MEDICAL STAFF RULES & REGULATIONS

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MEDICAL STAFF RULES AND REGULATIONS

TABLE OF CONTENTS

PREAMBLE 1

SECTION I - NAME 1

SECTION II - DEFINITIONS 1

SECTION III - ADMISSION AND DISCHARGE OF PATIENTS 3

SECTION IV - AUTOPSIES 5

SECTION V - MEDICAL RECORDS 6

SECTION VI - CONSENTS 11

SECTION VII - RESTRAINTS 12

CATEGORIES OF CHEMICAL AND PHYSICAL RESTRAINTS 13

SECTION VIII - REQUIREMENTS FOR SURGERY 14

SECTION IX - ANESTHESIA 18

SECTION X- PROGRESSION OF CASES 19

SECTION XII - CHAIN OF COMMAND - PATIENT CARE ISSUES 22

SECTION XIII - EMERGENCY SERVICES 22

SECTION XIV - DISASTER PLAN 23

SECTION XV - CONTROL OF INFECTIONS 23

SECTION XVI - PATHOLOGY 24

SECTION XVII - SELF-TREATMENT OR TREATMENT OF FIRST DEGREE FAMILY MEMBERS 25

SECTION XVIII - STURGIS STANDARD CODE OF PARLIAMENTARY PROCEDURE 25

SECTION XIX - MEMBERSHIP 25

20.1 COMPOSITION OF THE MEDICAL STAFF 26

20.2 NATURE OF MEMBERSHIP 26
20.3 RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP 26
20.4 DUES 28

SECTION XX - ALLIED HEALTH PROFESSIONALS 28

21.1 ALLIED HEALTH PROFESSIONALS 28
21.1-1 GENERAL 28
21.1-2 MEDICAL ASSISTANTS 29
21.1-3 MEDICAL ASSOCIATES 29

SECTION XXI - OFFICERS 30

22.1 OFFICERS OF THE MEDICAL STAFF 30
22.1-1 IDENTIFICATION 30
22.1-2 QUALIFICATIONS 30
22.1-3 NOMINATIONS 30
22.1-4 ELECTIONS 31
22.1-5 TERM OF ELECTED OFFICE 31
22.1-6 RECALL OF OFFICERS 31
22.1-7 VACANCIES IN ELECTED OFFICE 31
22.2 DUTIES OF OFFICERS 32
22.2-1 PRESIDENT OF THE MEDICAL STAFF 32
22.2-2 VICE-PRESIDENT 32
22.2-3 IMMEDIATE PAST PRESIDENT 33
22.2-4 MEDICAL STAFF REPRESENTATIVE 33

SECTION XXII - DEPARTMENTS AND DIVISIONS OF THE MEDICAL STAFF 33

23.1 CLINICAL DEPARTMENTS AND DIVISIONS 33
23.2 DEPARTMENTS 33
23.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS 35
23.4 FUNCTIONS OF DEPARTMENTS 35
23.5 FUNCTIONS OF DIVISIONS 36
23.6 DEPARTMENT HEADS (CHIEFS OF SERVICE AND VICE-CHIEFS OF SERVICE) AND DIVISION HEADS 36
23.6-1 QUALIFICATIONS 36
23.6-2 TERMS OF OFFICE 37
23.6-3 ELECTION 37
23.6-4 REMOVAL 37
23.6-5 VACANCIES 37
23.6-6 DUTIES 38
23.7 DIVISION HEADS 39
23.7-1 QUALIFICATIONS 39
23.7-2 SELECTION 39
23.7-3 TERM OF OFFICE 39
23.7-4 REMOVAL 40
23.7-5 DUTIES 40
23.8 CONTRACTED MEDICAL DIRECTORS 40

SECTION XXIII - COMMITTEES 40

24.1 DESIGNATION 40
24.1-1 CHAIRPERSONS 40
24.1-2 MEMBERS 41

24.2 QUALITY ASSURANCE AND OTHER FUNCTIONS PERFORMED BY MEDICAL STAFF COMMITTEES 41
24.3 CREATION OF STANDING COMMITTEES 41
24.4 CONFIDENTIALITY OF INFORMATION 41
24.5 EXECUTIVE COMMITTEE 41
24.5-1 COMPOSITION 42
24.5-2 DUTIES 42
24.5-3 MEETINGS 43
24.6 CREDENTIALS COMMITTEE 43
24.6-1 COMPOSITION 43
24.6-2 DUTIES 44
24.6-3 MEETINGS 44
24.7 PHYSICIAN HEALTH & REHABILITATION COMMITTEE 44
24.7-1 COMPOSITION 44
24.7-2 MEETINGS 45
24.8 BYLAWS COMMITTEE 45
24.8-1 COMPOSITION 45
24.8-2 MEETINGS 45
24.9 ETHICS COMMITTEE 45
24.9-1 COMPOSITION 45
24.9-2 MEETINGS 45
24.10 HOSPITAL QUALITY MANAGEMENT 45
24.10-1 COMPOSITION 45
24.11 QUALITY REVIEW COMMITTEE 47
24.11-1 COMPOSITION 47

SECTION XXIV – MEETINGS 48

25.1 MEETINGS 48
25.1-1 GENERAL MEETING 48
25.1-2 SPECIAL MEETINGS 48
25.2 COMMITTEE AND DEPARTMENT MEETINGS 49
25.2-1 REGULAR MEETINGS 49
25.2-2 SPECIAL MEETINGS 49
25.3 QUORUM 49
25.3-1 REGULAR MEDICAL STAFF MEETINGS 49
25.3-2 DEPARTMENT AND COMMITTEE MEETINGS 49
25.4 MANNER OF ACTION 49
25.5 MINUTES 50
25.6 ATTENDANCE REQUIREMENTS 50
25.6-1 REGULAR ATTENDANCE 50
25.6-2 ABSENCE FROM MEETINGS 50
25.6-3 SPECIAL ATTENDANCE 50
25.6-4 CONDUCT OF MEETINGS 50
25.6-5 CONFLICT OF INTEREST 51

SECTION XXV – GENERAL PROVISIONS 52

NOTE: SYSTEM STANDARDIZED LANGUAGE – MAY NOT BE CHANGED W/O PRIOR APPROVAL 52

25.1 ADMINISTRATIVE SUSPENSION OR REVOCATION 52

SECTION XXV – GENERAL PROVISIONS 52

25.1 ADMINISTRATIVE SUSPENSION OR REVOCATION 52

25.1-1 Definition of Administrative Suspension...52

A. Expiration of Licensure, DEA, DPS, and/or Professional Liability Insurance..........

B. Failure to Respond to Requests for Information...

C. Failure to Complete Medical Records..

C.1. Extended Leave or Vacation..

D. Repetitious Infractions...

25.1-2 Notification of Practitioner Suspension or Reinstatement.................................53

A. Notification to Suspend..

B. Notification to Reinstate...

25.1-3 Report to the Texas Medical Board...53

PREAMBLE

In recognition of the desire of the Medical Staff, Administration, and Board of Trustees of Baylor Regional Medical Center at Grapevine to strive for high ideals of humanitarian service to the community through the provision of quality health care, education and research; and in recognition of the need for a Medical Staff organization which can respond effectively to changing conditions in order that it can appropriately conduct its responsibilities subject to the ultimate authority of the Board of Trustees of this Medical Center, the Medical Staff of this Medical Center hereby formulates these Bylaws, subject to the approval of the Board of Trustees of Baylor Regional Medical Center at Grapevine.

SECTION I - NAME

The official name of this organization shall be the Medical Staff of Baylor Regional Medical Center at Grapevine.

SECTION II - DEFINITIONS

The words and phrases herein have the following meanings whenever used in these Bylaws, unless the context requires otherwise.

(a) The *Administration* refers to the Executive Director or his designee(s) who are responsible for managing the day-to-day operations of the Medical Center.

(b) *Adverse Action* means a peer (professional) review activity which results in reducing, restricting, suspending, revoking, denying or failing to renew clinical privileges or Medical Staff membership in a health care entity.

(c) *Applicant* means any individual possessing the qualifications for Medical Staff membership specified in these Bylaws who seeks membership to the Medical Staff.

(d) *Appointment and Reappointment* refer to the process specified herein by which one acquires and retains Medical Staff membership and delineated clinical privileges.

(e) *Board of Trustees* means the governing body of Baylor Regional Medical Center at Grapevine.

(f) *Chairman of the Executive Committee* is the elected President of the Medical Staff who presides at meetings of the Executive Committee

(g) *Executive Director* means the individual designated by the Board of Trustees to manage the operations of Baylor Regional Medical Center at Grapevine.

(h) *Chief of Service or Department Chairman* means the head of a Clinical Department, sometimes referred to as a clinical service, who is appointed by the Board of Trustees.

(i) *Clinical privileges* means the permission granted to an individual Physician, Dentist or Podiatrist, recommended by the Medical Staff and approved by the Board of Trustees, to provide specific professional, diagnostic, therapeutic, medical, dental, or surgical services and procedures at the Medical Center.

(j) *Department* means a division of the Medical Staff composed of members who practice a similar specialty or related specialties.

(k) A *division* is a sub-group of a Clinical Department.

(l) *Ex Officio* means one who serves as a resource person by virtue of an office or position held, but without voting privileges.

(m) For *editorial consistency*, only masculine word forms and pronouns, such as he or his, are used in these Bylaws when referring to both genders. This use is not intended to express an opinion about the gender of the individuals who may be affected by provisions in these Bylaws.

(n) *Medical Center* means Baylor Regional Medical Center at Grapevine.

(o) *Medical Staff Member* means, unless otherwise expressly limited, any fully licensed physician, dentist, or podiatrist, who is appointed by the Board of Trustees as a member of the Medical Staff of Baylor Regional Medical Center at Grapevine.

(p) *Monitoring committees* are those standing committees of the Medical Staff that are responsible for monitoring activities described by the Joint Commission on Accreditation of Healthcare Organizations.

(q) *Physician* means any Medical Staff member licensed to practice medicine by the Texas State Board of Medical Examiners, M.D. or D.O.

(r) *Dentist* means any Medical Staff member who has a doctorate in Dentistry or Dental Medicine and is licensed to practice by the Texas State Board of Dental Examiners.

(s) *Podiatrist* means any Medical Staff member who is licensed to practice podiatry by the Texas State Board of Podiatry Examiners.

(t) *Practitioner* means any individual who is a graduate of an approved medical, dental or podiatry school and holds an unrestricted license to practice medicine, dentistry, or podiatry in the state of Texas.

(u) *President of the Medical Staff* is the elected physician representative of the Medical Staff.

(v) *Professional review action* pertains to any good faith activity by a professional review body duly authorized by these Bylaws, in the furtherance of quality health care, which is taken based on the competence or professional conduct of an individual Medical Staff member which affects or may affect his Medical Staff membership or clinical privileges.

(w) *Professional review activity* means activities undertaken in determining whether a Physician, Dentist, or Podiatrist may be appointed or reappointed and/or be granted clinical privileges in this Medical Center, determining the scope or conditions of such clinical privileges or membership, or changing or modifying such clinical privileges or membership.

(x) *Professional review body* pertains to this Medical Center and the Board of Trustees or any committee of the Medical Center which conducts professional review activities, and includes any committee of the Medical Staff of the hospital when assisting the Board of Trustees in a professional review activity.

(y) *Year* means twelve consecutive months.

(z) The words "work cooperatively with others" as used in Sections 3.3-1(c)(2) and the words "working cooperatively with Medical Staff Members, nurses, Medical Center Administration and other" in Section 3.7(3) includes, but is not limited to, the following:

1. Medical Staff members must not berate other people who work at the Medical Center;

(2) Gentle and constructive suggestion in a private setting is sometimes appropriate, but scolding; sarcasm; put-downs; profanity; loud, angry or abusive language; and other similar behavior are unacceptable.

(3) It is not permissible to criticize a person because of difficulty in communication caused by such person's native language; such problems should be discussed only with Medical Center Administration or Chiefs of Service.

(4) Remarks of a sexual nature or reference to a person's ethnic background are not permitted

SECTION III - ADMISSION AND DISCHARGE OF PATIENTS

1. The Hospital shall admit patients suffering from all types of illness requiring general, acute care.

2. A patient may be admitted to the Hospital only by a member of the Medical Staff and all admissions shall be governed by the official admitting policies of the Hospital.

3. A physician member or oral surgeon with appropriate privileges of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for accurately and promptly completing the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring individual and to relatives of the patient. Whenever these responsibilities are transferred to another Staff member, a statement covering the transfer of responsibility shall be entered on the order sheet of the medical record. The admitting physician shall be considered the primary attending physician, unless this responsibility is transferred, as indicated above.

4. Except in emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible. When patient presents for admission, orders shall be written immediately or should already have been received or phoned in to Nursing Staff.

5. Staff members admitting emergency cases shall be prepared to justify to the Executive Committee and the Administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

6. A patient, who needs admission on an emergency basis that does not have a private physician, dentist, or podiatrist, may select any staff member in the applicable department to attend him/her, with the consent of the physician, dentist, or podiatrist. When no such selection is made, the patient will be assigned to the physician on-call in the Emergency Department.

7. Each Staff member shall name a member of the Staff who is to be called to attend his/her patients in an emergency if he/she cannot be reached. If neither the attending physician nor his/her designated associate can be reached and if the chief of the appropriate department cannot be reached, the Executive Director or his/her designee shall have the authority to call any member of the Staff to provide interim treatment, should this be considered necessary.

8. The Medical Staff shall define the categories of medical conditions and criteria to be used in the implementation of patient admission priorities and the review thereof. These shall be developed by several departments and approved by the Executive Committee. In accordance with these criteria, the Business Office will admit patients based on the following order of priorities:

a. Emergency Admissions: those patients who are designated by the attending physician as needing immediate Hospital care and whose condition would suffer if such admission were delayed;

b. Reservation Admissions: those patients already scheduled for surgery, as well as other patients who have previously made reservations in advance for admission on a particular day;

c. Routine Admissions: those patients who are elective admissions in all departments.

9. The attending physician shall be responsible to see a patient admitted to the medical/surgical floor within a reasonable time frame, no later than early morning rounds. The attending physician must document all diagnoses present on admission at the time of admission.

10. Requests for patient room transfer shall be accommodated where possible and in accordance with Hospital policies, but only with the approval of the responsible Staff member.

11. The admitting Staff member shall be responsible for providing such information as may be required, to assure the protection of the patient from self harm and to assure the protection of others whenever the patient(s) might be a source of danger to personnel or property. In the event of the admission of a patient with known or suspected suicidal intent, the admitting Staff member shall advise the patient to seek psychiatric consultation, shall offer assistance in the arrangement for such consultation and shall document this in the patient's medical record.

12. The Hospital medical record must reflect the need for continued hospitalization. Such documentation must contain:

    a. An adequate written record of the reason for the continued hospitalization;

    b. The estimated period of time the patient will need to remain in the Hospital when available;

    c. Plans for post-Hospital care when needed.

13. Patients shall be discharged only on order of the attending physician or oral surgeon. Should a patient leave the Hospital against medical advice without proper discharge, a notation of the incident shall be made in the patient's medical record by the attending Staff member and an attempt shall be made to have the patient sign an "Against Medical Advice" form for the record.

14. Patients admitted to the Hospital shall not be given a leave of absence from the Hospital for more than 24 hours. Any exception to this policy must be ordered by the attending Staff member and approved in advance by the Executive Director.

15. In the event of a death in the Hospital, the deceased shall be pronounced dead by the attending Staff member or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the

deceased by a member of the Medical Staff. Policies with respect to the removal of deceased patients shall conform to local law.

16. Consultations: 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. A request for a consultation from an appropriate source and the need for consultation (ie. the reason for a consultation service) shall be documented in the patient's medical record on the order sheet; failure to do so, constitutes an invalid order. The consultant shall see the patient within a reasonable time period as agreed upon between the attending and consulting physicians. A brief report of findings and recommendations shall be entered in the medical record at the time of the consultation. In the event that the consultant contacted is unable or unwilling to accept the requested consultation alternative arrangements shall be made between the two physicians. When operative procedures are involved, the consultant note, except in an emergency, shall be recorded prior to the operation. At any step along the consultation process the assistance of the Chief of the Medical Staff or designee may be enlisted if necessary.

Guidelines for calling consultations are as follows:

1. When the rules of any clinical unit, including any intensive or special care units, of the Staff require it;

2. When required by state law;

3. When requested by the patient or family;

4. Problems of critical illness when doubt exists as to the appropriate diagnostic or therapeutic measures to be utilized;

5. When additional expertise is needed for appropriate patient care.

SECTION IV - AUTOPSIES

1. It is the policy of the Medical Staff to encourage the seeking of autopsy permission for deaths based on clinical criteria. The following conditions serve as a basis for requesting autopsy:

   a. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician;
   b. All deaths in which the cause of death is not known with certainty on clinical grounds;
   c. Cases in which autopsy may help to allay concerns of and provide reassurance to the family and/or public regarding the death;
   d. Unexpected or unexplained deaths occurring during a dental, medical, or surgical diagnostic procedure or therapy;
   e. Deaths of patients who have participated in clinical trials approved by institutional review boards;
   f. Unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction;

g. Natural deaths that are subject to, but waived by, a forensic medical jurisdiction, such as persons dead on arrival at hospital; deaths occurring within 24 hours of admission, and deaths in which the patient sustained or apparently sustained an injury while hospitalized;
h. Deaths resulting from high-risk infectious and contagious diseases;
i. All obstetric deaths;
j. All neonatal and pediatric deaths;
k. Deaths in which it is believed that autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs;
l. Deaths know or suspected to result from environmental or occupational hazards.

2. In the following circumstances, the medical examiner has jurisdiction:

   a. Cases in which an individual expires within 24 hours following admission to the Emergency Room or ward;
   b. When death is, or is suspected to be, from accidental, suicidal, or homicidal causes, no matter how long the person has been hospitalized or has survived the injuries. The time span may run from minutes to years;
   c. Cases of anesthetic deaths, including those under initial induction and those who do not recover following the anesthesia;
   d. Deaths that occur during, following, or as a result of any diagnostic or therapeutic procedure in the hospital;
   e. Any death where the disease process responsible is either work related or suspicious of being aggravated or accelerated at work;
   f. Stillbirths and neonatal deaths when maternal injury has occurred or is suspected either prior to admission or during delivery;
   g. Maternal deaths, whether during or following delivery, and including death where abortion is suspected;
   h. Death of a child younger than six years of age.

3. Autopsies will be performed only with the documentation of proper consent. Data from autopsies will be used as a source of clinical information in quality assessment and improvement activities.

SECTION V - MEDICAL RECORDS

A. Documentation of Admission and Progress

1. The hospital shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include a history and physical examination, special reports such as consultations, clinical laboratory reports, radiological reports, respiratory therapy reports, physical therapy reports, provisional diagnosis; medical or surgical treatment; operative report, pathological findings, progress notes; final diagnosis, condition on discharge; summary or discharge note; clinical resume; autopsy report, when performed; and all consents for medical or surgical treatment and any special procedures performed.

2. A complete admission history and physical examination shall be dictated or recorded within twenty-four (24) hours after admission and for all outpatient invasive procedures.

It shall consist of a present illness, pertinent past history, family history, social history and review of system as well as a physical examination reflecting major body systems with emphasis on areas pertinent to the present illness.

If a complete H&P has been recorded within 30 days prior to the patient's admission to the Hospital, a durable legible copy of this report, in a form approved by the Hospital and done by a member of the Medical Staff, may be used in the medical record for the current admission. These reports must be updated at the time of admission by documentation on the progress note or on the H&P prior to the procedure.

3. A prenatal record or written evidence of prenatal care with laboratory tests and findings shall be included in all obstetrical cases and will remain a part of the medical record. If no prenatal care was provided, the record should so indicate.

4. When the history and physical examination are not dictated or recorded prior to scheduled surgery or any potentially hazardous diagnostic procedure, or invasive procedure, the Charge Nurse or Unit Supervisor or his/her designee, will cancel the procedure unless the physician documents in writing, that such delay would be life threatening to the patient.

5. Pertinent progress notes shall be recorded at the time of observation. These shall be sufficient to permit the continuity of patient care and facilitate transferability, if necessary. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and treatment. Progress notes shall be written at least daily.

6. A detailed operative report adequately describing techniques and findings is to be written or dictated within 24 hours following surgery and signed by the surgeon as soon as possible. A brief operative note should be written in the patient's progress notes immediately following surgery. Repeated violations of this rule shall be called to the attention of the Executive Committee.

7. A complete anesthesia record shall be written in each case and shall include at least the following:

    a. Pre-anesthesia evaluation of the patient by a physician, with appropriate documentation relative to choice of anesthesia, the anticipated surgical procedure, evaluation of the patient's previous anesthesia problems, if any. Except in extreme emergency cases, this evaluation should be recorded prior to the patient's transfer to the anesthesia and operating area and prior to the administration of pre-operative medication;
    b. Documentation of review of the patient's condition immediately prior to the induction of anesthesia;
    c. Recording of all events taking place during induction of maintenance of and emergence from anesthesia, including dosage and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood components;
    d. Documentation of post-anesthetic visits, including a note describing the presence or absence of anesthesia-related complications (specifying date and time). The record should reflect that one visit was made early in the post-operative period and one after complete recovery from anesthesia.

7. All clinical entries in the patient's medical record shall be accurately dated and authenticated. Authentication may be by written signatures, initials or computer key. The signatures of the person utilizing a computer key (electronic signature) must sign a statement that he/she alone will use the code for the computer key. Signature stamps are approved for outpatient diagnostic services and not for use in the inpatient medical record or for Outpatient Surgery. 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 acknowledgement states that the signature stamp must be in the control, of the physician and that they will not allow unauthorized use of the stamp. Opinions requiring medical judgment should be written, or authenticated, only by individuals who have been granted appropriate clinical privileges.

B. Orders

1. All orders must be legible, in writing, dated, timed and signed by the ordering physician. In addition to the signature, the practitioner will either print his/her name, or physician number or utilize a stamp following signature to ensure author legibility in the event an order needs to be clarified. Orders which are not legible or properly written are not to be carried out until corrected of clarified by the nursing staff. Advanced Practice Nurses and BUMC Residents/Fellows rotating to BMC at Grapevine may order diagnostic and therapeutic procedures on behalf of their supervising physician, but such orders must be co-signed by the supervising physician within 24 hours. Physician Assistants & Nurse Practitioners may order outpatient diagnostic and therapeutic procedures on behalf of their supervising physician, such orders do not require the supervising physician to co-sign. Verbal orders may be taken by the nursing staff and read back to the ordering physician. These must be signed by the physician within 48 hours. Orders for radiology examinations should include a concise reason for the study.

2. There will be orders that must be approved but can be used by nursing staff without being written. These orders must be approved by submission to the respective departments prior to use in patient care. All Orders must originate from and subsequently be signed by a physician.

    1. **Pre-printed Order Sets –** individual order sets for an individual medical staff member or licensed independent practitioner or a physician practice;

    2. **Protocol Order Sets –** orders for treatment or therapy approved by the appropriate medical staff department(s);

    3. **Standing Orders –** orders for specific patients initiated by specific medical staff members or licensed independent practitioners that may be a part of pre-printed orders, protocol order sets, or care paths;

    4. **Care Path Order Sets –** orders for specific diagnosis outlining care and treatment to correspond with the clinical pathway approved by the appropriate medical staff department(s). All orders must originate from and subsequently be signed by a physician.

Medication orders must include the name of the drug, dose or strength, route of delivery, and frequency or rate. PRN medications should include the indication for usage. Dose information should include a zero preceding a decimal point, and no trailing zeroes should be used. Unapproved abbreviations are not allowed and are included in the Hospital Patient Care Policy 7.003 "Physician Orders".

3. All orders must be rewritten when the patient is transferred to a different unit because of a change in status or when the patient returns from the OR, Endoscopy lab, or Labor and Delivery Unit, exception may be made where Carepath applies or procedure is not anticipated to impact patients ongoing care.

4. Drugs administered to patients in the hospital shall usually be obtained through the hospital pharmacy. Patients may, at times, bring their own drugs into the hospital. The use of such drugs shall be considered acceptable, provided that such drugs are identified by the responsible practitioner, or pharmacist, are legibly labeled for contents, dose, and frequency of administration. These are specifically ordered in the patient's medical record to comply with self-administration policies approved by the Medical Staff.

   Before the Institutional Review Board for Human Protection approves a project that requires the use of experimental or investigational drugs, the Medical Staff member performing the research will submit to the Review Board printed material released by the manufacturer of the medication, any additional information concerning side effects, dosage, antidotes, along with the name of the drug and explanation as to how it is to be dispensed.

5. Before an investigational drug is administered to a hospitalized patient in the Medical Center by nursing personnel:

   1. A copy of the Institutional Review Board for Human Protection approved protocol, approval letter and Investigator's brochure must be provided to the Pharmacy Department.

   2. All investigational drugs used in the Medical Center will be stored, labeled, and dispensed by the Department of Pharmacy in accordance with rules and regulations of the Texas State Board of Pharmacy, with the following requirements:

      a. A copy of the drug data sheet must be attached to the patient's chart before nursing may administer the investigational drug;

      b. A copy of the signed lay consent form must be placed in the patient's chart by the next working day after admission to the Medical Center. If a copy of the drug data sheet and lay consent form is not on the chart within the time frames specified, the drug must be administered by the physician.

   3. In emergent cases the above requirements may be waived up to one working day with the approval of the Pharmacy & Therapeutics Chairman or designee. The need for the medication and this waiver must be documented by the attending physician.

All information concerning these investigational drugs will be maintained in the Pharmacy and this information will be available for review.

Automatic Stop/Renewal Orders

All automatic Stop and Renewal Orders will be governed by the current hospital policy.

Neuromuscular blocking agents must be reordered every 7 days. All other orders must be reordered every thirty (30) days and/or when a patient changes status.

Hospital pharmacists approved to provide select medications management services may do so at the order of the attending physician and shall be subject to physician direction

C. Discharge

1. Upon discharge the final diagnosis, follow-up arrangements, and dietary or physical restrictions should be recorded in full without the use of symbols or abbreviations on the discharge form which shall be signed by the attending physician. A discharge summary should be written or dictated on all hospitalized patients and shall include sufficient information to support the final diagnosis and all treatment rendered.

D. Review

1. Health Information Management personnel will concurrently and/or retroactively perform medical record reviews. This practice will allow for the timely identification of deficiencies. Medical Staff members are encouraged to correct any identified deficiencies while the patient is an inpatient.

The requirements and suspension process for: 1) failure to complete medical records; 2) extended leave of absence or vacation; 3) repetitive infractions; and 4) reporting to the Texas Medical Board are stated under Section 14 General Provisions and shall be governed by HIM policies and procedures.

2. No medical record shall be filed until it has been completed by the responsible Staff member, except on order of the Medical Records/Utilization Review Committee in the performance of the medical record review function as specified in Section 25.1-3. This Committee shall be permitted to declare complete for purposes of filing the records of physicians, dentists or podiatrists who are deceased, or who have moved out of the community and no longer hold medical staff membership, or those who for any reason are unavailable to complete their records. No staff member may complete a record on a patient unfamiliar to him/her in order to retire a record of another Staff member who is deceased or otherwise permanently unavailable.

3. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive such information. Records of all patients shall be available to members of the Medical Staff for bona fide study and research consistent with the policies formulated to preserve the

confidentiality of personal information concerning patients. All such projects shall be approved by the Executive Committee prior to the study. Subject to the discretion of the Executive Director or his/her designee, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patient in the Hospital.

4. Records may be removed from the Hospital's safekeeping and jurisdiction only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Executive Director. In case of readmission of a patient, all previous records shall be available for the use of the attending Staff member or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the Staff member for a period to be determined by the Executive Committee.

SECTION VI - CONSENTS

1. GENERAL CONSENT

A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting office should notify the attending Staff member whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the Staff member's obligation to obtain proper consent before the patient is treated in the Hospital. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of risks inherent in any special treatment should be obtained. When consent cannot be obtained, the reason shall be documented in the patient's record.

2. INFORMED CONSENT

It is the duty of the physician, dentist, or podiatrist to obtain the patient's informed consent when required. The physician, dentist, or podiatrist performing a procedure, which is included in the Texas Medical Disclosure Panel's list of procedures requiring full disclosure, has the duty:

a. To disclose to the patient or person authorized to consent for the patient the risks and hazards identified by the Panel; and to document that such information was discussed;

b. To obtain the signature of the patient or person authorized to consent for the patient on a DISCLOSURE AND CONSENT FORM containing the wording promulgated by the Panel.

3. EMERGENCY CONSENT

A written, signed, informed surgical consent shall be obtained prior to an operative procedure, except in emergent situations. In such cases, consent for emergency care of an individual is not required if the individual (1) is unable to communicate because of an injury, accident, or illness or is unconscious and (2) suffers from what reasonably appears to be a life-threatening injury or illness. The circumstances shall be fully explained on the medical record. If time permits, it is recommended that a consultation be obtained before an emergency operative procedure is undertaken.

SECTION VII - RESTRAINTS

Patients have the right to be free from physical and chemical restraints and their use is restricted to clinically justified situations. The Medical Staff promotes patient safety by protecting the patient from self-injury and/or injury to others, while respecting the patient's rights and dignity.

DEFINITIONS:

RESTRAINT – Any method of restricting a person's freedom of movement, physical activity, or normal access to his or her body.

1. **Physical Restraint**: Any manual method, or physical or mechanical device, material or equipment, attached or adjacent to the patient's body that he or she cannot easily remove and that restricts freedom of movement or normal access to one's body. Soft halter/posey vest, wrist restraints are examples of restraints.

2. **Chemical Restraint**: The use of any chemical including pharmaceuticals, through topical
   application, oral administration, injection, or other means, for purposes of restraining a patient and is not a standard treatment for the patient's medical or psychiatric condition.

NON-RESTRAINT - Devices, materials and techniques that restrict patients' movement but are used for purposes other than restraint:

Medical Immobilization – The usual and customary requirements of medical, diagnostic, or surgical procedures leads to the need for limiting the patients' movement and are considered a regular part of such procedures. The mechanisms include, but are not limited to, body restraint/positioning during radiological, surgical and interventional procedures; are restraint via arm board during intravenous administration; and belts on stretchers during transport. Medical immobilization allows completion of the procedure without contamination, and protects the patient from harm.

Adaptive Devices – Devices intended to permit patient to achieve maximum normative bodily function. Adaptive devices may include, but are not limited to, orthopedic appliances, braces, casts, CPM machines, traction devices, and cervical collars.

Protective Devices – Devices intended to prevent possible harm. Helmets and transfer belts are examples of protective devices.

Forensic Devices – Devices applied by law enforcement officials to prevent escape by those under their surveillance.

POLICY:

1. The use of restraints is to be minimized. Alternative intervention strategies, as appropriate, from least restrictive to more restrictive, should be attempted to protect the patient or others from harm, prevent falls, and promote medical surgical healing prior to use of any restraint.

2. Restraints will NOT be used for:
   a. Discipline/punishment of the patient;
   b. Staff convenience;
   c. To administer medical treatment for which consent has not been obtained;
   d. Retaliation by staff.

3. The use of locked restraints is not permitted at the Baylor Medical Center at Grapevine.

4. Trial release on physician ordered restraints may be attempted after an in-person assessment by a credentialed RN determines the original reason for the restraint has abated.

Trial releases:

1. May not exceed one hour without obtaining a new order for re-restraint. If re-restraint is necessary after the one hour, a new order must be obtained.

2. May be reapplied during the one-hour trial period only for the same reason as the original order. If reapplied for a different reason, a new order must be obtained.

3. If reapplication is required during a trial release, the cumulative time may not exceed the maximum time limited order specified by the physician.

4. Therapeutic Intervention Release: Patients may be freed from restraints for the delivery of therapeutic interventions and then re-restrained. The patient's nurse should be notified for assistance in determining if the patient can be released, and to assist in monitoring of the application of restraints at the end of the delivery of therapy.

5. At discharge, no restraints will accompany patient.

CATEGORIES OF CHEMICAL AND PHYSICAL RESTRAINTS

NON-EMERGENT	EMERGENT
Use of restraint to promote medical/surgical healing. ▪ The qualified nurse may initiate use of restraint after alternative interventions have been tried and failed. ▪ Physician order must be obtained from attending physician within 1 hour of restraint initiation and must: ▪ Be time limited, not to exceed 24 hours. No PRN. ▪ Specify type of restraint ▪ Include clinical justification ▪ For each episode of restraint use, a new order is required every 24 hours. ▪ Telephone or verbal order must be signed by next visit. ▪ A face-to-face evaluation must be done within 24 hours by the physician and re-evaluated every 24 hours. ▪ Nurse re-assesses patient every 4 hours for restraint need.	Use of restraint for behavioral health reasons to manage an unanticipated outburst of severely aggressive or destructive behavior that poses an imminent danger to the patient or others. ▪ The qualified nurse may initiate use of restraint after alternative interventions have been tried and failed. ▪ An order must be obtained from attending physician within 1 hour of restraint application and must: ▪ Be time limited to 4 hours for adult, 2 hours for children and adolescents ages 9 to 17, and one hour for children less than 9 years. ▪ Specify type of restraint. ▪ Include clinical justification. ▪ Upon expiration of the original order, a new order must be obtained from the attending physician or designee. ▪ A telephone order is acceptable unless a face-to-face re-evaluation is due. ▪ A physician or other licensed independent practitioner (LIP) must do a face-to-face assessment within one (1) hour of restraint application. ▪ The physician conducts a face-to-face re-evaluation of the patient at least every 8 hours for patients 18 years of age and older and every 4 hours for patients ages 17 and younger.

SECTION VIII - REQUIREMENTS FOR SURGERY

1. Whenever possible, all elective surgical cases should be posted by 5:00 p.m. the day before surgery (or by 5:00 p.m. Friday for surgery on Monday). All cases will be posted on a "first come" basis. Only the surgeon or someone from his office can post the case.

2. At the time of posting, all procedures that will be done are to be posted and listed in the order that they will be done. This greatly assists the OR Staff in preparing for the case. If an additional procedure is possible or probable, based on the findings at surgery, this should also be noted. It is not acceptable to wait until the time of surgery to add additional procedures that were foreseen earlier, since this will result in delay to other physicians and their patients. Also, at the time of posting, the surgeon should list the anticipated length of surgery.

3. The surgery schedule will begin at 7:30 a.m. If there is no other case scheduled and the surgeon does not wish to begin at 7:30 a.m., the case may be tentatively scheduled later in the morning, but will be subject to change if other surgery is scheduled. All cases after the first case will be "on-call." However, a tentative start time will be assigned by the OR Supervisor by adding the anticipated "turn over" time to the previous surgeon's time estimate. If it appears that the actual start time will be later (or earlier), the physician will be notified as soon as this is anticipated.

4. Cases that arise after 5:00 p.m. that are not emergent, yet need to be done the following day, can be posted through the Nursing Supervisor or OR desk, if staffed.

5. The Anesthesiologist will discuss the anesthesia risks with the patient. It is the surgeon's responsibility to obtain an informed consent before surgery. The consent may be signed at the time of pre-op assessment. All procedures done at this facility require an informed consent regardless of status on "List A". The physician should document that risks/benefits have been explained and the patient agrees with treatment planned.

6. It is the surgeon's responsibility to assure that a History and Physical (H & P) and VTE Risk Assessment is completed prior to surgery and must be on patient chart prior to entering OR. If the surgeon is not the admitting physician, he must assure that the admitting physician has done the H & P, or he may, at his option, have his own H & P on the chart. A preoperative H & P must document present illness (pertaining to the operation), pertinent past history, risk factors for VTE, social history, family history and a physical exam, which clearly describes the patient's pulmonary status, cardiac status and the findings in regard to that part of the body upon which the operation must be performed.
   All elective surgical cases must have a complete H&P available for the nursing staff at the time of the preop visit which should include a VTE risk assessment in addition to the other components. The VTE Risk Assessment Form may be used to satisfy this aspect of the patient's history. An H&P performed within the last 30 days may be used as long as it is amended noting any changes or stating no changes immediately prior to surgery.

7. Prior to going to surgery, invasive lines will be disconnected and saline locked per IV Therapy: Initiating/Continuous/Intermittent with Saline Lock (Policy #10.019). Exceptions include patients in NICU, ICU, PCU or on critical drips and blood products. IV access will not be initiated on the affected operative site. The nurse will document IV process in the surgery checklist.

8. The surgeon should be present in the Medical Complex and notify the OR of this fact before the scheduled start time. The patient will not be moved to the OR table before that. If the surgeon is not present 15 minutes after the scheduled time, the physician

will be documented as a late start. Three occurrences of late 7:30 a.m. starts in a consecutive three-month period will result in loss of scheduling 7:30 a.m. cases for a 90-day period. If the surgeon is detained by an emergency, he will notify the OR as soon as possible and if possible, the schedule will be rearranged. However, this will be based on the consent of all physicians who will be affected, as well as appropriate operating room staff.

9. **Preoperative Evaluations:**
All patients undergoing any arterial bypass, aneurysm, or endarterectomy procedure must have a pre-op cardiac evaluation prior to the procedure. The results should be faxed to pre-op prior to the pre-op visit for Anesthesia Evaluation.

10. **Preoperative Testing:**
All pre-operative tests should be guided by information from the history and physical and if indicated, performed within 7 days of the scheduled procedure:

a. For male patients who are active and healthy without abnormal findings in history and physical, no pre-operative tests are required;
b. Menstruating or post-menopausal females should have a hematocrit;
c. Patients with recent cocaine history, mitral valve prolapse, frequent palpitations, or uncontrolled hypertension should have an EKG. If available for review, an EKG done within 6 months on stable or asymptomatic patients will suffice. All exceptions must have a written order;
d. A patient with a smoking history greater than or equal to 20 pack/year or pulmonary findings on history and physical, chest x-ray will be required. If available for review, films and/or radiologist reports done within 1 year;
e. Clinical judgment based on the history & physical exam dictates other preoperative tests. Consultation with the anesthesiologist is welcomed if any questions arise. Other screening laboratory studies may include but are not limited to:

   1. Hematocrit if there is a history of anemia or bleeding;
   2. Complete blood count if there is a history of bleeding or sepsis, or expected significant blood loss during procedure;
   3. Urinalysis if history of UTI, renal disease, or diabetes;
   4. Basic Metabolic Panel if there is a history of renal disease, diabetes, cardiopulmonary disease, hypertension, multisystem disease or patients on insulin, digitalis preparations, theophylline, or diuretics;
   5. Hepatic Panel if history of liver disease;
   6. Pregnancy test if ordered by the surgeon or at the request of the patient as noted on the Anesthesia Questionnaire;
   7. Coagulation profile, if there is a history of bleeding tendency or coagulaopathy;
   8. Pulmonary functions tests, ABG, serum drug levels, sickle cell prep, hepatitis B surface antigen, HIV or other screening tests should be considered as clinical judgment warrants based on the surgeon/anesthesiologist history & physical exam, type of procedure and type of anesthetic;
   9. The assigned anesthesiologist will have the right to postpone any scheduled surgery after consultation with the surgeon/physician when in his/her opinion the patient is not a satisfactory risk;
   10. Calcium and phosphorus on all thyroid surgeries;
   11. Drug Screen with history of recreational drug usage in past one (1) year;

12. Type and screen with history of hematologic abnormalities excluding vascular access.

11. A patient admitted for general dental care is a dual responsibility, which involves the dentist and a physician member of the Medical Staff.

Responsibilities of the dentist include:

a. A detailed dental history, which justifies admissions to the Hospital;
b. A detailed description of the examination of the oral cavity and a preoperative diagnosis;
c. A complete operative report, which describes the findings and techniques. In case of extractions, the number of teeth and fragments removed shall be stated and all teeth, tissue and fragments shall be sent to the pathologist for appropriate examination;
d. Progress notes as are pertinent to the oral condition; and
e. Clinical summary statement.

Responsibilities of the physician include:

a. A medical history pertinent to the patient's general health;
b. A physical examination to determine the patient's condition prior to anesthesia and surgery; and
c. Supervision of the patient's general health status while hospitalized.

Discharge of the patient shall be on written order of the dentist member of the medical staff with concurrence of the physician member of the Staff who is jointly responsible for the patient.

12. When appropriately credentialed a podiatrist may admit a patient for outpatient services. For patients with only few well-controlled or no medical problems (Anesthesia Class I-II), this may be done without the assistance of another physician. Any patient with significant medical problems shall be admitted by the patient's primary-care physician or other staff physician appropriate for the patient's history. Credentialing for this privilege shall be determined by the Department of Surgery and shall include training for and experience in admission history and physical.

The responsibilities of the admitting podiatrist and/or physician shall be the same as for any other patient admitted to the hospital and shall include a medical history pertinent to the patient's condition, a physical examination delineating any abnormalities, and assessment of the patient's ability to undergo surgery and anesthesia. The record should include a detailed description of the operative area with a pre-operative diagnosis and a written and dictated operative report detailing the procedure and intra-operative findings.

When admitted by a podiatrist and physician for inpatient services there shall be documentation of appropriate care by both on a daily basis and the discharge shall be a concurrent order written by both the podiatrist and the physician.

13. The need for a physician as a first assistant should be at the discretion of the primary surgeon, as long as the primary surgeon has the required privileges for the procedure.

    The request for a second scrub person should be made at the time of posting. The request will be accommodated by surgery as staffing permits. It cannot be automatically assumed that surgery can provide more than one scrub person per case.

    It is ultimately the primary surgeon's responsibility to assure that he/she has adequate assistance.

14. In all cases for which prophylactic antibiotics are indicated these shall be administered in the OR within 1 hour of incision,(with exceptions for those agents that require slower infusions). The identification and timing of these drugs shall be part of the "timeout" process and shall include a confirmation of an appropriate agent for the procedure. All prophylactic antibiotics shall be discontinued within 24 hours (48 hours for cardiac cases) unless an order for an established infection is entered in the chart with documentation of the infection.

15. In addition, physicians must adhere to the Rules & Regulations of the Medical Staff, Section V regarding history and physical requirements and Section 25.1-1 under Administrative Suspension.

SECTION IX - ANESTHESIA

1. Continual anesthesia coverage will be provided by Anesthesiologists on Staff or when an Anesthesiologist is not available by Certified Registered Nursing Anesthetists (CRNA). The type of anesthesia will be determined by the Anesthesiologist or by the surgeon supervising the CRNA. CRNAs must be supervised by a physician.

2. General anesthesia will be administered only by an Anesthesiologist or CRNA.

3. An Anesthesiologist or CRNA will be available for elective operations performed in the Operating Room upon request at the time of posting.

4. The Anesthesiologist or CRNA on-call shall be available upon request for emergency operations.

5. Regional anesthesia, such as subarachnoid blocks (spinal), epidural blocks, axillary blocks and bier blocks will be performed only by physicians and CRNAs trained in these techniques. A physician or CRNA's qualification to perform these techniques will be determined by the Medical Staff.

6. Local anesthesia, including field blocks and single nerve blocks such as digital nerve blocks, may be performed by any practitioner trained in such techniques. A practitioner's qualifications to perform these techniques will be determined by the Medical Staff.

7. Nitrox may be self-administered by a patient under the supervision of a physician qualified in its use.

8. A patient that is American Society of Anesthesiologists' Risk III or greater must have monitored anesthesia care.

9. Any physician administering "conscious sedation" for a procedure must demonstrate competence as determined by the Credentials Committee upon appointment and/or reappointment to the Medical Staff.

10. Anesthesia Technicians and Certified Anesthesia Technicians employed by the hospital may perform certain duties as outlined in respective job descriptions and delegated by the Anesthesiologist under their supervision. These duties are fully detailed in current job descriptions.

11. The anesthesiologist shall accompany any patient that has undergone an anesthetic to the PACU or the ICU and present the patient to the nurse that will be assuming care of the patient. The anesthesiologist shall receive and record the initial vital signs from the nurse, who should indicate an understanding of the patient's condition and remain with the patient until the patient has been assessed and deemed stable by the anesthesiologist. The anesthesiologist should leave a phone or beeper number, which the nurse could use to contact him/her or a covering physician.

12. Release of any post-anesthesia patient from the recovery area must be authorized by a physician. If the attending physician is not physically present, the discharge must be based on discharge criteria previously agreed upon by the Medical Staff and included in recovery area policies. Such information as will be necessary for the physician to arrive at the decisions to authorize release of the patient shall be relayed to him/her and the response will be documented as a verbal order. This order must be authenticated at the time of completion of record, as in the case of any verbal order. In the absence of an Anesthesiologist as Director, the CRNA shall perform his/her duties under the direction of the attending Staff member, with overall direction from the physician appointed as Director of Anesthesia in accordance with the Medical Staff Bylaws.

Section X- Progression of Cases

Objective:
Efficiency of Case Progression
Availability of rooms for elective and urgent or emergent operations
Problem:
Conflicts within the progression of add-on cases
Growing volume of add-ons and scheduled cases
Limited Staffing
    OR staff
    Anesthesia staff

Definitions:
Emergency add-on: operation or procedure for a condition that involves immediate threat to life or limb.
    Examples:
1. Ruptured or suspected AAA
2. GSW to abdomen or vessel of extremity, chest or neck

3. Near amputation
4. Life-threatening hemorrhage, i.e., ruptured ectopic pregnancy
5. Post-op bleeding

Urgent add-on: Condition that is not immediately life threatening but a delay of more than a few hours may adversely impact prognosis.

Examples:

1. Missed abortion/D&C
2. Open fracture
3. Appendicitis

Note: If bumping is necessary to post an urgent case this requires a call from the posting surgeon ("bumper") to the one who loses a scheduled or add-on time ("bumpee"). Urgent cases may be upgraded to emergent if no OR is available for a reasonable period of time and, in the opinion of the treating surgeon, a further delay would be detrimental to the patient.

Elective add-on: Patients whose condition would allow elective scheduling but are currently in-house and are currently prepared for surgery. These cases may have been in-house for over 24 hours and/or could be delayed for a day without excessive risk for further complications.

Examples:

1. ER admission for biliary disease without evidence of sepsis or choledocholithiasis.
2. Hip fractures
3. Missed abortion

Elective cases: Those that are scheduled in advance and admitted directly to surgery. These may include inpatients, outpatients and AM-admits.

Time-specific add-on: Those with a requested start-time.

Right of first refusal: Process by which a surgeon is notified of an available room and given the opportunity to proceed with the case immediately. If not able to proceed the room will be offered to the next surgeon on the list which may result in loss of a position on the list or a specified time, applies to add-ons

Case over-runs: Any case that is not completed at the appropriate time shall be recorded by the staff for review by the EUC.

The following are guidelines for efficiency and may be utilized or modified by the Efficiency and Utilization Committee (EUC).

1. Accurate estimation of case duration.

To have rooms available for add-ons the cases in the 5 rooms scheduled to 3:00 must run "on time" and finish promptly at 3:00 or sooner. Furthermore those cases scheduled to 7:00 must likewise finish at this time. This requires that cases be scheduled accurately by the surgeon. If a surgeon repeatedly underestimates the time required for a particular procedure the scheduling department may assign times that are more generous and based on past experience.

2. Prompt arrival of personnel.

All necessary staff must be available at the assigned time either as scheduled or when the staff is ready for "to-follows" and "add-ons". If a surgeon fails to report for a case within 30 minutes

of its scheduled or estimated time or declares “unavailable” the case may be bumped back one position to allow the next case to proceed if it is available immediately. Repeated tardiness may result in the loss of scheduling rights for a particular time of day and for a period as determined by the EUC.

3. Add-on triage.
All add-ons shall be posted in the order in which they are received from the posting surgeon. Only the charge nurse shall be allowed to accept cases and only after consulting with the responsible anesthesiologist. The surgeon shall be notified of the position on the list of add-ons and the estimated time at which the case may be expected to go to the room. While a surgeon may post a case without seeing the patient this position is “firm” only after the patient has been seen and evaluated by the surgeon. Any cases posted after evaluation may be placed ahead of those posted without being “seen” by the surgeon. The room will not be opened until this evaluation has been confirmed except in those emergent cases in which a delay may be life threatening.

4. Time-specific add-ons.
Cases posted for a specific time may be subject to displacement to allow for a case that is available at an earlier time. The surgeon being displaced shall be notified when a room is available and be allowed “right of first refusal”. To refuse displacement the surgeon must be available immediately to “move up”.

5. Progression of scheduled and add-on cases.
When called for a case whether scheduled or as an add-on the surgeon should be available and present for the case within 30 minutes or, where applicable, another case that is immediately available may be allowed to proceed. Only one position in the sequence can be lost and each time the surgeon shall be notified of the availability of the room and allowed right of first refusal if immediately available to do the case in question.

6. After-hours Emergencies
While it is possible to call in the OR team for an after-hours emergency prior to seeing the patient this should be done only when confident that the case will be done and there is very little likelihood that it would be cancelled by the surgeon after this evaluation. Any cases canceled by the surgeon after this evaluation will be reported to the EUC for review. If a quality issue is identified it should be referred to QRC.

Urgent cases that present in the late evening hours may be posted as early time-specific add-ons at 05:00 AM (to avoid running over into scheduled 7:15 cases) as an option to calling in the on-call team in the middle of the night. This is at the discretion of the surgeon and anesthesiologist and should require a call from the surgeon to the anesthesiologist to confirm.

If staffing limitations do not allow for the completion of scheduled or add-on cases there should be a consideration of postponement to a later date if the patient's condition permits rather than render the emergency crew unavailable after 7:00 PM. The surgeon and patient should be allowed the first add-on slot the next day if there is an agreement to postpone the case to the following day.

Violations

It is inherent that cases may not begin or end as scheduled and most overruns are not the fault of the surgeon or staff. Any episodes of tardiness, over-runs or miscommunications should be

brought to the attention of the (EUC) for discussion and action. Any quality concerns should be referred to the Quality Review Committee (QRC).

Corrective actions are the judgment of the EUC and may be taken to the DOS or MEC when appropriate. These actions may result in the loss of scheduling times or the right to estimate durations as mentioned in the above sections.

SECTION XII - CHAIN OF COMMAND - PATIENT CARE ISSUES

The following mechanism for resolution will be implemented to procure immediate patient care in the event of physician unavailability:

The authority for direction to provide interim treatment if necessary belongs with the present attending physician, if one is assigned. In the event that he/she cannot be reached, the following individuals will be contacted:

1. Chief of Service or Vice Chief of Service;
2. President of the Medical Staff;
3. Hospital Executive Director or Hospital Administrative Representative on call.

EXCEPTIONS:

1. **Emergency Department**

    a. Patient's physician or physician on call;
    b. Emergency Department's Medical Director;
    c. Hospital Executive Director or Hospital Administrative Representative on call.

2. **Intensive Care**

    a. Patient's physician or appropriate consultant;
    b. Emergency room physician will respond in an emergency situation until the patient's physician arrives;
    c. ICU Medical Director, or his designee;
    d. President of the Medical Staff;
    e. Hospital Executive Director or Hospital Administrative Representative on call.

All shall have the authority to call any member of the staff to provide interim treatment, should this be considered necessary.

SECTION XIII - EMERGENCY SERVICES

ER Call responsibility at Baylor Regional Medical Center at Grapevine is determined by the appropriate clinical specialty department. It is required that all “Active-Clinical” medical staff members participate in their department’s monthly call schedule. Courtesy staff members may be required to participate in ER call if it is determined by the department. The ER call schedule is published monthly through the Medical Staff Office.

If the call schedule is already out and an assigned physician is unable to serve his/her scheduled call period (for whatever reason), he/she is responsible for arranging for another physician in the same specialty to take the call period. The physician must then notify Medical Staff Services that he/she will be unable to take call and which physician will be covering the call period. Medical Staff Services will make the revision to the call schedule and will notify the appropriate individuals/departments of the charge.

The specialists that are on call are to be determined by the respective departments subject to approval by the Medical Executive Committee (MEC) and Board of Trustees and must be in compliance with government regulations. While it is desirable to have coverage for all services there may be cases in which there are not sufficient physicians or similar practitioners to cover all days of the month. The MEC can establish the minimum number of days of call coverage required to fulfill the requirements of active-clinical staff and to provide for the care of the ER patients of our community

The on-call physician is required to respond by telephone within 30 minutes of being paged by Emergency Services. If the on-call physician does not respond within 30 minutes, the designated backup physician will be contacted. If the physician on-call or the backup physician does not respond within 1 hour, the Chief of the Department will be contacted. The Chief will then be responsible for contacting the on-call physician or appointing another physician to respond to the call. If the Chief has to be called regarding a no response from a physician, the Emergency Services Manager will document the incident and forward the written summary to Medical Staff Services for action.

Members of the Active Medical Staff may request reassignment to the Senior Active Category, if the sum of the members' age and years of continuous active medical staff membership equals or exceeds 70. (e.g. age 55 with 15 years service, age 50 with 20 years of service, age 65 with 5 years service). Active medical staff, meeting the criteria may petition their clinical department for exemption for the Emergency Department call schedule 90 days in advance of the requested effective date. Their clinical department may or may not approve the exemption. If approval is granted by the clinical department, approval must next be sought from the Executive Committee, and finally from the Board of Trustees.

SECTION XIV - DISASTER PLAN

Members of the Medical Staff of the Hospital shall participate in the Disaster Plan of the Hospital as approved by the Governing Body, as it pertains to disaster readiness drills, assignments, in the event of disaster and authority for patient evaluation and evacuation in times of emergency. In accordance with the Hospital's Plan, patients would be evaluated for possible dismissal or transfer to other specified areas of the Hospital, so that the required areas of the Hospital would be utilized for disaster work.

SECTION XV - CONTROL OF INFECTIONS

1. **Reporting of Infections:**

   It is the duty of the attending physician to notify the charge nurse if a particular patient has an infection, which is transmissible within the hospital.

The physician should specify the diagnosis so that, if any measures beyond Standard Precautions are required, they may do so.

If the physician for some reason is not available to order the isolation and, if the nurses become aware of a diagnosis, which requires special isolation, they may isolate the patient until they can consult the physician.

The nurse should notify the Infection Control Coordinator of the name of the patient and the diagnosis.

If any unusual incidences of infections, such as wound infections or urinary tract infections are suspected, the physician or the nurses should notify the Infection Control Coordinator.

Physicians are urged to report nosocomial infections, which are discovered after the discharge of the patient.

2. **Isolation Procedures**

The Hospital Quality Management Committee shall monitor policies and procedures regarding the isolation of patients admitted with infectious diseases and for those patients who develop infectious diseases subsequent to admission.

If any questions arise about the appropriateness of the isolation procedures, the questions may be resolved by discussion with the Infection Control Coordinator and/or the physicians of the Infectious Diseases Service.

SECTION XVI - PATHOLOGY

Tissues removed at operation shall normally be sent to the hospital pathology laboratory for examination, and consultation. Limited categories of specimens may be exempted from this requirement. Exemptions should be established by the Chief of Surgical Department or section, and agreed upon by the Chief of the Department of Pathology. The exempted specimen should only be those that by their nature do not permit fruitful examination (e.g. cataract, orthopaedic appliance, foreign body, incidental rib removal, arthroscopic surgery fragments, and traumatic injured tissue)

Many specimens should be sent for gross examination to establish operative procedure or information for the medical record. Bullets, etc., for legal reasons are given directly in the chain of custody to law enforcement representatives. A record of all tissues and appliances removed during an operative procedure shall be made in the Operative Record. When sending tissue or appliances to pathology, the surgeon may indicate on the pathology information sheet when gross examination only is desired. A more detailed examination of the specimen may be done if the pathologist considers it indicated. When a specimen is sent to the laboratory, whether intentional or not, it will be considered as a request for examination and at least a gross pathology report will be issued. Therefore, when no examination is desired, or required, the specimen should not be sent to the laboratory.

A complete surgical pathology requisition form will be filled out on all specimens by the surgeon or at his direction. This form shall accompany the tissue to the laboratory and include adequate information for the pathology consultation, such as pre and post-operative

diagnosis, the nature of the specimen, and sufficient clinical data to assist the proper pathological examination, and to provide the information for justification by the Committee on Surgical Case Review.

SECTION XVII - SELF-TREATMENT OR TREATMENT OF FIRST DEGREE FAMILY MEMBERS

Physicians should not treat themselves or members of their first-degree families. Professional objectivity may be compromised when a first-degree family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is a first-degree family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or first-degree family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their first-degree family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of a first-degree family member. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as primary or regular care providers for first- degree family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or first-degree family members. They shall not participate in the care of a first degree relative as an admitting physician or consultant.

SECTION XVIII - STURGIS STANDARD CODE OF PARLIAMENTARY PROCEDURE

Unless otherwise specified, meetings shall be conducted according to the Sturgis Standard Code of Parliamentary Procedure; however; technical or non-substantive departures from such rules shall not invalidate actions taken at such a meeting.

SECTION XIX - MEMBERSHIP

20.1 COMPOSITION OF THE MEDICAL STAFF

The Medical Staff of Baylor Regional Medical Center at Grapevine shall be composed of fully licensed, independent practitioners, specifically Physicians, Dentists and Oral Surgeons, and Podiatrists, who are selected on the basis of their professional and personal qualifications and for their ability to further the fulfillment of the Medical Center's objectives in patient care. The Medical Center shall endeavor to maintain a balance among the various specialties required for an outstanding medical and referral center. It shall also endeavor to provide for systematic admission of outstanding members in a manner that will assure a continued development of the Medical Staff in future years.

Pursuant to the policy of the Board of Trustees, the size of the Medical Staff - the number of practitioners in the Active, Consulting, Courtesy and Proctor categories - shall be related to the capacity of the Medical Center's facilities to serve its patients effectively and meet the needs of the community it serves.

20.2 NATURE OF MEMBERSHIP

No practitioner, including those in a medical administrative position, shall admit or provide medical or health-related services to patients in the Medical Center unless he is a member of the Medical Staff and has been granted clinical privileges in accordance with these Bylaws or unless he has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws

20.3 RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Membership to the Medical Staff of Baylor Regional Medical Center at Grapevine is considered a privilege, and with this privilege, there shall be certain responsibilities.

1. Basic responsibilities that apply to all members include:

    a. providing patients with the quality of care meeting the professional standards of the Medical Staff of this Medical Center;

    b. abiding by these Bylaws and the Rules and Regulations of the Medical Staff;

    c. working cooperatively with Medical Staff members, nurses, Medical Center administration and others;

    d. discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership;

    e. abiding by applicable Medical Center bylaws, rules and policies;

f. providing medical care to patients in emergency situations wherever and whenever needed regardless of the member's category of appointment or the patient's ability to pay;

g. actively participating in the Medical Center's quality assurance and utilization review activities;

h. performing other staff obligations as may be established from time to time by the Medical Staff;

i. to promote and participate in a work environment that is conducive to the well being of patients and Medical Center personnel including an environment that is free of unlawful harassment. Unlawful harassment includes that which is based on race, color, religion, national origin, sex, disability, age, citizenship or harassment which may be considered sexual in nature.

2. By virtue of appointed category, Medical Staff members may also be expected to discharge in a reasonable manner the following responsibilities:

   a. Serving on Medical Staff Committees;

   b. providing Emergency Department call coverage;

   c. regularly attending Medical Staff meetings and departmental meetings as specified in these Bylaws;

   d. participating in continuing education programs.

   e. Maintain the minimum number of patient contacts per appointment period for the applicable category of Medical Staff membership as designated in 2.8 of the Medical Staff Bylaws:

      1. Active-Clinical- All Departments with the exception of Family Medicine 24 contacts. Family Medicine is 12 contacts.

      2. Courtesy Staff – All Departments with the exception Family Medicine 1-23, Family Medicine is 1-11 contacts.

3. Reporting of Incidents and Sentinel Events.

   Each member of the Medical Staff has the duty to report timely any incident or Sentinel Event (as defined below) to the nursing supervisor or to the Director of Quality Assurance. A 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.

Definitions:

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
- A prenatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams

A "Sentinel Event" is an event that meets one of the following criteria:

1. 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
2. The event is one of the following:
    a. Patient suicide
    b. Infant abduction
    c. Rape or sexual assault
    d. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities;
    e. Surgery or other procedure on wrong patient or wrong body part;
    f. Retained foreign objects remaining from surgery or other procedure;
    g. Brain or spinal damage

20.4 DUES

Dues may be assessed, the use of which, will be determined by the Executive Committee of the Medical Staff. Dues may be assessed regardless of Category. Funds will be kept separate from hospital funds.

SECTION XX - ALLIED HEALTH PROFESSIONALS

21.1 ALLIED HEALTH PROFESSIONALS

21.1-1 GENERAL

Allied Health Professionals are not Medical Staff Members nor shall Allied Health Professionals be considered a category of Medical Staff membership. Allied Health Professionals shall not have any of the prerogatives or responsibilities of Medical Staff membership.

The approved categories of Allied Health Professionals as well as the prerogatives, responsibilities and procedure for requesting to perform patient care services are outlined in the Medical Center's Allied Health Professional Manual.

Allied Health Professionals and the employment of such individuals by Medical Staff members are subject to these Bylaws and Rules and Regulations of the Medical Staff, as well as any Medical Center policies and procedures, Medical Center approved position descriptions and any local, state or national requirements applicable to a particular category of Allied Health Professionals.

21.1-2 MEDICAL ASSISTANTS

Medical Assistants are those:

1. who are employed by Medical Staff members to assist them in the care of their patients in the Medical Center and function under the direction and supervision and/or delegation of a Medical Staff member(s) by whom they are employed; and

2. who are qualified by academic and clinical training, prior and continuing experience, and current competence in a discipline which the Medical Center's Board of Trustees allows to practice in the Medical Center; and

3. whose patient care services are provided within the scope of their education, training and Texas license, as well as in accordance with the specific clinical privileges granted.

21.1-3 MEDICAL ASSOCIATES

Medical Associates are those individuals are not members of the Medical Staff but who are licensed to practice independently and participate in patient care when consulted by a physician member of the medical staff. Psychologists are approved to serve as Medical Associates at this facility. They shall:

1. provide patient care services within the scope of their education, training and Texas license, as well as in accordance with the specific clinical privileges granted;

2. shall be qualified by academic and clinical training, prior and continuing experience, and current competence in a discipline which the Medical Center's Board of Trustees allows to practice in the Medical Center; and

3. their patient care services shall be provided within the scope of their education, training and Texas license, as well as in accordance with the specific clinical privileges granted.

SECTION XXI - OFFICERS

22.1 OFFICERS OF THE MEDICAL STAFF

22.1-1 IDENTIFICATION

The officers of the Medical Staff shall be the President, Vice-President and Immediate Past-President.

22.1-2 QUALIFICATIONS

1. The President, Vice-President and the Immediate Past-President shall be members of the Active Category for at least two years. The President shall have been a member of the Executive Committee for at least one year at some time during the past 5 years.

2. Officers of the Medical Staff must be Board Certified in their specialty, not be presently serving as a Medical Staff or corporate officer, Chief of Service or credentials chairman at another hospital and shall not so serve during the term of office.

3. Officers must remain members in good standing during their term of office. They must have no pending adverse recommendations concerning staff appointment or clinical privileges Failure to maintain such status shall create a vacancy in the office involved.

4. Officers must have constructively participated in Medical Staff affairs, including quality review and peer review activities, possess and have demonstrated an ability for harmonious interpersonal relationships, and be knowledgeable concerning the duties of the office and be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected.

22.1-3 NOMINATIONS

1. Nominating Committee

At least three months before the scheduled date of the next Medical Staff election, the President of the Medical Staff shall appoint a Nominating Committee consisting of one Active Staff appointee from each department. Members of the Nominating Committee shall serve for a term of one year and may serve a maximum of two consecutive one-year terms. Any member who has served the maximum term shall not be eligible for reappointment to the committee for a period of one year.

2. Nomination and Election of Officers and At-Large Member

a. The Nominating Committee shall prepare a slate of nominees for each office and for the at-large seat on the Executive Committee to be filled at that election, each of whom must possess all the qualifications set forth above.

b. Nominations for officers of the Medical Staff and the at-large member of the Executive Committee shall be presented to the Medical Staff office at least two weeks prior to each annual meeting. The Medical Staff office shall post the slate no later than 10 days prior to the Medical Staff meeting.

c. Any nomination made by appointees other than the Nominating Committee must be submitted, in writing, to the Nominating Committee at least two weeks and one day prior to the election and must be endorsed by ten (10) Active Staff appointees who would be eligible to vote for the proposed nominee. All 10 must certify that the nominee possesses all qualifications set forth above.

22.1-4 ELECTIONS

1. A meeting will be called in each election year during which officers for the ensuing years shall be elected. This shall be the last general Medical Staff meeting before the end of the Medical Staff year. The candidates who receive a majority vote of those Medical Staff appointees eligible to vote and present at the meeting at the time the vote is taken shall be elected. In any election in which there are two or more candidates for an office, the vote shall be by written secret ballot. The election of each officer shall become effective as soon as approved by the Board.

2. In any election, if there are three or more candidates for an office and no candidate receives a majority vote on the first ballot there shall then be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one candidate.

22.1-5 TERM OF ELECTED OFFICE

Each officer shall serve for a period of two years, beginning on January 1 of year one and ending on December 31 of year two or until their successors are chosen unless that officer shall sooner resign or be removed from office.

22.1-6 RECALL OF OFFICERS

The Executive Committee, by a two-thirds vote, may remove any Medical Staff officer or the at-large members of the Executive Committee who is found to no longer meet any one or more of the qualifications set forth above or, if the individual elected is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of the office, provided that notice of the meeting at which such action shall be decided is given in writing to such officer at least ten 10 days prior to the date of the meeting. The individual shall be afforded the opportunity to speak prior to the taking of any vote on such removal. The removal shall be effective when approve by the Board.

22.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the Medical Staff. If the office of President is vacated during the year, the Vice-President is elevated to that office and shall serve as President for the remainder of the unexpired term. If the office of Vice-President is vacated, a replacement shall be elected as soon as feasible to serve the remainder of the term. A slate of nominees shall be developed by the previous election's Nominating Committee and voting shall take place by mail ballot. Should the office of the Immediate Past President be vacated, it shall remain unfilled until the next following election.

22.2 DUTIES OF OFFICERS

22.2-1 PRESIDENT OF THE MEDICAL STAFF

The duties of the President of the Medical Staff shall include, but not be limited to:

1. calling, presiding at, and being responsible for the agenda at the Executive Committee;

2. serving as a member of the Executive Committee

3. serving as a liaison between the Medical Staff and the Board of Trustees. The President shall attend meetings of and communicate Medical Staff matters to the Board of Trustees;

4. reporting to the Medical Staff on actions taken the Executive Committee

5. serving as an ex officio member of all other staff committees without vote, unless his membership in a particular committee is required by these Bylaws; and

6. interacting with the Administration and Board of Trustees on matters of mutual concern within the Medical Center;

7. make recommendations for appointment of committee chairpersons and members, in accordance with the provisions of these bylaws, to all standing and special medical Staff committees except the Executive Committee;

8. have the right to participate on all medical Staff committees;

9. make known the views, needs, and grievances of the Medical Staff and report on the medical activities of the staff to the Board of Trustees and to the Executive Director;

10. is responsible for the organization and conduct of the Medical Staff

22.2-2 VICE-PRESIDENT

The duties of the Vice-President shall include, but not be limited to:

1. assuming all duties and authority of the President in the absence of the President;

2. serving as a member and Executive Committee

3. performing such other duties as the President may assign or as may be delegated by these Bylaws, or by the Executive Committee.

22.2-3 IMMEDIATE PAST PRESIDENT

The duties of the Immediate Past-President shall include, but not be limited to:

1. serving as a member of the Executive Committee

2. performing such other duties as the President may assign or as may be delegated by these Bylaws, or by the Executive Committee

22.2-4 MEDICAL STAFF REPRESENTATIVE

A representative of the Medical Staff at large shall include the one elected at-large representative to the Executive Committee. This representative shall be elected at the same time and in the same manner as the elected officers of the Medical Staff. The At-Large Representative to the Executive Committee shall serve a term of two years.

SECTION XXII - DEPARTMENTS AND DIVISIONS OF THE MEDICAL STAFF

23.1 CLINICAL DEPARTMENTS AND DIVISIONS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have clinical services under the direction of a Chief of Service. The Chief of Service shall be selected and entrusted with the authority, duties, and responsibilities specified in Section 11.6-5. A department may be further divided, for the purpose of development or strengthening the subspecialty, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division head selected and entrusted with the authority, duties and responsibilities specified in Section 11.7-5.

Proposals to realign, rename, create, eliminate, or modify departments and divisions must first be presented and approved by a majority vote of the members of the departments present at a regular or specially called meeting for that purpose. Proposals shall then be presented to the Executive Committee and the procedures outlined in Article XIII shall apply.

23.2 DEPARTMENTS

Departments are Medicine, Surgery, Pediatrics, OB/GYN, Family Medicine, and Anesthesiology. There shall be a Division of Emergency Medicine and a Division of Radiology under the Department of Medicine. There shall be a Division of Pathology under the Department of Surgery. Departments include but are not limited to the following specialties:

Department of Medicine:

Allergy & Immunology
Cardiology
Critical Care Medicine
Dermatology
Endocrinology
Gastroenterology
Geriatric Medicine
Hematology
Internal Medicine
Oncology
Infectious Disease
Nephrology
Neurology
Psychiatry
Pulmonary Disease
Rheumatology
Physical Medicine and Rehabilitation
Psychology

Department of Family Medicine:

Family Medicine

Department of Surgery:

General Surgery
Colorectal Surgery
Vascular Surgery
Podiatry
Plastic Surgery
Cardiovascular Surgery
Thoracic Surgery
Urology
Orthopedics
Ophthalmology
Otolaryngology
Neurosurgery
Dentistry

Department of OB/GYN:

Gynecology
Gynecologic Oncology
Obstetrics & Gynecology
Perinatology
Maternal & Fetal Medicine
Reproductive Endocrinology

Department of Pediatrics:

Neonatology
Pediatric Cardiology
Pediatric Gastroenterology
Pediatric Ophthalmology

Pediatric Neurology

Department of Anesthesiology:
Anesthesiology
Pain Management
Critical Care Medicine

23.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

Practitioners shall be a member of only one department known as the primary department. The Chief of Service of the primary department shall recommend to the Credentials Committee the clinical privileges to be granted to the practitioner.

Practitioners may apply for clinical privileges in departments other than their primary department. In these instances, the practitioner's application must also be evaluated and a subsequent recommendation as to the granting of such privileges given by the Chief(s) of Service in the other department(s) in which clinical privileges is requested. Such recommendation(s) will be sent to the Chief of Service in the primary department who will forward them along with his own recommendation to the Credentials Committee.

23.4 FUNCTIONS OF DEPARTMENTS

Under the responsibility of its Chief of Service, each department shall perform certain functions.

The Chief of Service may assign the responsibility for the accomplishment of specific functions to a sub-committee or to a department member(s). Such committees or member(s) shall perform delineated functions pursuant to these Bylaws.

The general functions of each department shall include:

1. recommending to the Credentials Committee guidelines for the granting of clinical privileges and the performance of specified services within the Department;

2. evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department;

3. conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice;

4. reviewing and evaluating departmental adherence to Medical Staff policies and procedures, as well as sound principles of clinical practice;

5. coordinating patient care provided by the department's members with nursing and ancillary patient care services.

6. submitting written reports to the Executive Committee concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results

of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and the Medical Center;

7. meeting at least quarterly, or more often at the discretion of the chief, for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and Staff functions;

8. establishing and appointing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it;

9. taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;

10. accounting to the Executive Committee for professional and Medical Staff administrative activates within the department;

11. formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval of the Executive Committee

23.5 FUNCTIONS OF DIVISIONS

Subject to approval of the Executive Committee each division shall perform the functions assigned to it by the Chief of Service of the respective department. Such functions may include, without limitation, patient care reviews, evaluation of patient care practices, credentials review and clinical privileges delineation, and continuing education programs. The division shall transmit regular reports to the Chief of Service on the conduct of its assigned functions.

23.6 DEPARTMENT HEADS (CHIEFS OF SERVICE AND VICE-CHIEFS OF SERVICE) AND DIVISION HEADS

23.6-1 QUALIFICATIONS

Each department shall have a Chief of Service, and Vice-Chief of Service who shall be members of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in the clinical services covered by the department. In addition, a Chief of Service should be Board Certified by the appropriate specialty board, have demonstrated leadership qualities and be a strong supporter of Baylor Regional Medical Center at Grapevine. Under special circumstances, in order to serve the best interests of the Medical Center, one or more of the above requirements may be waived.

Chiefs and Vice-Chiefs of Service must be Board Certified in their specialty, not be presently serving as a Medical Staff or corporate officer, Chief of Service or vice-chief or

credentials chairman at another hospital and shall not so serve during the term of office.

Chiefs and Vice-Chiefs of Service must remain members in good standing during their term of office. They must have no pending adverse recommendations concerning staff appointment or clinical privileges Failure to maintain such status shall create a vacancy in the office involved.

Chiefs and Vice-Chiefs of Service must have constructively participated in Medical Staff affairs, including quality review and peer review activities, possess and have demonstrated an ability for harmonious interpersonal relationships, and be knowledgeable concerning the duties of the office and be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected.

23.6-2 TERMS OF OFFICE

Chiefs of Service in departments and Vice-Chiefs of Services shall be appointed by the Board of Trustees for terms of two years.

23.6-3 ELECTION

The chief shall be appointed by the Board after considering the recommendation of the department, which shall be the individual who is elected by a majority of the members of the department present and voting.

The nominee(s) for chief and vice chief shall be selected by a nominating committee of three individuals appointed by the chief. The names of the nominee(s) must be submitted to the department members at least ten (10) days prior to the last department meeting of the Medical Staff year.

Should any member of the department choose to nominate an additional candidate, it shall be done in the following manner: The nomination must be submitted in writing to the current Chief of Service at least three (3) days prior to the last annual meeting; the nomination must state that the individual meets all of the qualifications and has agreed to serve, if elected.

23.6-4 REMOVAL

A Chief of Service may be removed by the Board of Trustees after consultation with the Executive Committee A Chief of Service or a Vice-Chief of Service may also be removed during a term of office by a two-thirds vote of all Active Staff appointees in the department. This removal shall be effective when it has been approved by the Board of Trustees.

23.6-5 VACANCIES

Vacancies in department heads/division chiefs occur upon the death or disability, resignation, or removal of the department head/division chief, or the loss of their membership in the Medical Staff. If the position of section chief/division head is vacated during the year, the Vice-Chief is elevated to that position and shall serve as Chief for the remainder of the unexpired term subject to approval by the Board of Trustees.

In the event that the position is not filled by the Vice-Chief, for any reason, an interim appointment shall be made by the Board of Trustees until such time that the division or department can select a permanent chief through the process described in 11.6-3 or 11.7-2.

23.6-6 DUTIES

1. Each Chief of Service shall have the following authority, duties and responsibilities, and the Vice-Chief of Service, in the absence of the Chief of Service, shall assume all of them and shall otherwise perform such duties as may be assigned:

    a. act as presiding officer at departmental meetings and provide appropriate minutes of such meetings;

    b. assure that the departmental functions in Section 11.4 are carried out.

    c. responsible to the Executive Committee for all professional and administrative activities within the department.

    d. monitor and evaluate the quality and appropriateness of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Executive Committee

    e. develop and implement departmental programs for retrospective patient care review, on-going monitoring of practice, credentials review and clinical privilege delineation, medical education, utilization review, and quality assurance.

    f. be a member of the Executive Committee, and give guidance on the overall medical policies of the Medical Staff and Medical Center and make specific recommendations and suggestions regarding the department.

    g. recommend to the Credentials Committee department membership appointments and reappointments, as well as clinical privilege delineations.

    h. recommend criteria for membership and clinical privilege delineation.

    i. recommend and cooperate in corrective action with respect to persons with clinical privileges in the department when necessary.

    j. endeavor to enforce the Medical Staff bylaws, rules and regulations and policies within the department;

k. implement within the department appropriate actions taken by the Executive Committee or its designee.

l. participate in every phase of administration of the department, including cooperation with other departments, as well as the nursing service and the Administration in matters such as personnel, supplies, special regulations, standing orders and techniques.

m. direct and participate in continuing medical education programs in the department and provide support to such programs throughout the Medical Center.

n. perform such other duties commensurate with the office as may from time to time be reasonably requested.

o. delegate to a vice Chief of Service such duties as appropriate, but notably review of applications for appointment, reappointment or clinical privileges or questions that may arise if the chief has a conflict of interest with the individual under review or could be reasonably perceived to be biased;

p. be responsible for the integration of the department/service into the primary functions of the organization; and

q. be responsible for the coordination and integration of interdepartmental and intradepartmental services.

r. recommend criteria for and the scope of practice allowed for Medical Associates and Medical Assistants assigned to their respective departments

s. recommend to the Credentials Committee the approval for appointment and reappointment of Medical Associates and Medical Assistants to the Allied Health Professional Staff.

23.7 DIVISION HEADS

23.7-1 QUALIFICATIONS

Each division shall have a head who shall be a member of the Active Medical Staff and a member of the division which he is to head, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the division.

23.7-2 SELECTION

The Chief of Service over the respective division shall recommend to the Executive Committee persons for appointment. The Executive Committee shall review the recommendation and make its own recommendation to the Board of Trustees, which shall make the appointment.

23.7-3 TERM OF OFFICE

Each Division Head shall serve for a term of two- years or until the end of the year after appointment.

23.7-4 REMOVAL

A Division Head may be removed by the Board of Trustees after consultation with the Chief of Service and the Executive Committee

23.7-5 DUTIES

1. act as presiding officer at division meetings and ensure that appropriate minutes are kept;

2. assist in the development and implementation, in cooperation with the Chief of Service, of programs to carry out the patient care quality review, and evaluation and monitoring functions assigned to the division;

3. monitor the clinical work performed in the division;

4. conduct investigations and submit reports and recommendations to the Chief of Service regarding the clinical privileges to be exercised within the division by members of or applicants to the Medical Staff;

5. direct and participate in the medical education programs of his specialty and department, as well as continuing medical education programs in other departments.

6. perform such other duties commensurate with the office as may be requested by the Chief of Service or Executive Committee or its designee.

23.8 CONTRACTED MEDICAL DIRECTORS

Contracted Medical Directors shall be appointed by the Board of Trustees, with advice from the appropriate departments of the Medical Staff. The Board of Trustees shall establish procedures for securing the advice and shall also establish formal means of having the incumbent's professional and administrative qualifications evaluated periodically by his peers which may include evaluation by the department

Contracted full-time or part-time Medical Directors shall be appointed on a continuing basis by the Board of Trustees, subject to the terms of the contract between the individual and the Medical Center.

SECTION XXIII - COMMITTEES

24.1 DESIGNATION

24.1-1 CHAIRPERSONS

All committee chairpersons, unless otherwise provided for in these bylaws, will be appointed by the Board after receiving and considering recommendations from the President of the Medical Staff.

All chairpersons shall be selected based on the criteria set forth in these Bylaws for Chiefs and Vice-Chiefs of Service. Such appointments will be made by the Board at its first meeting after the end of the Medical Staff year, for an initial term of two (2) years.

After serving an initial term, a chairperson may be reappointed by the Board upon the Board's receiving and considering a recommendation from the President of the Medical Staff and the Executive Director.

24.1-2 MEMBERS

Except as otherwise provided for in these bylaws, members of each committee shall be appointed every two years by the President of the Medical Staff, in consultation with the Executive Director, not more than ten (10) days after the end of the Medical Staff year, and there shall be no limitation in the number of terms they may serve.

All appointed members may be removed and vacancies filled at the discretion of the President of the Medical Staff.

The Executive Director and the President of the Medical Staff or their respective designees shall be members, ex officio, without vote, on all committees.

24.2 QUALITY ASSURANCE AND OTHER FUNCTIONS PERFORMED BY MEDICAL STAFF COMMITTEES

A description of other medical staff committees that carry out quality assurance functions and other functions delegated to the medical staff, including their composition, duties and reporting requirements, is contained in the Medical Staff Committee Manual.

24.3 CREATION OF STANDING COMMITTEES

The Executive Committee may, by resolution and upon approval of the Board, without amendment of these bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Executive Committee may, by resolution and upon approval of the Board, dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these bylaws, which is not assigned to a standing or special committee, shall be performed by the Executive Committee.

24.4 CONFIDENTIALITY OF INFORMATION

Records and proceedings of all committees of the Medical Staff shall be confidential pursuant to Article XV.

24.5 EXECUTIVE COMMITTEE

24.5-1 COMPOSITION

The Executive Committee shall be composed of:

1. Chiefs of Service of the Departments of Medicine, Surgery, Pediatrics, OB/GYN, Anesthesia, and Family Medicine
2. The President of the Medical Staff
3. The Vice-President of the Medical Staff
4. The Immediate Past-President of the Medical Staff
5. The Chairmen of Each Standing Committee noted in the Committee Manual
6. One elected representatives of the Medical staff
7. The Chief Executive Officer and/or designee(s) and the Nurse Executive shall attend each meeting as non-voting members and shall serve as a liaison officer between the Board of Trustees and the Executive Committee

The same person holding two or more of the positions qualifying for Executive Committee membership shall serve with one vote.

24.5-2 DUTIES

The duties of the Executive Committee shall be to:

1. represent and to act on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the staff, subject only to any limitations imposed by these bylaws;

2. coordinate the activities and general policies of the various departments;

3. receive and to act upon those committee reports as specified in these bylaws and to make recommendations concerning them to the Executive Director and the Board;

4. implement policies of the hospital that affect the Medical Staff;

5. provide liaison among the Medical Staff, the Executive Director and the Board;

6. keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the hospital;

7. enforce hospital and Medical Staff rules in the best interest of patient care and of the hospital with regard to all persons who hold appointment to the Medical Staff;

8. refer situations involving questions of the clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff appointee to the Credentials Committee for appropriate action;

9. be responsible to the Board for the implementation and participation of the medical staff in organizational performance-improvement activities as well as the mechanism used to conduct, evaluate, and revise such activities;

10. review the bylaws, policies, rules and regulations, and associated documents of the Medical Staff at least once a year and recommend such changes as may be necessary or desirable;

11. determine minimum continuing education requirements for appointees to the staff;

12. review all information available regarding the performance and clinical competence of persons who hold appointments to the Medical Staff and as a result of such review to make recommendations for reappointments or changes in clinical privileges; and

13. review the credentials of all applicants and to make recommendations for appointment to the Medical Staff, assignment to departments, and delineation of clinical privileges;

14. be responsible for the mechanism used to review credentials and to delineate individual clinical privileges;

15. be responsible for the mechanism by which medical staff membership may be terminated; and

16. be responsible for the mechanism for fair-hearing procedures.

17. designate and appoint special or ad hoc committees to assist in carrying out the duties and responsibilities of the Executive Committee.

24.5-3 MEETINGS

The Executive Committee shall meet at least six (6) times each year or more often if necessary to transact pending business. The Secretary will maintain reports of all meetings, which reports shall include the minutes of the various committees and departments of the staff. Copies of all minutes and reports of the Executive Committee shall be transmitted to the Executive Director routinely as prepared. Recommendations of the Executive Committee shall be transmitted to the Board with a copy to the Executive Director. The Chairperson of the Executive Committee shall meet with the Board or its applicable committee on all recommendations that the Executive Committee may make.

Each member of the Executive Committee shall attend at least 50% of the meetings held each calendar year. A quorum shall consist of 50% of the members of the Committee.

24.6 CREDENTIALS COMMITTEE

24.6-1 COMPOSITION

The Credentials Committee shall be composed of six (6) members of the medical staff and at least one (1) member of the board of Trustees. The members shall serve a term of two years. Service on this committee shall be considered as the primary Medical Staff obligation of each member of the committee and other Medical Staff duties shall not interfere.

24.6-2 DUTIES

The duties of the Credentials Committee shall be to:

1. review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations to the Executive Committee;

2. review the credentials of all applicants who request to practice at the hospital as Medical Associates and Medical Assistants, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations; and

3. review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of those practicing as Medical Associates and Medical Assistants and as a result of such review, to make a written report of its findings and recommendations to the Executive Committee.

24.6-3 MEETINGS

The Credentials Committee shall meet at least six (6) times each year or more often if necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Executive Committee, the Executive Director and the Board. The Chairperson of the Credentials Committee shall meet with the Board or its applicable committee on all recommendations that the Credentials Committee may make.

Each member of the Credentials Committee shall attend at least 50% of the meetings held each calendar year. A quorum shall consist of 50% of the members of the Committee.

24.7 PHYSICIAN HEALTH & REHABILITATION COMMITTEE

24.7-1 COMPOSITION

The Physician Health & Rehabilitation Committee shall be composed of at least three (3) members of the Active Medical and Allied Health Professional Staff of Baylor Regional Medical Center at Grapevine, its President, the Director of Quality Resources, and as an ex-officio member, the Manager of Medical Staff Services.

Purpose: to provide education about physician health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment and rehabilitation of medical staff members who suffer from a potentially impairing condition for the purpose of assisting and rehabilitation, rather than disciplinary action.

The committee's key functions are:

1. Self-referral to other organizations

2. Referral of the affected medical staff member to the appropriate resource for diagnosis and treatment of the condition or concern
3. Evaluation of the credibility of the complaint, concern, or allegation
4. Monitoring the affected staff member
5. Reporting, if necessary, to the Executive Committee instances where there may be a lack of quality care
6. Aid medical staff members in retaining or regaining optimal performance.

24.7-2 MEETINGS

The Physician Health & Rehabilitation Committee shall meet as needed.

24.8 BYLAWS COMMITTEE

24.8-1 COMPOSITION

The Bylaws Committee shall be composed of at least five (5) members of the Active Medical Staff of Baylor Regional Medical Center at Grapevine, its President, and as an ex-officio member, the Manager of Medical Staff Services.

Purpose: to review the Bylaws at least annually. The purpose is also to provide recommendation for revision and update as may be needed from time to time.

24.8-2 MEETINGS

The Bylaws Committee shall meet as needed.

24.9 ETHICS COMMITTEE

24.9-1 COMPOSITION

The membership will be composed of six physicians, one of which will be the Chairperson and one of which will be the President of the Medical Staff, one R.N., one Chaplain, one community representative, one social worker, and an Administrative Director. The Committee may request participation of others as appropriate.

Purpose: The purpose of the Ethics Committee will be to develop policies that enable or assist the Clinical Staff to perform their functions in an ethical and fair manner and offer consultation to staff regarding ethical questions and dilemmas, and provide a conduit of ethics education to the institution. The Ethic Committee will report to the Executive Committee for Quality Improvement purposes.

24.9-2 MEETINGS

The Ethics Committee shall meet bi-monthly and on an as needed basis.

24.10 HOSPITAL QUALITY MANAGEMENT

24.10-1 COMPOSITION

The Hospital Quality Management Committee is a hospital-wide committee that consists of the Physician Advisors, Medical Directors, The Executive Director, Administrative Directors of Patient Care Services, Clinical Support, Finance, and Ancillary Services, all Departments Directors, Managers, Supervisors and Coordinators will be members of the committee. All members will have voting privileges. The committee will have one chairperson who will be appointed in accordance with the bylaws of the Medical Staff.

Purpose: The Hospital Quality Management Committee oversees implementation of the Quality Improvement philosophy, and the Quality Improvement Process.

The Committee's key functions are to:

1. Initiate and redesign organizational structure for a Quality Improvement Culture.
2. Establish strategic goals, objectives and quality indicators that proliferate a Quality Improvement Culture.
3. Identify and initiate Quality Improvement activities, approve formation of Quality Improvement teams.
4. Monitor Quality Improvement team activities, and approve teams" proposed solutions prior to implementation of solutions.
5. Serve as a role model for the Quality Improvement philosophy.

The Committee's Goals are to:

1. Ensure that Baylor Medical Center at Grapevine clinical services are provided in a timely, high quality manner to all patients (through yearly assessment).
2. Promote continuous improvement of the quality of clinical services to exceed customer expectations.
3. Maintain cost effectiveness in the provision of BMCG health services
4. Assist BMCG patients to achieve an optimal level of wellness and function by facilitating the delivery of timely and appropriate health services.

The Committee's objectives are to:

1. Support and promote the mission, vision and values of Baylor Medical Center at Grapevine.
2. Provide a customer-focused organizational structure for integration and communication of quality monitoring, evaluation and improvement activity,
3. Maintain an operational linkage between the risk management function related to the clinical aspects of patient care, safety and quality.
4. Provide a customer-focused approach, documenting the delivery of optimal customer service, taking any age specific needs of patients into consideration.
5. Ensure that patient care personnel are qualified and competent.

6. Utilize monitoring sources, pre-established clinically valid indicators/criteria, and information management systems to review elements of patient care and clinical performance. Indicators related to the quality of care/service are objective, measurable, based on current knowledge and clinical experience, and age specific as necessary.
7. Provide mechanisms for taking action to improve customer care/service, and monitor the dimensions of performance of quality activities.
8. Provide a mechanism to report quality activities to the Board of Trustees.
9. Meet requirements of accreditation, reviewing and licensing agencies.
10. Evaluate the Quality Improvement Plan on an annual basis.

Meetings, reports and recommendations:

The Hospital Quality Management Committee shall meet monthly or as needed to carry out its functions and duties; shall make a record of its findings, proceedings and actions; and shall make recommendations to the Executive Committee with a quarterly report being made to the Board as needed.

24.11 QUALITY REVIEW COMMITTEE

24.11-1 COMPOSITION

The Quality Review Committee shall consist of those members of the medical staff that shall be appointed from time to time to serve on such committee in accordance with the Bylaws of the Medical Staff and shall also have as a non-voting member the Director of Quality Management to carry out support functions. The chairman of this committee shall be appointed in accordance with the Bylaws of the Medical Staff.

Purpose: This Committee addresses peer review issues and reviews the reports submitted through the physician advisors, and the departmental and functional committee structure of the Medical Staff. It reviews and acts upon, on a regular basis, factors affecting the quality and efficiency of patient care provided in the hospital. It is a standing committee of the Medical Staff and it reports to the Executive Committee. Minutes are submitted directly to the Executive and Credentials Committee. In order to facilitate the successful operation of the Quality Plan, which at times mandates change through corrective action, the Quality Review Committee is authorized and empowered to affect the following procedures:

1. Submission of peer review reports from Medical Departments or Committees at designated time intervals for communication of findings, conclusions, recommendations, actions, and evaluations of actions taken from quality activities.

2. Recommendation of specific corrective action for the solution of concerns when it has been judged that there is inaction, or inadequate action, at the department level.

3. Submission of reports detailing problem resolution or specific concerns.

Meetings: The Quality Review Committee shall meet monthly or as needed to carry out its functions and duties; shall make a record of its findings, proceedings and actions; and shall make such recommendations to the appropriate hospital departments and committees as deemed necessary. Self-reported incidents shall be noted as such in the record and this shall be taken into consideration by the Credentials Committee and the Executive Committee when action or discipline is deemed necessary.

SECTION XXIV – MEETINGS

25.1 MEETINGS

25.1-1 GENERAL MEETING

There may be one or more annual meetings of the Medical Staff, which shall be called by the President of the Medical Staff when it shall be determined necessary or beneficial by the Executive Committee. The program shall be determined by the President of the Medical Staff. Notice of this meeting shall be given to the members at least [30] days prior to the meeting. The meeting at which Officers of the Medical Staff are elected shall be the last general medical staff meeting of that year; other business may be conducted at this meeting.
AGENDA

The order of business at a meeting of the Medical Staff shall be determined by the President of the Medical Staff. The agenda shall include insofar as feasible:

1. administrative reports from the President of the Medical Staff and the Administration;

2. election of officers when required by these Bylaws;

3. voting on proposed changes to these Bylaws when required by these Bylaws;

4. reports by responsible officers, committees and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions;

5. old business; and

6. new business.

25.1-2 SPECIAL MEETINGS

Special meetings may be called at any time by the President of the Medical Staff or upon the written request of [25%] of the members of the Active Medical Staff. Such members requesting a meeting shall first consult with the President of the Medical Staff and Chairman of the Executive Committee as to the purpose and need to call a special meeting. Called special meetings shall be scheduled by the President within [30] days after receipt of such request. No later than 30 days prior to the meeting, notice shall be mailed or delivered to the members of the Staff, which includes the stated purpose of

the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

25.2 COMMITTEE AND DEPARTMENT MEETINGS

25.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the chairmen of committees, Chiefs of Service, and Division Heads may establish the times for the holding of regular meetings. The chairmen shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

25.2-2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee, department or division may be called by the chairman thereof, Chief of Service, Executive Committee, President of the Medical Staff, or by written request of [one-third] of the current members, eligible to vote, but not less than [five] members.

25.3 QUORUM

25.3-1 REGULAR MEDICAL STAFF MEETINGS

Except as otherwise specified, the action of a majority of the total of those Active Medical Staff members who vote at any regular or special meeting shall constitute the action of the group. A majority shall be defined as one member over half of the total of those Active Medical Staff members who are present and voting and any members who may have submitted written ballots.

25.3-2 DEPARTMENT AND COMMITTEE MEETINGS

The presence of at least two voting members shall be required for all departmental and committee meetings to constitute a quorum with the exception of the Executive Committee, the Credentials Committee and the Quality Review Committee. The presence of fifty percent (50%) of the Members of the Executive Committee, the Credentials Committee, and the Quality Review Committee shall constitute a quorum for any regular or special meeting of that committee.

25.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at all department and committee meetings at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee if it is acknowledged in writing setting forth the action so taken which is signed by at least [two thirds] of the members entitled to vote.

25.5 MINUTES

Minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and actions taken on significant matters. A confidential copy of the minutes shall be signed by the presiding officer of the meeting. All original minutes shall be forwarded to the Quality Management Department. Summaries of the minutes of standing Medical Staff committees shall be forwarded to the Executive Committee for review and whatever action warranted. By December of each year, each standing committee of the Medical Staff shall submit to the Executive Committee an annual report of its activities of the past year.

25.6 ATTENDANCE REQUIREMENTS

25.6-1 REGULAR ATTENDANCE

It is expected that each member of the Active Staff shall be required to attend:

1. At least one of each department and/or division meetings of each department, division, and committee of which he is a member in a calendar year; with the exception of the Executive Committee, the Credentials Committee and the Quality Review Committee. Members of the Executive Committee, the Credentials Committee, and the Quality Review Committee shall be required to attend fifty percent (50%) of each meeting in a calendar year.
2. Each member of the Courtesy or Consulting Category, as well as those practitioners in the Provisional Status shall be required to attend such other meetings as may be determined by the Executive Committee

25.6-2 ABSENCE FROM MEETINGS

Unless excused for good cause by the presiding officer of the department, division, or committee for Medical Staff regular meetings, failure to meet the attendance requirements may be grounds for removal from such committee or corrective action, including termination of Medical Staff membership.

25.6-3 SPECIAL ATTENDANCE

At the discretion of the chairman or presiding officer, individuals other than members and non-voting members may be asked to attend meetings of the Medical Staff, departments, divisions, or committees. When a member's practice or conduct is scheduled for discussion at a department, division, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least [7] days prior to the meeting and shall include the time, place, and general indication of the issue involved. Failure of a member to appear at any meeting, with respect to which he was given such notice, unless excused by the Executive Committee of the Executive Committee upon a showing of good cause, shall be a basis for corrective action.

25.6-4 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to the Sturgis Standard Code of Parliamentary Procedure; however; technical or non-substantive departures from such rules shall not invalidate actions taken at such a meeting.

25.6-5 CONFLICT OF INTEREST

1. In any instance where an officer, or Chief of Service or committee chairperson, or member of any Medical Staff committee has or reasonably could be perceived to have a conflict of interest or to be biased in any matter involving another Medical Staff appointee that comes before such individual or committee, or in any instance where any such individual or committee member brought the complaint against that appointee, such individual or member shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time, although that individual or committee member may be asked, and may answer, any questions concerning the matter before leaving. As a matter of procedure, the chairperson of that committee designated to make such a review shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of any committee member may be called to the attention of the chairperson by any committee member with knowledge of the matter.

2. A Chief of Service shall have a duty to delegate review of applications for appointment, reappointment or clinical privileges, or questions that may arise to a vice chief or other member of the department, if the chief has a conflict of interest with the individual under review, or could be reasonably perceived to be biased.

SECTION XXV – GENERAL PROVISIONS

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

25.1 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.

25.1-1 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/or 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/or professional liability insurance may be prohibited from providing patient care (as defined in section 25.1-1A 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 records were 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.

25.1-2 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, and/or 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.

25.1-3 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.