting shall be so notified and invited to present the case. If the practitioner is not present, the case will be

discussed unless the practitioner has requested a postponement. In no case shall a postponement be granted beyond the next regular meeting.

- b) Whenever a Staff, Department or Section education program or clinical conference is prompted by findings of quality improvement or other review, evaluation and monitoring activities, the practitioners whose patterns of performance prompted the program will be notified of the time, date and place of the program, of the subject matter to be covered, and of its special applicability to the practitioner's practice. Attendance is mandatory. Failure to attend, unless excused by the MEC upon a showing of good cause, may result in such corrective action as deemed necessary by the MEC and the JCGC or Board, as applicable.
- c) Whenever a pattern or significant instance of apparent or suspected deviation from standard clinical practice is identified, the Chief of Staff or the applicable Department or Section Chief may require the practitioner to confer with him or with a standing or ad hoc committee that is considering the matter or to respond to the particular concern raised in some other manner. If the practitioner fails to comply with the request, the Chief of Staff or the applicable Department or Section Chief shall give him special notice indicating that failure to appear or respond within five (5) days of the notice, unless excused by the MEC upon a showing of good cause, will result in a summary suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct. A suspension under this section will remain in effect until the matter is resolved, pursuant to the applicable provisions the Medical Staff Bylaws.

18.5 MEETING PROCEDURES

Notice, quorum, minutes and agenda requirements for meetings are set forth in the Medical Staff Rules & Regulations.

SECTION XIX: GENERAL PROVISIONS

19.1 STAFF RULES AND REGULATIONS

Subject to approval by the Board, the MEC shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found in the Bylaws. The principles and procedures outlined in SECTION XXIV of these Rules & Regulations shall be followed in the adoption and amendment of the rules and regulations.

19.2 DEPARTMENT RULES

Each Department shall formulate, as necessary, written rules for the conduct of its affairs and the discharge of its responsibilities. All such rules must be consistent with these Rules & Regulations, the Bylaws of the Hospital, and other Hospital policies. Department rules and any amendments thereto must be approved by the MEC and the JCGC.

NOTE: System Standardized language – may not be changed w/o prior approval

19.3 ADMINISTRATIVE SUSPENSION OR REVOCATION

The purpose of this section is to establish an enforcement mechanism for physician and house staff suspension processes. This section addresses the processes for any administrative suspension of medical staff privileges authorized under the Medical Staff Bylaws, including such reasons as; medical record delinquency; lapse or suspension of medical license, Drug Enforcement Agency (DEA) Certification, Department for Public Safety (DPS) Registration, or professional liability insurance; failure to respond to requests for information; or repetitious infractions.

19.3-1 The Administrative Suspension as provided in the Medical Staff Bylaws is as follows:

- A. Expiration of Licensure, DEA, DPS and/or Professional Liability Insurance**
Upon expiration of licensure, DEA, DPS and professional liability insurance the practitioner is immediately prohibited from providing patient care, which includes, but is not limited to: elective and emergency admissions, admission scheduling, consultative and treating privileges, surgery or invasive procedure scheduling, elective anesthesia scheduling, voting and office-holding prerogatives until such document(s) is updated and verified.
- B. Failure to Respond to Requests for Information**
Practitioners suspended for failure to respond to requests for information related to expiration of licensure, DEA, DPS and professional liability insurance may be prohibited from providing patient care (as defined in section 19.3-1A above). Failure to respond to other requests for information will be addressed as defined in Section 3.3-5 of the Medical Staff Bylaws.
- C. Failure to Complete Medical Records**
Practitioners shall be denied scheduling privileges for elective admissions, surgery or invasive procedure and elective anesthesia (with the exception of in-house patients), as well as voting and office-holding prerogatives, for failure to complete medical records within twenty-one (21) days from the time the medical record is first made available to the practitioner. In addition, the practitioner's membership and clinical privileges may be suspended for failure to complete medical records for three (3) weeks in a row from availability until such records are completed. Suspended practitioners providing operative procedures on an in-house patient(s) or currently treating an in-house patient(s), may continue to treat that in-house patient(s). Future admission and surgical scheduling will be denied until the practitioner is removed from suspension for failure to complete medical records.
- C.1. Extended Leave or Vacation**
It is the practitioner's responsibility to notify the Health Information Management Department at the respective facility if a leave or vacation is planned that exceeds three (3) weeks. In the event the leave extends unexpectedly past three (3) weeks, the Health Information Management Department will initiate the process to file the charts as permanently incomplete.
- D. Repetitious Infractions**
Practitioners suspended under any definition of administrative suspension will be addressed as defined in Section 3.3-7 (Repetitious Infractions) in the Medical Staff Bylaws.

19.3-2 Notification of Practitioner Suspension or Reinstatement

- A. Notification to Suspend**
The process for notification to suspended practitioners and appropriate hospital personnel is

defined in Medical Staff Services and Health Information Management Policy and Procedures.

B. Notification to Reinstate

Upon receipt of current documentation for licensure, DEA, DPS, professional liability insurance, or other requested documentation and completion of all incomplete medical records, the practitioner's clinical privileges may be reinstated as defined in facility specific Medical Staff Services and Health Information Management Policy and Procedures.

19.3-3 Reporting to Texas Medical Board for Failure to Complete Medical Records

If a practitioner leaves the facility either voluntarily or involuntarily and does not complete their medical records within sixty (60) days, the medical records may be filed as permanently incomplete and the practitioner may be reported to the Texas Medical Board by the MEC.

SECTION XX RESPONSIBILITIES AND AUTHORITY OF OFFICERS

20.1 OF THE CHIEF OF STAFF

The Chief of Staff serves as the Medical Staff's representative in its relationships to others within the Hospital and, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services provided and all other functions of the Medical Staff as outlined in the Medical Staff Bylaws and related manuals. Specific responsibilities and authority are to:

- (a) Be accountable for the clinical policy-making activities of the Medical Staff and work with the Department Chiefs and Vice Chiefs in coordinating these among the clinical Departments and with administration, nursing and other patient care support services.
- (b) Direct the development, implementation, organization and functioning of Medical Staff credentialing processes, quality assessment and improvement initiatives, utilization review, and clinical risk review in compliance with regulatory and accrediting agencies' requirements.
- (c) Participate in continuing education activities on the subject of continuous quality improvement (CQI).
- (d) Ensure that relevant findings and results of the quality assessment and improvement activities are communicated to the Staff.
- (e) Ensure that corrective action plans are developed and implemented by the applicable Medical Staff authorities/groups as required, and reported to the JCGC and the Board.
- (f) Report, at least quarterly, the relevant findings, conclusions and recommendations resulting from the quality assessment and improvement activities and other monitoring activities to the Board through the JCGC.

- (g) Report to the JCGC the MEC's recommendations concerning appointment/affiliation, reappointment/reappraisal, delineation of clinical privileges or specified services, and corrective action with respect to practitioners or allied health professionals who are applying for appointment/affiliation or privileges/services or who are appointed to/affiliated with or are exercising privileges or services in the Hospital.
- (h) Continuously evaluate, and periodically report to the Hospital President, the JCGC and the Board, on the effectiveness of the systems used to carry out the Staff's responsibilities.
- (i) Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the Medical Staff in their relations with each other, the Board, Hospital management, other professional and support staff, and the community the Hospital serves.
- (j) Enforce the Medical Staff Bylaws and related manuals, rules, policies and procedures of the Staff and Hospital.
- (k) Serve as chairperson of the MEC and as an ex officio member of all standing committees of the Staff, with vote when so specified in the statement of the committee's composition.
- (l) Unless otherwise provided in the Medical Staff Bylaws or any of the related manuals, appoint chairpersons and members of Staff committees.
- (m) Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting Hospital operations to the Hospital President and the Board.
- (n) Attend meetings of the JCGC and the Board and, upon invitation, other Board committees.
- (o) Ensure that the decisions of the Board and the JCGC are carried out within the Medical Staff.
- (p) Perform such other duties and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws and any of the related manuals and as may from time to time be assigned by the MEC.

20.2 OF THE VICE CHIEF OF STAFF

The Vice Chief of Staff shall be a member of the MEC, with vote, and shall perform such additional duties and exercise such authority as may be assigned or granted by the Chief of Staff, by the MEC, or in the Medical Staff Bylaws and related manuals or other Medical Staff or Hospital policies. The Vice Chief of Staff will also serve as the Chairman of the Medical Staff Quality Council, and will attend any Sentinel Event meetings.

20.3 OF THE SECRETARY

The Secretary has these responsibilities and authority:

- (a) Serve as an ex officio member of the MEC, with vote.
- (b) Be responsible for reporting on meetings of the Medical Staff and for assuring that accurate and complete minutes of all meetings of the Medical Staff and MEC are kept.

- (c) Serve as the Chairman of the Credentials Committee.
- (d) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or organization.

20.4 OF THE SOUTHWEST REPRESENTATIVE

The Southwest Representative has these responsibilities:

- (a) Serve as an ex officio member of the MEC, with vote, representing the views, needs and grievances of those members of the Medical Staff with the Southwest Facility designated as their primary Facility of practice.
- (b) Perform such additional duties as may be assigned by the Chief of Staff, by the MEC, or in the Medical Staff Bylaws and related manuals or other Medical Staff or Hospital policies.

20.5 OF THE DEPARTMENT CHIEFS

In assuring the accomplishment of the functions of a Department provided in Part Two of this Medical Staff Organization Manual and in meeting his responsibility to direct, supervise and coordinate all professional, educational, administrative, clinical and research activities within the Department, a Department Chief has these specific responsibilities and authority:

- (a) Manage all clinical and administrative aspects of the Department in cooperation and coordination with administration, other clinical Departments, nursing and other patient care support services, and the Chief of Staff.
- (b) In coordination with the MEC, assist in developing, consistent with the Hospital's mission, objectives and policies, annual and long- term budget plans to support the personnel, equipment, facilities, services and material requirements of the Department. Coordinate departmental services into the primary function of the organization.
- (c) Participate with the MEC and the other Department Chiefs in evaluating current programs and services, in determining the need for new or modified programs and services, and in analyzing medical personnel needs to assure qualified and competent individuals to provide care or service. Make recommendations when changes are needed.
- (d) Promote, monitor and review, in conjunction with the Baylor Research Institute, clinical research activities within the Department.
- (e) Participate in developing, planning, implementing and evaluating the orientation and continuing education programs for the Department and the Staff.
- (f) Participate in continuing education activities on the subject of continuous quality improvement (CQI).
- (g) Ensure the department is consistently compliant with standards for quality and patient safety.
- (h) Maintain continuing review of patient care and the professional performance of practitioners and allied health professionals with clinical privileges or specified services in the Department, investigate and respond to issues raised regarding clinical care with expediency and in a professional manner, and report evidence of professional

incompetence or misconduct to the Chief of Staff, MEC, and Hospital President.

- (i) Prepare and transmit to the appropriate authorities, as required by the Medical Staff Bylaws, the Credentialing Procedures Manual or other relevant protocols, recommendations concerning appointment/affiliation, reappointment/reappraisal, delineation of clinical privileges or specified services, and corrective action with respect to practitioners or allied health professionals who are applying for appointment/affiliation or privileges/services or who are appointed to/affiliated with or are exercising privileges or services in the Department.
- (j) Communicate and implement within the Department actions taken by the MEC, the Board and relevant committees thereof, and other relevant authorities.
- (k) Oversee development and coordination of Departmental policies and procedures and give guidance on the clinical policies of the Hospital related to the Department.
- (l) Enforce the Hospital and Medical Staff Bylaws and related manuals, rules, policies and procedures within the Department, including, without limitation, initiating corrective action and investigation of clinical performance and ordering consultations to be provided or sought when necessary.
- (m) After consultation with members of the Department, the MEC and the Hospital President, recommend to the JCGC for its confirmation through the MEC practitioners for appointment as Section Chiefs.
- (n) In consultation with the MEC, designate an appropriate organizational structure of the Department in accordance with the provisions in the Medical Staff Bylaws and related manuals.
- (o) Assign individual Department members and/or appoint Department committees as necessary to perform the functions of the Department and designate a chairperson of each committee created.
- (p) Preside over and prepare the agenda for all Department meetings.
- (q) Report to the MEC and other such authorities regarding the professional and administrative activities of the Department.
- (r) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or organization.
- (s) Coordinate and integrate interdepartmental and intradepartmental services.
- (t) Perform such other duties and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws or any of the related manuals, in other Hospital or Medical Staff rules and policies, and, if applicable, in a contract with the Hospital, and as may from time to time be reasonably requested by the Chief of Staff, the MEC, the Hospital President, or the JCGC.

20.6 OF THE DEPARTMENT VICE CHIEFS

The Department Vice Chief has these responsibilities and authority:

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- (a) Assume all of the duties and responsibilities and exercise all of the authority of the Department Chief when the latter is unable to accomplish the same.
- (b) Perform such additional duties and exercise such authority as may be assigned or granted by the Department Chief.
- (c) Serve as the Department's representative on the Medical Staff Quality Council and perform all review activities of the Department.
- (d) Ensure the development and implementation of Departmental quality assessment and improvement initiatives to monitor and evaluate the quality of patient care in accordance with the Medical Staff Quality Assessment and Improvement Plan as approved by the MEC, the development of credentialing standards and requirements for appointment to the Department and for the granting of clinical privileges, and the development of clinical policy for the Department.
- (e) Ensure that quality assessment and improvement data/information, recommendations and requests that are forwarded to the Department or directly to the Chief are responded to in a timely and appropriate manner.

20.7 OF THE DIVISION CHIEFS

A Division Chief shall report directly to the Department Chief and shall have the responsibility and authority to carry out those duties and functions delegated to him by the Department Chief. Each Division Chief shall designate another qualified member of the Division to temporarily assume all the responsibility and authority of the Chief in his temporary absence.

Specifically, the Division Chief must:

- (a) Participate on a continuous basis in managing the Division through cooperation and coordination with the Department Chief and the MEC and with the nursing and other patient care services and Hospital management on all matters affecting patient care.
- (b) Assist the Department Chief in preparing annual and long-term budget plans with respect to the Section's personnel, equipment, facilities, services and material requirements.
- (c) Assist the Department Chief in evaluating current programs and services within the Department, in determining the need for new or modified programs and services, and in analyzing medical personnel needs.
- (d) Participate in continuing education activities on the subject of continuous quality improvement (CQI).
- (e) Implement and supervise, in cooperation with the Department Chief or designee and other appropriate officials and committees of the Staff and Hospital, systems to carry out the quality assessment and improvement initiatives assigned to the Division.
- (f) Maintain continuing review of patient care and of the professional performance of practitioners and allied health professionals with clinical privileges or specified services in the Division, investigate and respond to issues raised regarding clinical care with expediency and in a professional manner, and report evidence of professional incompetence or misconduct to the Department Chief and the Chief of Staff.

- (g) Ensure the division is consistently compliant with standards for quality and patient safety.
- (h) Review data/information forwarded from any of the various Medical Staff committees and officials charged with quality assessment and improvement activities, respond to requests from and recommendations by said committees/officials, and make recommendations or take action as appropriate.
- (i) Report to the appropriate Division members and, through the Department Chief or designee, to other appropriate Medical Staff or Hospital committees/groups, in a timely and appropriate manner, the findings, conclusions, recommendations and actions taken related to Division-specific CQI and other assessment, monitoring and review activities.
- (j) Receive reports on the findings, conclusions, recommendations and actions taken related to other Medical Staff quality assessment and improvement initiatives and other assessment, review and monitoring activities relevant to the Division and coordinate with the Department Chief or designee the communication of the same to appropriate Section members in a timely and appropriate manner.
- (k) Participate in the development of standards and criteria for the evaluation of practitioners for appointment to the Division and for the granting of clinical privileges to individual practitioners within the defined scope of the Division services.
- (l) Prepare and transmit to the Chief of the Department, as required by the Medical Staff Bylaws, the Credentialing Procedures Manual or other relevant protocols recommendations regarding appointment/affiliation, reappointment/reappraisal, delineation of clinical privileges or specified services, and corrective action with respect to practitioners or allied health professionals who are appointed to/affiliated with or are exercising privileges or services in or applying to the Division.
- (m) Communicate and implement within the Division, in cooperation with the Department Chief, actions taken by the MEC, the JCGC, the Board, and other relevant Staff and Hospital authorities.
- (n) Enforce the Hospital and Medical Staff Bylaws and related manuals, rules, policies, procedures, and regulations within the Section, including initiating corrective action and investigation of clinical performance and ordering consultations to be provided or sought when necessary.
- (o) Preside over and prepare the agenda for all Division meetings.
- (p) Designate, subject to the approval of the Department Chief, an appropriate organizational structure of the Division in accordance with the provisions of the Medical Staff Bylaws and related manuals.
- (q) Perform such other duties and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws or any of the related manuals, in other Hospital or Medical Staff rules and policies, and, if applicable, in a contract with the Hospital and as may from time to time be reasonably requested by the Chief of Staff, the Department Chief, the MEC, the Hospital President, or the JCGC.

20.8 OF THE DIVISION VICE CHIEF

Revised/Approved 10/28/2008

The Division Vice Chief has these responsibilities and authority:

- (a) Assume all of the duties and responsibilities and exercise all of the authority of the Division Chief when the latter is unable to accomplish the same.
- (b) Perform such additional duties and exercise such authority as may be assigned or granted by the Division Chief.
- (c) Serve as the Division’s representative on the Medical Staff Quality Council and perform all review activities of the Division.
- (d) Ensure the development and implementation of divisions quality assessment and improvement initiatives to monitor and evaluate the quality of patient care in accordance with the Medical Staff Quality Assessment and Improvement Plan as approved by the MEC, the development of credentialing standards and requirements for the division and for clinical privileges, and the development of clinical policy for the division.
- (e) Ensure that quality assessment and improvement data/information, recommendations and requests that are forwarded to the division are responded to in a timely and appropriate manner.

20.9 OF THE MEDICAL DIRECTORS OF SPECIAL UNITS

A special unit medical director shall have the responsibility and authority to carry out the duties assigned to him by the MEC, or by the applicable Department Chief or Section Chief, or in the Bylaws and related manuals and unit policies, or by contract or job description if applicable. When contacted, the medical director may provide advice to unit clinical personnel regarding individual patient care issues and unit policies and procedures. This advice may, from time to time and in certain circumstances, involve intervening in the care of specific unit patients.

SECTION XXI FUNCTIONS OF THE STAFF

21.1 DESCRIPTION OF STAFF FUNCTIONS

21.1-1 GOVERNANCE, DIRECTION, COORDINATION AND ACTION

- (a) Receive, coordinate and act upon as necessary the reports and recommendations from Departments, committees, other groups and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities.
- (b) Coordinate the activities of and policies adopted by the Staff, Departments, other clinical units and committees.
- (c) Account to the Board through the JCGC and to the Staff by written reports on the overall quality and efficiency of patient care in the Hospital as documented in the findings and actions from the Medical Staff’s quality assessment and improvement activities.

- (d) Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of Staff members, including initiating investigations and initiating and pursuing corrective action, when warranted.
- (e) Make recommendations on medico-administrative and Hospital management matters.
- (f) Inform the Medical Staff of the accreditation program and the accreditation status of the Hospital.
- (g) Act on all matters of Medical Staff business, subject to such limitations as may be imposed by the Staff.
- (h) Fulfill the reporting requirements in section 17.4-3 of the Medical Staff Bylaws.

21.1-2 PATIENT SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

- (a) Adopt and modify, subject to the approval of the MEC and the JCGC, and supervise the conduct of specific programs and procedures for assessing, maintaining and improving, as required, the safety, quality and efficiency of patient care provided in the Hospital.
- (b) Implement the procedures required by defining important aspects of care and developing indicators and criteria to measure them, by assessing and evaluating the processes and outcomes of care, by identifying opportunities to improve care, by identifying patterns of performance within or outside the acceptable range, by receiving and evaluating explanations for patterns significantly different from the norm, and by reporting these findings and explanations.
- (c) Formulate and act upon specific recommendations to correct identified improvable situations.
- (d) Follow-up on action taken.
- (e) Coordinate the Staff's patient safety/improvement activities with those of other health care disciplines.
- (f) Staff officers and committees charged with specific patient safety and performance improvement activities send written reports, as frequently as required for each specific activity in the Bylaws and related manuals, to the organizational entities to which they are responsible on the results (including findings, conclusions, recommendations, actions taken and follow-up) and progress of the activities.
- (g) Participate annually in evaluating the overall quality assessment and improvement activities for their comprehensiveness, integration, effectiveness and cost efficiency.
- (h) Participate in case reviews, sentinel event reviews and in failure mode analysis.

21.1-3 MONITORING ACTIVITIES

- (a) Adopt, modify, supervise and coordinate the conduct and findings of the patient care monitoring activities, including core measures.
- (b) Conduct review of mortalities, including analysis of autopsy reports when available.
- (c) Conduct surgical and invasive procedure review to improve the selection (appropriateness) and performance (effectiveness) of surgical and other invasive procedures, including tissue review, evaluation and comparison of preoperative and postoperative diagnosis, indications, actual diagnosis of tissue removed, and situations in which no tissue was removed.
- (d) Conduct blood usage reviews, including evaluation of the appropriateness and effectiveness with which all categories of blood and blood components are used, review of all confirmed transfusion reactions, and review of ordering practices for blood and blood products.
- (e) Review and evaluate drug therapy practices and drug utilization following a criteria-based, on-going, planned and systematic process designed to continuously improve the appropriate and effective use of drugs, reporting conclusions, recommendations, actions taken and action results.
- (f) Review on a continuous basis other general indicators of the quality of care and of clinical performance, including unexpected patient care management events.
- (g) Review on a continuous basis and enforce or coordinate compliance with consultation requirements and other established policies and protocols relating to clinical practice in the Hospital.
- (h) Those responsible for conducting any of these monitoring activities shall submit written reports of conclusions, recommendations, actions taken and action results as required by the frequency of the activity to the Medical Staff Quality Council or MEC, as appropriate, and for information purposes to any other Staff organizational entity or official with an official interest in the activity. The Medical Staff Quality Council reports similarly to the MEC and for information to any other Staff organizational entity or official with an official interest in the activity and to the JCGC. The MEC and the Staff report on the overall activity to the Board through the JCGC.

21.1-4 UTILIZATION MANAGEMENT

- (a) Develop a utilization management (UM) plan for approval by the MEC, Hospital Administration, and the JCGC. The plan must apply to all patients regardless of payment source, outline the confidentiality and conflict of interest policy, and include provision for at least: (1) review of the appropriateness and medical necessity of admissions, continued hospital stays and the use of

clinical support services; (2) discharge planning; (3) data collection and reporting requirements; and (4) use of written, objective, measurable criteria in conducting the reviews.

- (b) Review and monitor that the UM plan is in effect, known to the Staff members and functioning at all times.
- (c) Analyze utilization profiles on a periodic basis and prepare written evaluations of utilization activities on a continuous basis, including a determination of the effectiveness of the utilization program.
- (d) Conduct studies, take actions, submit reports and make recommendations as required by the UM plan.
- (e) The Medical Staff Quality Council submits a written report of the findings of and specific recommendations resulting from the utilization review program to the MEC and JCGC, and for information, utilization patterns to the Departments and Sections, as appropriate, and to any other Staff organizational entity or official with an official interest in the activity. The MEC and Staff report to the Board through the JCGC.

21.1-5 CREDENTIALS REVIEW

- (a) Review, evaluate and transmit written reports as required by the Medical Staff Bylaws on initial appointments, concluding or extending the provisional period, reappointments, modifications of appointment, clinical privileges, and the performance of specified services by allied health professionals.
- (b) Initiate, investigate, review and report on corrective action matters according to the procedures set forth in the Medical Staff Bylaws Manual and on any other matters involving the clinical, ethical or professional conduct of any practitioner assigned or referred by: (1) the Staff; (2) the MEC; (3) those responsible for the functions; (4) the JCGC or the Board.

21.1-6 EDUCATION AND LIBRARY

- (a) Participate in developing, planning, implementing, and evaluating programs of, and requirements for, continuing education that are relevant to the type and scope of patient care services delivered in the Hospital, designed to keep the Medical Staff informed of significant new developments and new skills in medicine, and responsive to quality assessment and improvement activities.
- (b) Coordinate, as necessary, the various education activities of the Departments, Sections and other committees.
- (c) Work with Baylor Research Institute regarding research projects and clinical investigations.
- (d) Provide medical direction and advice to the Hospital's medical reference services.
- (e) Maintain a written record of education activities and participation in them.

21.1-7 MEDICAL RECORDS

- (a) Review and evaluate medical records to determine that they: (1) properly describe the condition and progress of the patient, the therapy and tests provided, the results thereof, and the identification of responsibility for all actions taken; and (2) are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the Hospital.
- (b) Develop, review, enforce and maintain surveillance over enforcement of Staff and Hospital policies and rules relating to medical records, including medical records completion and preparation and recommend methods of enforcement thereof and changes therein.
- (c) Provide liaison with Hospital Administration, nursing service and medical records professionals in the employ of the Hospital on matters relating to medical records practices.

21.1-8 PHARMACY AND THERAPEUTICS

- (a) Consult on the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital.
- (b) Conduct drug usage evaluations with reports provided on at least a quarterly basis to the Hospital Quality Council and the Medical Staff Quality Council.
- (c) Advise the Medical Staff and the Hospital's Pharmacy on matters pertaining to the choice of available drugs.
- (d) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
- (e) Develop and review periodically a drug formulary for use in the Hospital, prescribe the necessary operating rules for its use, and assure that said rules are available to and observed by all Staff members.
- (f) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.
- (g) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
- (h) The Pharmacy & Therapeutics Committee submits written reports at least quarterly concerning drug utilization policies and practices in the Hospital.
- (i) Major Pharmacy Department and Nutrition/Food Services policy review.

- (a) Maintain surveillance over the Hospital Infection Control Program.
- (b) Develop and implement a system for reporting, identifying and analyzing the incidence and cause and reviewing the proper management and epidemic potential of infections among patients.
- (c) Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.
- (d) Develop, evaluate and review preventive, surveillance and control policies and procedures relating to all phases of the Hospital's activities, including: operating rooms, delivery rooms, special care units; central service, housekeeping and laundry; sterilization and disinfection procedures by heat, chemicals, or otherwise; isolation procedures; prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment; testing of Hospital personnel for carrier status; disposal of infectious material; food sanitation and waste management; and other situations as requested.
- (e) Coordinate action on findings from the Medical Staff's review of the clinical use of antibiotics.
- (f) Conduct on a periodic basis statistical/prevalence studies of antibiotic usage and susceptibility/resistance trend studies.

21.1-10 EMERGENCY PREPAREDNESS

- (a) Assist in developing and periodically reviewing, in cooperation with the Hospital administration, a written plan that is designed to safeguard patients at the time of an internal disaster.
- (b) Assist in developing and periodically reviewing, in cooperation with the Hospital administration, a written plan for the care, reception and evacuation of mass casualties due to an external disaster that is coordinated with the inpatient and outpatient services of the Hospital, that adequately relates to other available resources in the community and coordinates the Hospital's roles with other agencies in the event of disasters in the Hospital's or nearby communities, and that is rehearsed by all personnel involved at least twice yearly.

21.1-11 PLANNING

- (a) Participate in evaluating on an annual basis existing programs, services and facilities of the Hospital and Medical Staff and recommend continuation, expansion, abridgment or termination of each.
- (b) Participate in evaluating the financial, personnel and other resource needs for

beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment, and assess the relative priorities of services and needs and allocation of present and future resources.

21.1-12 NOMINATING

Identify nominees for election to general Staff offices and to the Nominating Committee.

21.2 FUNCTIONS OF DEPARTMENTS AND SECTIONS

The specific clinical, administrative, quality assessment and improvement, and collegial and education functions of the Departments and Sections are described below.

21.2-1 CLINICAL FUNCTIONS

(a) Departments: Each Department shall:

- (1) establish, implement and monitor its members' adherence to clinical standards, policies, procedures and practices relevant to the various clinical disciplines under its jurisdiction;
- (2) provide an inter-specialty and inter-Department forum for matters of clinical concern and for resolving clinical issues arising out of the interface between its members' activities and the activities of other patient care and administrative services;
- (3) develop patient care standards, policies, and procedures within the Department and across its constituent Sections; and
- (4) develop, with assistance from the various Sections and other specialists and sub-specialists, criteria for use in making credentials recommendations on initial appointments, reappointments, grants of clinical privileges, concluding the provisional period, and other credentials matters, and make recommendations on these matters as outlined in the Medical Staff Bylaws-

(b) Divisions: Each Division shall perform the same functions as identified above for Departments as applicable to its particular specialty or subspecialty, coordinating its activities with those of the Department as a whole and with the other Sections within the Department.

21.2-2 ADMINISTRATIVE FUNCTIONS

(a) Departments: Each Department shall:

- (1) provide a forum for its members to contribute their professional views and insights to the formulation of the Department, Medical Staff and Hospital policies and plans;
 - (2) coordinate, through its Chief, the professional services of its members with those of other Departments and with Hospital support services; and
 - (3) make recommendations, through its Chief, to the MEC, the Hospital, and other clinical and administrative services.
- (b) Divisions: Each Division shall perform the same functions as identified above for Departments as applicable to its particular specialty or subspecialty, coordinating its activities with those of the Department as a whole and with the other Sections within the Department.

21.2-3 QUALITY IMPROVEMENT AND PATIENT SAFETY ACTIVITIES

- (a) Departments: Each Department shall:
- (1) review quality improvement and patient safety data and findings pertinent to the Department, and make recommendations or take action as appropriate;
 - (2) Review data and findings related to JCAHO core measures and Best Care Measures; and
 - (3) Make recommendations or take action as appropriate.
 - (4) participate in mortality and morbidity review, review medical records for quality and clinical practice patterns, conduct special studies of inputs, processes and outcomes of care as requested, perform specified monitoring activities, and otherwise participate as required in the quality assessment and improvement activities; and
 - (5) report findings, conclusions, recommendations and actions taken relative to the activities performed under paragraphs (1), (2) and (3) immediately above to appropriate members of the Department and to the appropriate Staff-wide committee.
- (b) Divisions: A Division shall perform the function identified in (1) above for Departments if it meets on a regularly scheduled basis or as specifically requested by the Department Chief, the Medical Staff , the MEC, or the Medical Staff Quality Council. It shall perform the functions identified in (2), (3) and (4) above for Departments as the same are assigned to it by the Department Chief, the Medical Staff , the MEC, or the Medical Staff Quality Council.

When necessary for coordination of activities across Sections and in the absence of Sections, each Department shall serve as the most immediate peer group for:

- (a) providing clinical support among and between peers;
- (b) research, continuing education and sharing new knowledge relevant to the practice of Department members; and
- (c) providing consultative advice in its area to members of other Departments.

SECTION XXII MEDICAL STAFF COMMITTEES

22.1 DESIGNATION

There will be a Medical Executive Committee (MEC) and the following standing committees responsible to the MEC: Credentials, Pharmacy and Therapeutics, Medical Staff Quality Council, Infection Control Committee, Cancer Committee and Continuing Medical Education.

22.2 OPERATIONAL MATTERS RELATING TO COMMITTEES

22.2-1 REPRESENTATION ON HOSPITAL COMMITTEES AND PARTICIPATION IN CERTAIN HOSPITAL DELIBERATIONS

Staff functions and responsibilities relating to liaison with the Board and Management, accreditation/licensure/certification, disaster planning, facility and services planning, financial management, and functional and physical plant safety which require participation of, rather than direct monitoring by, the Staff shall be discharged in Section by various officers and organizational components of the Staff as described in the Bylaws and the related manuals and in Section by Medical Staff representation on Hospital committees established to perform such functions. The Medical Staff, through its general Staff and clinical unit officers or their respective designees or through other organizational components, will be represented and Section in any Hospital deliberations affecting the discharge of Medical Staff responsibilities.

22.2-2 EX OFFICIO MEMBERS

The Medical Staff, the Hospital, and the Southwest Representative, or their respective designees, are ex officio members of all standing and special committees of the Staff, with vote when so specified in the provision or resolution creating the committee.

22.2-3 ACTION THROUGH SUBCOMMITTEES

Any standing committee may elect to perform any of its specifically designated functions by constituting a

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subcommittee for that purpose, reporting such action to the MEC. Any such subcommittee may include individuals in addition to or other than members of the standing committee. Such additional members are appointed by the committee chairperson after consultation with the Chief of Staff in the case of Medical Staff members, and with the approval of the Hospital President, or his designee, when administrative staff appointments are to be made.

22.2-4 COMPOSITION

A Staff committee created in the Bylaws or this Manual or otherwise is composed as stated in the description of the committee. Any other committees that may be established to perform one or more of the Staff functions required by the Bylaws and the related manuals will be composed of members of the Active Staff and may include, where appropriate, Courtesy members, allied health professionals and representation from Management, Nursing Services, Health Information and Records Management and such other Hospital sections as are appropriate to the functions to be discharged. Each designated member of a committee Section with vote, unless the statement of committee composition designates the position as non-voting.

22.2-5 APPOINTMENT OF MEMBERS AND CHAIRPERSON

The Chief of Staff appoints the chairpersons and members of committees, in consultation with the Vice-Chief and subject to the approval of the MEC. Non-Medical Staff members are subject to the approval of the Hospital CEO or his designee. Where necessary to accomplish a function or task assigned to a committee, the committee chairperson may call on outside consultants or on special advisors from clinical specialties or administrative or patient care departments with expertise in the subject matter involved, after consultation with the Chief of Staff, and with the Hospital President, or his designee when Hospital administrative or patient care departments or outside consultants are involved. Each committee chairperson appoints a vice-chairperson of the committee to chair any meeting from which the chairperson is absent. Each committee chairperson or other authorized person chairing a meeting has the right to participate in discussion of and to vote on issues presented to the committee.

22.2-6 TERM, PRIOR REMOVAL AND VACANCIES

Except as otherwise expressly provided, each appointed committee member serves a two-year term, unless he sooner resigns or is removed from the committee or the Staff, and may be reappointed to the committee. To facilitate continuity of function, terms of committee members may be staggered so that complete turnover in committee membership does not occur at any given point in time. To create or maintain such a staggered term mechanism, the term of a committee member may be less than two years. Each chairperson of a committee should have served for at least a year on the committee or otherwise have experience in the functions assigned to the committee.

A Medical Staff member serving on a committee, except one serving ex officio, may be removed from the committee for failure to maintain himself in good standing as a Staff member, for failure to satisfy the attendance requirements specified in this Manual, or by action of the MEC. Any ex officio member of a Staff committee ceases to be such if he ceases to hold a designated position which is the basis of ex officio membership. A vacancy in any committee is filled for the unexpired portion of the term in the same manner in which original appointment is made.

22.3 MEDICAL EXECUTIVE COMMITTEE

The composition, duties and authority, and meeting and reporting responsibilities of the MEC are as set forth in section 17.1-17.4 of the Rules & Regulations. Its governance, direction, coordination, action, and reporting functions are as identified in section 17 of this Manual.

22.4 CREDENTIALS COMMITTEE

22.4-1 PURPOSE AND MEETINGS

The Credentials Committee:

- (a) Coordinates the Staff credentials function by:
 - (1) Receiving and analyzing applications and recommendations for initial appointment, reappointment, provisional period conclusion or extension, clinical privileges, and changes therein, and recommending action thereon in accordance with the guidelines set forth in the Medical Staff Bylaws;
 - (2) Reviewing and recommending qualifications for granting clinical privileges based upon Departmental recommendations and in accordance with the guidelines set forth in the Medical Staff Bylaws;
 - (3) Developing or coordinating, periodically reviewing, and making recommendations on the procedures and forms used in connection with each component of the credentialing process and recommending standards for the content and organization of the individual credentials files.
- (b) Oversees implementation of the credentialing procedures for allied health professionals (AHP) and receives reports of findings, conclusions and recommendation regarding clinical privileges/specified services for allied health professionals.
- (c) Investigates, reviews and reports to the MEC on matters referred to it regarding the clinical or ethical conduct of any practitioner.

The Committee meets monthly or as often as necessary to fulfill its functions and reports to the MEC and the JCGC.

22.4-2 COMPOSITION

The Credentials Committee includes:

- (a) A Chairperson (Secretary of the Medical Staff)
- (b) A minimum of seven (7) members of the Active Medical Staff, one of whose practice is based at the Southwest facility; with vote;
- (c) Vice President/Chief Operating Officer, as staff and without vote.
- (d) Medical Staff Services representatives, as staff and without vote;

22.5-1 PURPOSE AND MEETINGS

The Pharmacy and Therapeutics Committee fulfills Staff functions relating to medication utilization and the Formulary. In addition, it advises the Medical Staff, Nutrition and Food Services, and Pharmacy on matters of nutrition, including guidelines/protocols on the use of special diets and total parenteral nutrition. The Committee meets on a bi-monthly basis or as needed and reports to the Medical Staff Quality Council.

22.5-2 COMPOSITION

The Pharmacy and Therapeutics Committee includes:

- (a) A Chairperson;
- (b) Seven (7) members of the Active Medical Staff, one of whose primary practice is at Southwest, with vote;
- (c) Director of the Pharmacy, with vote;
- (d) Representative of Nutrition and Food Services, with vote;
- (e) Vice President/Chief Nursing Officer, with vote;
- (f) Risk Management, without vote
- (g) Director of Health Care Improvement, as staff and without vote.
- (h) Infection Control Committee Chairman

22.6 MEDICAL STAFF QUALITY COUNCIL

22.6-1 PURPOSE AND MEETINGS

The Medical Staff Quality Council directs the quality, peer review and utilization management programs for the Medical Staff. The Medical Staff Quality Council will serve as a liaison to the Hospital Quality Council. The Committee will meet monthly, or as required.

22.6-2 COMPOSITION

The Medical Staff Quality Council includes:

- (a) A Chairperson (Vice Chief of Staff);
- (b) Vice Chiefs of Departments, with vote;
- (c) Vice Chiefs of Divisions, with vote;
- (d) Medical Directors of Special Care Units, with vote;
- (e) Representative of Inpatient Care Associates, with vote
- (f) Medical Director of Transplant Services, with vote
- (g) Risk Management, without vote
- (h) Vice President/Chief Operating Officer, without vote;
- (i) Director of Health Care Improvement, as staff and without vote.
- (j) Pharmacy and Therapeutics Committee Chairman with vote.

22.7-1 PURPOSE AND MEETINGS

The Continuing Medical Education Committee provides ongoing curriculum which enables physicians and allied health professionals to increase their knowledge, clinical expertise and improve their organization and interpersonal skills in an effort to provide optimum patient care. This will be accomplished through regularly scheduled weekly educational programs as well as half day and full day seminars. CME programs will be presented in topic areas identified as needed through lectures, case presentations, slide presentations, video tapes and discussions. The Committee will meet annually or as needed.

22.7-2 COMPOSITION

The Continuing Medical Education Committee includes:

- (a) A Chairperson;
- (b) Seven (7) members of the Medical Staff, with vote;
- (c) Director of Health Care Improvement as staff and with vote.
- (d) Representative from Department administratively responsible for CME activities, as staff and without vote.

22.8 INFECTION CONTROL COMMITTEE

22.8-1 PURPOSE AND MEETINGS

The Infection Control Committee fulfills Staff functions relating to infection control. The functions of the Infection Control Committee are as follows:

- (a) Approval of the type and scope of surveillance activities including review of microbiological reports, determination of definitions and criteria for nosocomial infections, prevalence and incidence studies, as appropriate and collection of additional data as needed;
- (b) Approve infection prevention and control actions based on evaluation of surveillance reports and other information;
- (c) Develop procedures and systems for identifying, reporting and analyzing the incidence and causes of infection;
- (d) Institute any surveillance, prevention and control measures or studies when there is reason to believe any patient or personnel might be at risk;
- (e) Review all policies and procedures on infection prevention, and control at least biannually;
- (f) Make recommendations for policy and procedure additions, deletions or modifications to the Hospital Quality Council and/or System Policy and Procedure Committee;
- (g) Review and analyze any antimicrobial susceptibility/resistance trend studies;
- (h) Develop a plan and participate in the orientation of new employees and continuing education of all employees regarding infection control;
- (i) Participate in the review of proposed equipment, supply and product purchases for their safety and efficacy as it relates to infection control;

- (j) Serve in an advisory capacity to departments performing studies related to infection control and review the results of those studies;
- (k) Participate in the safety and environmental risk management program;
- (l) Evaluate on a continuous basis the biohazard, surveillance and control procedures relating to the hospital environment;
- (m) Review and approve procedures to prevent transmission of infection including, but not limited to infection control supplies and devices available to patient care areas, infectious waste management, cleaning procedures, agents and schedules for cleaning, decontamination and sterilization activities, soiled and contaminated supplies management (equipment, linen, etc.);
- (n) Review and approve policies and procedures that describe the role of each department/service in infection prevention and control including the participation of employee health activities in the program; and
- (o) Implement additional infection surveillance and control activities as required by the State of Texas Health Department.

22.8-2 COMPOSITION

The Infection Control Committee includes:

- (a) A Chairperson;
- (b) Seven (7) members of the Medical Staff, with vote;
- (c) Chief Nursing Officer, without vote;
- (d) Infection Control Practitioner, without vote
- (e) Director of Health Care Improvement, as staff and without vote.
- (f) Director of Surgery, without vote;
- (g) Employee Health Nurse, without vote.

22.9 CANCER COMMITTEE

22.9-1 PURPOSE AND MEETINGS

The Cancer Committee:

- (a) Remains in compliance with the current American College of Surgeons Cancer Program Standards.
- (b) Follows the guidelines for patient management and treatment that are currently required by the American College of Surgeons.
- (c) Maintains the authority, responsibility and accountability for the cancer program activities.
- (d) Develops and evaluate the annual goals and objectives for the clinical community outreach, quality improvement, and programmatic endeavors related to cancer care.
- (e) Organizes, publicizes, conducts and evaluates regular education and consultative cancer conferences that are multidisciplinary, institution-wide, predominately prospective, and patient oriented.
- (f) Actively supervises the Cancer registry for quality control of abstracting, staging, and reporting.
- (g) Participates in special studies as requested by the American College of Surgeons.
- (h) Assures that consultative services from all major disciplines, treatment

- options and cancer rehabilitation services are available and utilized.
- (i) Develops and documents staging Policies and Procedures.
 - (j) Provides information about the availability of cancer-related clinical trials and assures that at least 2% of all analytical cases accrue to a clinical trial.
 - (k) Provides 2 prevention or early detection programs each year and monitors community outreach activities on an annual basis.
 - (l) Offers one cancer-related educational activity each year to all members of the Medical Staff and allied health professionals.
 - (m) Completes and documents the required studies that measure quality and outcomes and documents implementation of two improvements that directly affect cancer care.

The Cancer Committee shall meet at least bimonthly or as often as required. Findings and activities shall be reported to the Medical Staff Quality Council.

22.9-2 COMPOSITION

The Cancer Committee shall be a multidisciplinary standing committee consisting of:

- (a) Chairperson, with vote.
- (b) At least 1 Board Certified physician from the specialties of Oncology, Surgery, Diagnostic Radiology, Radiation Oncology, Pathology, and Palliative Care. Other physicians should represent major areas of care appropriate to BASMC, such as Urology, Colon/Rectal Surgery, Plastic Surgery and Head and Neck Surgery, with vote.
- (c) Cancer Liaison physician, with vote.
- (d) Cancer Program Administrator, with vote
- (e) Oncology Nurse, with vote
- (f) Case Manager or Social Worker, with vote
- (g) Cancer Registrar, with vote
- (h) Director of Health Care Improvement, as staff and without vote.
- (i) Pharmacist, with vote
- (j) Other Ad Hoc members such as American Cancer Society representative, Pastoral Care, Physical Therapy Specialists, all without vote.

22.10 TASK FORCES

22.10-1 PHYSICIAN HEALTH AND REHABILITATION TASK FORCE

The Physician Health and Rehabilitation Task Force provides mechanisms for the identification, intervention and referral for treatment for a Medical Staff member who is identified as possibly being impaired. The Task Force also provides a positive assistance program for impaired Staff members. The mission of the Physician Health and Rehabilitation Task Force is to be an advocate and educators for Medical Staff and Affiliate Staff.

The composition of the Physician Health and Rehabilitation Task Force includes three (3) Active Medical Staff members and medical staff representative. The Task Force meets on an as needed basis.

The Professional Conduct Task Force provides mechanisms for investigating matters of disruptive conduct. The Task Force works in conjunction with the Physician Health and Rehabilitation Task Force. The mission of the Professional Conduct Task Force is three fold: 1) investigate and decide if there was disruptive behavior; 2) if there was disruptive behavior, decide if action is needed, or referral to Physician Health and Rehabilitation Task Force is appropriate (this latter action will lead to placing practitioner on a “contract”); decide if there was a quality issue which requires an entry in the practitioner’s quality file.

The composition of the Professional Conduct Task Force includes a past Chief of Staff of the Medical Staff as Chairman, President of BASMC (or designee), Board Members, the current Chief of Staff, the current Vice Chief of Staff, and other participants, upon invitation of the Chairman, which could include the Department Chief, the Compliance Officer, etc. The Task Force meets on an as needed basis.

22.10-3 NOMINATING TASK FORCE

The Nominating Task Force shall nominate, when required under the provisions of the Medical Staff Bylaws, one or more qualified candidates for the offices of Vice Chief, and Secretary. They shall meet, respectively, as required under sections 15.3 and 15.4 of the Medical Staff Rules & Regulations and otherwise as necessary to accomplish their function.

The composition of the Nominating Task Force includes three (3) Active Staff members in good standing appointed by the Chief of Staff.

SECTION XXIII MEETING PROCEDURES

23.1 NOTICE OF MEETINGS

Written notice of any regular general Staff meeting, or of any regular committee, Department or Section meeting not held pursuant to resolution, must be delivered personally or by mail to each person entitled to be present thereat not less than seven days nor more than thirty (30) days before the date of such meeting and must be posted. Notice of any special meeting of the Staff, a Department, Section, or a committee must be given orally or in writing at least seventy-two (72) hours prior to the meeting and must be posted. Personal attendance at a meeting constitutes a waiver of written notice of such meeting, except when a person attends a meeting for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting was not duly called or convened. No business shall be transacted at any special meeting except that stated in the meeting notice.

23.2 QUORUM**23.2-1 GENERAL STAFF MEETINGS**

Those members of the Medical Staff in attendance at the Annual Meeting will constitute a quorum for the transaction of any business. The Chief of Staff (or designee) and one member must be present.

23.2-2 DEPARTMENT, SECTION AND COMMITTEE MEETINGS

- a) **Departments:** Those members of the Medical Staff in attendance at the Department Meeting(s) will constitute a quorum for the transaction of any business. The Chief of the Department (or designee) and one member must be present.
- b) **Committees:** Those members of Committees present at the meeting will constitute a quorum for the transaction of any business (the Chairman [or designee] and one member must be present), with the exception of the following committees:
 - 1) **Medical Staff Executive Committee:** The presence of 1/3 of the voting members of the Committee will constitute a quorum.
 - 2) **Credentials Committee:** The presence of 1/3 of the voting members of the Committee will constitute a quorum.

23.3 ORDER OF BUSINESS AT REGULAR STAFF MEETINGS

The order of business at a regular Staff meeting is determined by the Staff. The agenda includes at least:

- (a) Acceptance of the minutes of the last regular and all special meetings held since the last regular meeting.
- (b) Administrative reports from the Medical Staff and the Hospital.
- (c) The election of officers and of representatives to committees, as required.
- (d) When requested, reports by responsible officers, Departments and committees and discussion on the overall results of the Staff's quality assessment and improvement activities and on fulfillment of the other required Staff functions.
- (e) New business.
- (f) Education program, as needed.

23.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present is the action of the group. Action may be taken without a

meeting by the Staff, a Department, Section, or committee by presentation of the question to each member eligible to vote, in person, and their vote returned to the chairperson/chief of the group or to the Chief of Staff in the case of a Staff vote. In cases in which a decision needs to be made prior to the next meeting, the Chairperson may conduct business by mail, providing a fair and complete presentation of the issue. Such vote shall be binding so long as the question is voted on by at least the number of voting members of the group that would constitute a quorum.

23.5 MINUTES

Minutes of all meetings shall be prepared and include a record of attendance and the results of the vote taken on each matter. Copies of said minutes must be signed by the presiding officer, approved by the attendees, and forwarded to the MEC or the parent committee in the case of a subcommittee. Minutes shall be made available, upon request to and upon the approval of the Staff to any Active Staff member who functions in an official capacity within the Hospital so as to have a legitimate interest in them. When access is approved, it shall be afforded in a manner consistent with the confidentiality policies of the Hospital concerning Medical Staff minutes and activities. A permanent file of the minutes of each meeting shall be maintained.

23.6 PROCEDURAL RULES

Meetings of the Staff, Departments, Sections, and committees will be conducted according to the then current edition of Robert's Rules of Order. In the event of conflict between said Rules and any provisions of the Medical Staff Bylaws or any of its related manuals, the latter are controlling.

23.7 ATTENDANCE

All Medical Staff members are encouraged to attend meetings of the General Staff.

In regard to Committee meetings, Medical Staff members on Committees are required to attend fifty percent (50%) of the meetings. Failure to attend the required meetings may cause the physician to be replaced on the Committee.

SECTION XXIV REVIEW AND AMENDMENT

This Rules & Regulations of the Medical Staff shall be reviewed at least annually by the MEC, and may be reviewed more frequently when deemed necessary by the appropriate Medical Staff or Hospital authorities.

The Rules & Regulations Manual may be amended or repealed, in whole or in part, or a new one proposed by the affirmative vote of a majority of the MEC present at a regular or special meeting at which a quorum is present. Amendments or a new Rules & Regulations Manual shall become effective upon the affirmative vote of the Board. Any changes in the MEC's recommendations proposed to the JCGC shall be first submitted to the MEC for its recommendations, including 30 working days for response, and any response timely made shall be carefully considered by the Board prior to its action on the proposed amendments .

APPENDIX

CLINICAL DEPARTMENTS AND THEIR SECTIONS

1. Anesthesiology
Pain Management
2. Emergency Medicine
3. Family Practice
4. Medicine
Division of Cardiovascular Services

Allergy/Immunology
Cardiology
Dermatology
Endocrinology/Metabolism
Gastroenterology
Hematology
Infectious Disease
Internal Medicine
Nephrology
Neurology
Teleneurology
Medical Oncology
Physical Medicine/Rehabilitation
Pulmonary Disease
Rheumatology
5. Obstetrics/Gynecology/Pediatrics
Genetics
Gynecology
Gynecological Oncology
Neonatology
Obstetrics
Pediatrics
Pediatric Cardiology
Pediatric Dermatology
Pediatric Gastroenterology
Pediatric General Surgery
Pediatric Hematology/Oncology
Pediatric Infectious Disease
Pediatric Nephrology
Pediatric Neurology
Pediatric Ophthalmology

Pediatric Orthopedic Surgery
Pediatric Pulmonology
Pediatric Urology

6. Pathology

7. Psychiatry

8. Radiology

Diagnostic Radiology
Radiation Oncology
Teleradiology

9. Surgery

Division of Cardiovascular Services

Cardiovascular/Thoracic Surgery
Pediatric Cardiovascular/Thoracic Surgery

Colon/Rectal Surgery

Dentistry

General Surgery

Bariatric Surgery

Breast Surgery

Transplant Surgery

Neurosurgery

Ophthalmology

Oral/Maxillofacial Surgery

Orthopedic Surgery

Otolaryngology

Plastic Surgery

Podiatry

Urology