RULES AND REGULATIONS OF

THE MEDICAL STAFF

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DEFINITIONS

1. Adverse: An action or recommendation as defined in section 8.1.2 of the Bylaws.

2. Allied health professional: An individual other than a practitioner or a Hospital employee who is qualified to provide health care services independently in a discipline or practice area approved by the Board.

3. Attending practitioner: is the practitioner with primary responsibility for the care or treatment of the patient or, in his/her absence, the practitioner covering for the attending practitioner who has assumed responsibility for the patient and who possesses the requisite clinical privileges to care for the patient.

4. CEO: The Chief Executive Officer or other individual appointed by the Board of Trustees to act in its behalf in the overall management of the Hospital.

5. Board: The Board of Trustees of Baylor Medical Center at Irving.

6. Bylaws: The Bylaws of the Medical Staff, as may be amended from time to time.

7. Days: Calendar days. In computing any period of time prescribed or allowed under the Bylaws or a Manual, the day of the act or the event from which the designated period of time begins to run shall not be included. If the last day of the period of time or day on which a notice, request or report under this Plan must be received or sent falls on a Saturday, Sunday or official Hospital holiday, the deadline shall be the next regular working day thereafter.

8. Dentist: An individual who has received a Doctor of Dental Surgery or a Doctor of Dental Medicine degree and is currently fully licensed to practice dentistry.

9. Department: A clinical department of the Medical Staff.

10. Ex officio: Service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

11. Hospital: The facility or facilities of Baylor Medical Center at Irving licensed as a Hospital.

12. Manuals: The Medical Staff Organizational Manual, Credentialing/Peer Review Manual, Fair Hearing Plan, Rules and Regulations, and any other Manuals adopted as set forth in section 10.0.

13. Medical Staff or Staff: The integral component of the Hospital comprised of all physicians, dentists and podiatrists who are privileged to provide patient care services in the Hospital.

14. Medical staff year: The period from January 1 to December 31.

15. Member: A practitioner who has been appointed to the Staff and granted clinical privileges pursuant to these Bylaws.

16. Patient: Any individual at the Hospital requesting or receiving inpatient or outpatient health care services.

17. Physician: An individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently fully licensed to practice medicine.

18. Podiatrist: An individual who has received a Doctor of Podiatric Medicine degree and is fully licensed to practice podiatry.

19. Practitioner: A physician, dentist or podiatrist with a current license duly issued by the State of Texas.

20. Procedural rights of review: Those procedures and rights afforded by the Board to a practitioner pursuant to the Bylaws and the Fair Hearing Plan.

21. Special notice: Notice in writing, return receipt requested, delivered either by hand or by certified mail, effective on the date received.

22. Hospital based physician: Anesthesiologists, emergency medicine physicians, pathologists, and radiologists.

PREAMBLE

Recognizing that the Board of Directors of Baylor Medical Center at Irving must rely on the physicians, dentists and podiatrists who are privileged to attend patients to evaluate, monitor and advise the Board of Directors on the competence and conduct of certain practitioners and the quality of health care services they provide in the Hospital, as well as to fulfill certain legal and accreditation obligations,

Therefore, these Bylaws and the ancillary Manuals are created to set forth principles, requirements and procedures within which the physicians, dentists and podiatrists shall carry out the responsibilities delegated to the Medical Staff, as an integral component of Baylor Medical Center at Irving, subject to the ultimate authority of the Board of Directors.

SECTION 1: ADMISSION OF PATIENTS

1.1 Types of Patients

Patients are admitted without regard to race, creed, color, sex, sexual preference, national origin, ability to pay, or other grounds not permitted by law. Admission of any patient is contingent on adequate facilities and personnel being available to care for the patient, as determined by the CEO (or designee) after consultation with the applicable department chair in any case in which there is a question.

1.2 Admitting Prerogatives - Dental and Podiatric Practitioners

Prior to admission of a patient, dental and podiatric practitioners must secure the agreement of a physician practitioner with the appropriate clinical privileges to be responsible for the patient's general medical care during hospitalization. The name of the physician must be shown in the admission orders.

1.3 Admission Priorities Based on Patient Condition

1.3.1 Emergent Condition - First Priority

A case may be declared an emergency by the attending practitioner. Prior to referral of an emergency patient for admission to the Hospital, the attending practitioner must, when possible, call the admitting office to determine bed availability. For each patient admitted as an emergency, the attending practitioner (or the emergency department practitioner at the request of the attending practitioner) must provide the following documentation or information within the time frames indicated:

(a) within 4 hours of the patient's arrival at the Hospital, an admission note which indicates involvement in the immediate care of the patient; and

(b) within 24 hours of the admission, sufficient documentation on the chart to justify the emergency admission.

1.3.2 Urgent Condition - Second Priority

The attending practitioner must document as part of his request for an urgent admission the specific reason for admission supportive of the request and the degree of urgency involved. When all such admissions for a specific day are not possible, the applicable department chair will review the urgent cases listed in the admitting office and determine the priority of the admissions. The Utilization Management Review Committee will periodically review admissions classified as "urgent" to identify patterns of possible noncompliance or misuse and report its findings to the Medical Executive Committee.

1.3.3 Scheduled Elective Admissions - Third Priority

This category includes all elective medical and surgical patients scheduled in advance. When all such admissions for a specific day are not possible, the applicable department chair will review the cases listed in the admitting office and determine the priority.

1.3.4 Current Day Requests for Elective Admissions - Fourth Priority

This category includes all elective admissions that are not covered under Section 1.3.3.

1.4 Admission Information

Except in an emergency, a patient will not be admitted to the Hospital until a provisional diagnosis or valid reason for admission is provided by the practitioner requesting admission. The practitioner requesting admission is also responsible for providing the following information concerning a patient to be admitted: any source of communicable or significant infection in accord with infection control policies; any behavioral characteristics that would disturb or endanger others; and any need for protecting the patient from self-harm or harm to others.

1.5 Timely Visitation after Patient Admitted

The attending practitioner must see the patient within the time frames provided below or within any shorter time frame if the patient's condition requires it:

1.5.1 Patients admitted directly to or transferred into an intensive or critical care area from another facility, the admitting office, emergency department, or general care area should be seen by a physician within 4 hours or sooner as determined by the clinical condition.

1.5.2 Patients admitted via the emergency department or transferred from another facility to a general care area within 12 hours; and

1.5.3 Elective admissions within 24 hours.

1.6 Number of Inpatient Admissions

Except as provided below, for purposes of calculating the maximum number of inpatient admissions permitted for Courtesy Staff members as defined in Section 1.6.1, the inpatient admission shall be attributed to the admitting practitioner. If the admitting practitioner is a different practitioner from the attending practitioner (as defined in Section 1.1), however, the admission shall be attributed to the attending practitioner, not the admitting practitioner.

1.6.1 Courtesy Staff members shall be limited to twelve (12) inpatient admissions and/or elective procedures during each twelve (12) month period of their two (2) year appointment term. If the member exceeds the limitation, he/she will be automatically advanced to the Active-Clinical Staff category at reappointment or sooner if brought to the Credentials Committee for review.

SECTION 2: ASSIGNMENT AND ATTENDANCE OF PATIENTS

2.1 Assignment to Unit

All patients are assigned to the unit concerned with the treatment of the problem or disease which necessitated admission and must meet any unit admission criteria. Questions regarding admission to or discharge from any of the units shall be referred to the applicable department chair or medical director. When deviations are made from assigned units, the admitting clerk will correct these assignments at the earliest possible moment, in keeping with the transfer priorities set forth in Section 1.3 above.

2.2 Attendance of Patients

Each patient will be attended by the practitioner of his/her choice provided the practitioner has appropriate clinical privileges. When a patient is attended by two or more members of the staff, one practitioner serves as the attending practitioner and all others are designated as consulting practitioners. The name of the attending practitioner must be entered officially in the patient's medical record. A patient requiring admission who has no personal practitioner may request any practitioner who has appropriate clinical privileges. When no such request is made or when the requested practitioner chooses not to undertake the care of the patient, a practitioner with the requisite privileges will be assigned to the patient according to the on-call schedule of the applicable department.

SECTION 3: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

3.1 General

The attending practitioner is responsible for the care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of those portions of the medical record for which he/she is responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner, if any.

3.2 Transfer of Responsibility

Primary responsibility for a patient's care may be transferred from the attending practitioner to another practitioner who has appropriate clinical privileges only after personal contact between the two practitioners. The transferring practitioner shall enter a note covering the transfer of responsibility and documenting the receiving practitioner's acceptance of the transfer on the order sheet and progress notes. Transfer is not effective until acceptance by the receiving practitioner has been confirmed by the unit nursing staff. If the patient or the patient's legally authorized representative terminates the services of the attending practitioner and there is no receiving practitioner, the attending practitioner shall notify the department chair who shall be responsible for arranging for coverage until a new attending practitioner is selected.

3.3 Alternate Coverage

Each attending practitioner must assure timely, adequate professional care for his/her patients in the Hospital by being available or designating a qualified alternate practitioner with whom prior arrangements have been made and who has the appropriate clinical privileges to care for the patient. Each practitioner who will be out of town or unavailable in case of emergency must make arrangements for coverage in accord with this section. In the absence of such designation, the CEO (or designee), the President of the Medical Staff or the applicable department chair has the authority to call any member of the staff with the requisite clinical privileges.

3.4 Policy Concerning Immediate Questions of Care

If any health care professional involved in the care of a patient has any reason to doubt or question the care provided by a practitioner to that patient, or feels that appropriate consultation is needed and has not been obtained, such individual shall bring the matter to the attention of the individual's supervisor. If warranted, the supervisor may bring the matter to the attention of the chair of the department in which the practitioner has clinical privileges, or, if not available, through the Medical Staff chain of authority. If the practitioner whose care is being questioned is a department chair, the supervisor may refer the matter to the next practitioner in the chain of authority.

3.5 Consultations

3.5.1 Responsibility

The good conduct of medical practice includes the proper and timely use of consultation. The attending practitioner is primarily responsible for calling a consultation from a qualified practitioner who has the appropriate clinical privileges when indicated. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending practitioner.

When a consultation is indicated under these Rules and Regulations or when the best interests of the patient will be served, any of the following may direct that a consultation be held and, if necessary, arrange for it:

(a) the applicable department chair;

(b) the medical director of the unit; or

(c) the President of the Medical Staff.

If the attending practitioner disagrees with the necessity for consultation, the matter shall be brought immediately to the President or the applicable department chair for final decision and direction. If an attending practitioner has requested a consultation but is unable to secure a practitioner who is willing to perform the consultation, the chair of the department in which the consultation is requested shall be contacted. The department chair shall arrange for the consultation or perform it personally.

3.5.2 Department/Unit Guidelines

A department or unit may establish guidelines for consultation for patients with certain diagnoses or complications or patients admitted to a certain unit. Guidelines shall be subject to the approval of the Medical Executive Committee and CEO.

3.5.3 Qualifications of Consultant

Any practitioner who has appropriate clinical privileges may be called as a consultant regardless of staff category. A consultant must have demonstrated the skill and judgment requisite for the evaluation and treatment of the condition or problem presented.

3.5.4 Documentation

A request for consultation must be made through an order by the attending practitioner. The consultant must make and sign a report of his/her findings, opinions and recommendations that reflects an actual examination of the patient and the medical record. Such report shall become part of the patient's medical record.

3.6 Residents/Fellows

The following rules will apply to Residents and Fellows of Baylor University Medical Center or other accredited schools or facilities who desire to function within any facility owned or operated by Baylor Medical Center at Irving.

3.6.1 General Rules

a. Residents and Fellows Rotating to BMCI

The BUMC, or other accredited school or facility, Director of Medical Education or and each rotating resident's/fellow's chief of service/program director shall approve and schedule the resident's/fellow's rotation at BMCI. Such scheduling shall involve communication among 1) the resident/fellow; 2) the BMCI medical staff member supervising the resident's/fellow's rotation at BMCI; 3) the resident's/fellow's chief of service; 4) the BUMC, or other accredited school or facility, Director of Medical Education; 5) BMCI's hospital President; and 6) the President of the Medical Staff at BMCI. The BMCI medical staff member supervising the resident/fellow shall notify the hospital President and the President of the Medical Staff of the name of the resident/fellow and the dates of the resident's/fellow's rotation at BMCI. Residents/Fellows must provide proof of professional liability insurance coverage under the insurance plan of the school, with copies sent for verification.

b. Supervising Physician.

1. Each rotating resident/fellow must have a supervising physician who is in good standing as a member of the medical staff at BMCI. Such physician shall be responsible for supervising all patient care rendered by the resident/fellow whether such care is rendered in the physician's private office or at BMCI facilities. Such physician shall co-sign all entries made by the resident/fellow in the record of an inpatient or outpatient at BMCI facilities.

2. The resident/fellow may write physician orders in the patient's medical records, but such orders must be countersigned by the supervising physician within twenty-four (24) hours after the order is written. Supervising physicians cannot "check out" to residents or fellows.

3. Residents/fellows cannot admit patients to the hospital in their name. Admissions may be made under the responsible physician's name.

4. Residents/fellows cannot provide emergency coverage for the responsible physician.

5. Each supervising physician shall report to the BUMC, or other accredited school or facility, Director of Medical Education or the resident's/fellow's chief of services, as appropriate, concerning the resident's/fellow's performance during the rotation.

c. Hospital President and/or President of the Medical Staff.

At any time during the resident's/fellow's rotation at BMCI, the BMCI Hospital President and/or President of the Medical Staff may inform the supervising physician

that the resident/fellow shall not participate in patient care at BMCI facilities and the supervising physician shall so direct the resident/fellow. The reasons for such action shall be communicated to the resident's/ fellow's BUMC, or other accredited school or facility, Chief of Service and the Director of Medical Education.

SECTION 4: TRANSFER OF PATIENTS

4.1 Hospital Policy

All transfers shall be in accord with Hospital policy and these Rules and Regulations.

4.2 Transfers to another Facility

4.2.1 General Requirements

A patient shall be transferred to another medical care facility only upon the order of the attending practitioner, only after arrangements have been made for admission with the other facility and the receiving practitioner including consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport or, if not stabilized, the attending practitioner has certified that the medical benefits of transfer outweigh the risks. The attending practitioner shall determine the equipment and type of personnel that shall accompany the patient during transfer. All pertinent medical information necessary to provide continuity of care must accompany the patient.

4.2.2 Requested by Patient

If transfer is requested by a patient or the patient's legally authorized representative contrary to the attending practitioner's recommendation, the practitioner shall be immediately contacted and shall explain to the patient or the patient's legally authorized representative the seriousness of the condition and risks of transfer. An appropriate transfer request and release form shall be executed in accord with Hospital policy. If the patient or the patient's legally authorized representative refuses to sign the form, a completed form without the signature and a note indicating refusal to sign must be included in the patient's medical record.

4.3 Transfers from another Facility

Emergency Department practitioners may not accept transfer patients for direct admission unless an attending practitioner has already been consulted and has agreed to accept the transfer

SECTION 5: DISCHARGE OF PATIENTS

5.1 Required Order

A patient may be discharged only on the written or verbal order of the attending practitioner or by Medical Executive Committee approved discharge criteria.

5.2 Leaving Against Medical Advice

If a patient desires to leave the Hospital against the advice of the attending practitioner or without proper discharge, or such request is made by the patient’s legally authorized representative, the attending practitioner shall be notified. The patient or the patient’s legally authorized representative will be advised of the risks of discontinuing care and requested to sign the appropriate release form in accordance with Hospital policy. If the patient or the patient’s legally authorized representative refuses to sign the form, a completed form without the signature and a note indicating refusal to sign shall be included in the patient’s medical record.

5.3 Discharge of Minor Patient

Any minor patient who cannot legally consent to his/her own care shall be discharged only to the custody of a parent, legal guardian or managing conservator, unless otherwise directed by that individual or a court of competent jurisdiction. If the individual directs that discharge be made otherwise, the direction shall be in writing in accordance with Hospital policy and shall be made a part of the patient's medical record.

SECTION 6: ORDERS

6.1 General Requirements

Drugs or treatment shall not be administered unless a verbal or written order has been given by a practitioner who has appropriate clinical privileges in accord with these Rules and Regulations. Orders for outpatient diagnostic tests may be accepted from practitioners who are not members of the Medical Staff in accord with Hospital policy. Orders for diagnostic tests will be considered to include an order for the administration of any necessary test substances or medications if so provided by department or unit protocol.

6.2 Written Orders

All written orders for treatment or diagnostic tests must be written clearly, legibly and completely, dated, timed, and signed by the practitioner responsible for them. In addition to his/her signature, the practitioner will either print his/her name, or document physician number or utilize a stamp following signature to ensure author legibility in the event an order needs to be clarified. Orders which are illegible, improperly written, or that utilize non-approved abbreviations will not be carried out until rewritten by the practitioner or clarified with the practitioner by the appropriate healthcare provider as designated in Section 6.3.2.

6.3 Verbal Orders

6.3.1 Issuance

Verbal or telephone orders may be issued only by appropriately credentialed practitioners. Faxed written orders are encouraged when possible.

No hospital staff may accept a verbal or handwritten order for oncologic chemotherapeutic agents. The preprinted chemotherapy order form must be used.

6.3.2 Acceptance

Except as provided below, verbal orders (which include telephone orders) may be accepted only by another practitioner or a registered nurse or LVN employed, contracted or appropriately credentialed by the Hospital. The following personnel, if approved in accordance with Hospital policy, may take verbal orders for medication, treatment and/or procedures within their respective areas of practice and which they will prepare, deliver or perform:

(a) registered pharmacist,
(b) respiratory therapist/technician,
(c) physical therapist,
(d) laboratory technician,
(e) radiology technician,
(f) physician's assistant,
(g) advanced nurse practitioner,
(h) occupational therapist,
(i) speech pathologist,
(j) certified social worker, and
(k) registered dietician.

6.3.3 Documentation

All verbal orders shall be transcribed in the proper place in the medical record preceded by "V.O." and shall include the date, time, name and signature of the person transcribing the order and the name of the practitioner. Once recorded in the medical record, verbal orders have the same authority as written orders. All telephone or verbal orders shall be authenticated, dated, timed, and signed by the responsible practitioner within 48 hours of order.

6.4 Protocol Orders

Protocol orders for any department or a unit may be formulated by the department and/or its quality management committee and must be approved by the hospital committee designated by the CEO and the Medical Executive Committee. Additional protocol orders may be formulated by an individual member of the medical staff for his patients, subject to the approval of the department quality management committee. All protocol orders shall be listed on the physician orders form, included in the patient's medical record, and signed and dated by the prescribing practitioner. Protocol orders shall be considered a specific order by the practitioner for that patient and shall be followed in the absence of other specific orders by the practitioner, insofar as the proper treatment of the patient will allow.

6.5 Automatic Cancellation of Orders

All existing orders, other than an order for limitation of life sustaining treatment are automatically discontinued when the patient goes to surgery or is transferred to or from a different level of care unless a specific order is written otherwise. When a decision is made to perform surgery on a patient who has an order to limit or withhold care, the surgeon-anesthesiologist, in collaboration with the patient and/or family, shall make the decision whether or not to discontinue the order during the surgical process.

6.6 Stop Orders

6.6.1 Drugs/Treatments Covered and Maximum Duration

When feasible and in order to assure that the proper and complete therapeutic regimen intended by the prescribing practitioner is carried out, the exact total dosage or total period of time for the drugs or treatments ordered shall be specified in the order. When that has not been done, if required by pharmacy policy, a stop order will be placed automatically in the medical record by pharmacy department staff at the terminal date and time. In implementing the stop order, pharmacy will calculate the maximum duration permissible so as to cover the total number of hours indicated. In no event shall the drug or treatment be given longer than the interval or particular dosage specified in the order.

6.6.2 Notification of Stop Order

As applicable, pharmacy shall notify the prescribing practitioner at least 48 hours before an order is automatically stopped.

6.7 Blood Transfusions and Intravenous Infusions

Blood transfusions and intravenous infusions require an order and may only be started by a practitioner who has appropriate clinical privileges or by a registered nurse who has the requisite training and has been authorized to do so in the Hospital. The order must specifically state the rate of infusion.

6.8 Orders by Allied Health Professionals/Health Care Affiliates

An allied health professional (AHP) or health care affiliate (HCA or affiliate) may write orders only to the extent specified in the grant of clinical privileges or authorization to practice.

6.9 Special Orders

6.9.1 Patient's Own Drugs and Self-Administration

Drugs brought into the Hospital by a patient may not be administered unless the drugs have been identified by pharmacy, are of the type permitted to be administered by Hospital policy, and there is a written order from the attending practitioner for the patient to self-administer the drugs. Self-administration shall be in accordance with Hospital policy.

6.9.2 Order for Limiting Life Sustaining Treatment

Orders for limiting life sustaining treatment must be written by the attending practitioner on the order sheet and progress notes in accord with Hospital policy. A verbal order to limit life-sustaining treatment must be witnessed by two registered nurses both of whom must sign the verbal order. Other documentation, including any consents/authorizations, and any notices required shall be accomplished in accordance with Hospital policy. Orders to limit life-sustaining treatment may be canceled during surgery or on transfer to or from ICU or CCU only with the consent of the patient or the patient's legally authorized representative and in accord with Hospital policy.

6.9.3 Hospital pharmacists approved to provide Coumadin management services may do so at the order of the attending physician and shall be subject to physician direction in accord with Pharmacy Policy #2.22.

SECTION 7: INPATIENT MEDICAL RECORDS

7.1 Required Content

The attending practitioner and other practitioners participating in the patient's care shall be responsible for the preparation of a complete and legible medical record for each patient. The record's content shall be pertinent, accurate, legible, timely and current. The record shall include:

7.1.1 Identification data;

7.1.2 History and physical examination;

7.1.3 Diagnostic and therapeutic orders;

7.1.4 Evidence of appropriate informed consent;

7.1.5 Treatment provided;

7.1.6 Progress notes and other clinical observations, including results of therapy;

7.1.7 Special reports, when applicable (such as, clinical laboratory, radiology, radiotherapy, EEG, EKG, consultation, pre- and post-anesthesia, operative and other diagnostic and therapeutic procedures, and AJCC cancer staging form);

7.1.8 Pathology findings;

7.1.9 Final diagnosis without the use of symbols or abbreviations; and

7.1.10 Condition on discharge, including discharge plan and instructions, if any, to the patient or the patient's legally authorized representative.

7.2 History and Physical Examination/Admission Note

7.2.1 General

A complete history and physical examination must be recorded in the medical record or dictated within 24 hours after admission of the patient. H&Ps must be dated, timed, and authenticated. If the history and physical examination has been dictated but is not in the medical record within 24 hours, an admission note must be entered that includes pertinent findings from the history and physical examination.

7.2.2 Content

The history and physical examination report must include the chief complaint, details of the present illness, all relevant past medical, social and family histories, the patient's emotional, behavioral and social status when appropriate, and all pertinent findings resulting from a comprehensive, current assessment of all body systems.

7.2.3 History and Physical Examination

A short history and physical examination may be used for patients admitted for minor surgical procedures and whose hospital stay is not expected to exceed 48 hours.

7.2.4 Dental and Podiatric Practitioners

The admitting dental or podiatric practitioner shall ensure that the patient receives a medical evaluation in accord with the Rules and Regulations and has a medical history and physical examination performed by a physician practitioner. The physician practitioner shall also assess the medical risks of any proposed surgical or other invasive procedures. The dental or podiatric practitioner is responsible for the part of the history and physical examination that deals with dentistry or podiatry.

Qualified oral surgeons who admit patients without medical problems may be privileged to perform the medical history and physical examination and assess the medical risks of the proposed surgical or other invasive procedures.

7.2.5 Use of Reports Prepared Prior to Current Admission

(a) External to Hospital: If a practitioner with the required clinical privileges has obtained a complete history and performed a complete physical examination within 30 days prior to the patient's admission to the Hospital, a legible copy of the report may be used in the patient's medical record. An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. If there are no changes, there must be documentation of such and the statement must be dated, signed, and timed.

(b) Readmission: When a patient is readmitted to this Hospital within 30 days for the same or a related problem, the attending practitioner may use an interval history and physical examination reflecting subsequent history and any changes in physical findings, provided the original history and physical examination is available for reference.

7.3 Preoperative Documentation

7.3.1 History and Physical Examination

A history and physical examination as set forth in Section 7.2.1 above is required on each patient having surgery. Except in an emergency, surgery shall not be performed until after a presumptive preoperative diagnosis has been established and the history, physical examination and required laboratory tests have been performed and recorded in the patient’s medical record.

In cases of emergency, the operating practitioner shall enter in the medical record a brief note regarding the patient's condition prior to induction of anesthesia and start of the procedure, including the presumptive preoperative

diagnosis. The history and physical examination shall be recorded immediately after the emergency surgery has been completed.

7.3.2 Laboratory Tests

Any laboratory test results shall be documented in the patient's medical record prior to the performance of the operative procedure, in accord with department policy.

7.3.3 Preoperative Anesthesia Evaluation

The anesthesiologist (or other licensed independent professional responsible for the patient's anesthesia care) must conduct and document in the record a pre anesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, ASA patient status classification, and orders for preoperative medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered.

7.3.4 Outpatient/Admission Day Surgery

The attending practitioner shall comply with Hospital policies and the requirements above concerning preoperative laboratory tests, documentation and scheduling.

7.4 Progress Notes

7.4.1 General

Pertinent progress notes must be recorded at the time of or immediately following observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Progress notes by the attending practitioner must be written at least daily unless otherwise provided by unit policy. All Progress notes must be legible, dated, timed, and authenticated (signed) in written or electronic form.

7.4.2 Notes by Individuals Other Than Attending Practitioner

(a) Consultant Physician Notes: Consultant physician's progress notes must clearly identify the patient's problems pertinent to the consultation and should correlate with specific orders as well as results of tests and treatment.

(b) Physician Extender Notes. In non-critical areas, progress notes by authorized health care affiliates shall be recorded in the Physician Progress Notes and must be countersigned, dated, and timed at the time of the next visit by the supervising physician. In critical care units, the supervising or alternate supervising physician must see patients daily to review and countersign, date, and time any documentation provided by the APN or PA within 24 hours after the note was written. The physician counter-signature must be time-stamped on the electronic medical record or manually dated and timed if in manually written form.

(b) Multidisciplinary Progress Notes. Progress notes may be prepared by any of the following and shall be recorded in the Multidisciplinary Progress Notes:

(1) Hospital employee, if authorized by job description;
(2) registered pharmacist;
(3) physical therapist;
(4) occupational therapist;
(5) speech pathologist;
(6) certified social worker;
(7) registered dietician;
(8) chaplain; and
(9) patient services representative.

7.5 Operative/Special Procedure Reports

7.5.1 Content

Operative and special procedure reports must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, estimated blood loss, and the name of the primary performing practitioner and any assistant practitioners.

7.5.2 Time Requirements

The complete report must be written or dictated immediately following the procedure, filed in the medical record as soon after the procedure as possible, and promptly signed by the primary performing practitioner. The primary performing practitioner must enter a non-dictated post operative note in the medical record immediately after the procedure providing pertinent information for use by any practitioner who is required to attend the patient.

7.6 Tissue Examination and Reports

All tissues, foreign bodies, artifacts and prostheses removed during a procedure, except those specifically excluded by policy of the Medical Executive Committee, shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the pathologist. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. An authenticated report of the pathologist's examination shall be made a part of the patient's medical record within 72 hours.

7.7 Post- Anesthesia Follow-up Report

The anesthesiologist (or other licensed health care professional who administered anesthesia) shall include a post-anesthesia follow-up report in the patient's medical record within 48 hours after surgery. The report shall include: cardiopulmonary status, level of consciousness, any complications or problems occurring during anesthesia, and any follow-up care and/or observations.

7.8 Obstetrical Record

The current obstetrical record must include a complete prenatal record if available. The prenatal record may be a durable, legible copy of the attending practitioner's office or clinic record transferred to the Hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings since the date of preparation of the copy. All obstetrical patients undergoing surgery must have a history and physical examination recorded as required under Sections 7.2 and 7.3 of these Rules and Regulations.

7.9 Entries at Conclusion of Hospitalization

7.9.1 Discharge Summary

(a) General: A discharge summary must be recorded by the attending practitioner for his patients within 30 days of discharge. The summary must recapitulate concisely the reason for hospitalization, the significant findings including complications, the procedures performed and treatment rendered, the condition of the patient on discharge outcome of hospitalization, final diagnosis, case disposition, and any provisions for follow-up care stated in a manner allowing specific comparison with the condition on admission, unless already documented in the discharge order record.

(b) Exceptions: A final progress note may be substituted for the discharge summary in the case of patients who require less than 48 hours of hospitalization and in the case of normal newborn infants or uncomplicated obstetrical deliveries. Unless already documented in the

discharge order record, the note must include the outcome of hospitalization, final diagnosis, the case disposition, and any provisions for follow-up care.

7.9.2 Instructions to Patient

The discharge order record, discharge summary or final progress note under 7.9.2(b) must indicate any discharge plan and specific instructions given to the patient or the patient's authorized representative relating to physical activity, medication, diet and follow-up care. If no discharge plan or instructions were required, a record entry must be made to that effect.

7.10 Authentication

All clinical entries in the patient's medical record must be accurately dated and individually authenticated. Authentication means to establish authorship by written signature, identifiable initials or computer key. The signature of a 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. If used in the inpatient medical record, then the signature stamp must be authenticated with an original signature. Acknowledgements for the use of the signature stamp will be filed in the Health Information Department 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. The following portions of the medical record require the responsible practitioner's signature:

7.10.1 Admission progress notes and orders;

7.10.2 History and physical examination;

7.10.3 Immediate pre-operative and post-operative progress notes;

7.10.4 All operative or special procedure reports;

7.10.5 Discharge summary;

7.10.6 All other clinical entries, diagnoses, orders, reports and progress notes personally given or written by the practitioner; and

7.10.7 Attestation statement (if required).

7.11 Use of Symbols and Abbreviations

Symbols and abbreviations may be used only when they have been approved by the Medical Executive Committee. Use of symbols and abbreviations is discouraged. A list of commonly used symbols and abbreviations and their interpretation is available in Health Information Management. Certain symbols and abbreviations may not be used, this list is also available in Health Information Management. An official record of approved symbols and abbreviations is available at each nursing station and in the health information management department.

7.12 Filing

A medical record may not be filed until it is complete and properly signed. In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the Medical Executive Committee shall consider the circumstances and may enter such reasons in the record and order it filed.

7.13 Medical Records Completion

7.13.1 Medical Record Delinquency

Medical Records will routinely be made available to the practitioner for completion within seven (7) days of discharge. A medical record will be considered delinquent if it remains incomplete 30 days after discharge

7.13.2 Incomplete Record List

The Incomplete Record List will be published weekly. The practitioner will be placed on the Incomplete Record List if medical records remain incomplete for ten (10) days after being available to the practitioner for completion. The practitioner will be given written notice of such placement.

7.13.3 Certified Letter

If the practitioner fails to complete the record within 7 days following placement on the Incomplete Record List, the practitioner will receive a certified letter with copy to the department chairman advising of the continued incompleteness and pending suspension of privileges.

7.13.4 Automatic Suspension

If the record is not completed within 7 days following the practitioners receipt of the certified letter, all admitting and consulting privileges will be automatically suspended pursuant to Section 3.3 of the Medical Staff Bylaws until the records are completed.

If a practitioner receives a third certified letter in any 12-month period regarding delinquent records, then he/she will be asked to appear at the next scheduled MEC meeting to address the issue of delinquent records.

If there is a 4th occurrence in any 12-month period, the practitioner will be advised by certified letter of automatic suspension of all hospital privileges for a minimum of 24-hours or until all records are signed and/or dictated; if there is a 5th occurrence in any 12-month period, the practitioner will be advised by certified letter of automatic suspension of all hospital privileges until the practitioner has completed all the delinquent records and has met before his department chairman and the President of the Medical Staff for an automatic Quality Improvement Plan. If the practitioner does not meet with these officers or has a 6th occurrence in any 12-month period, then the practitioner's membership on the Medical Staff is automatically revoked.

7.14 Ownership and Removal of Records

All original patient medical records, including x-ray films, pathology specimens and slides, are the property of the Hospital and may be removed only in accordance with Hospital policy, court order or statute, or with the permission of the CEO. Only the health information management department may release copies of a medical record which shall be done in accord with Hospital policy.

SECTION 8: CONSENTS

8.1 General

8.1.1 Consent

Each patient's medical record must contain evidence of the patient's or patients legally authorized representative's consent for treatment during hospitalization. Consent shall be obtained from the competent adult patient or from a legally authorized representative of the patient in accord with Hospital policy. Consent for treatment of minors who lack legal authority to consent shall be obtained from the patient's legally authorized representative in accord with Hospital policy. Any questions regarding legal authority or capacity to make health care decisions shall be referred to the CEO or his designee.

8.1.2 Refusal

If a patient or a patient's legally authorized representative refuses appropriate and clinically indicated treatment, the patient or the patient's legally authorized representative shall be advised by the practitioner of the risks associated with the refusal and, unless court authorization for treatment is sought, asked to sign

a refusal of treatment form in accord with Hospital policy. If the patient or the patient's legally authorized representative refuses to sign the form, the disclosure of risks and decision should be documented on the form by the practitioner or Hospital staff witnessing the disclosure.

8.1.3 Emergency Exception

Informed consent is not required in an emergency. The emergency must be documented in the medical record by the attending or operating practitioner and a second practitioner if practical. An emergency is defined as a life or death situation in which treatment is immediately required to prevent death and/or extreme deterioration or aggravation of the patient's condition.

8.2 Attending Practitioner and/or Anesthesia Provider Responsibility

The attending practitioner and/or anesthesia provider shall be solely responsible for providing the patient or the patient's legally authorized representative with information as required by law and Hospital policy to enable the patient or the patient's legally authorized representative to make an informed decision with regard to consent to treatment by the attending physician and/or anesthesia provider respectively. This includes information about the procedure, treatment and/or anesthetic, associated risks, hazards and benefits, and alternatives. Written consent shall be obtained, using the Hospital's approved forms, for those procedures designated in Hospital policy and approved by the Medical Executive Committee. Hospital staff may assist the practitioner and/or anesthesia provider in obtaining written consent.

8.3 Preoperative Consent

Consent to any operative procedure shall be obtained by the operating practitioner and anesthesia provided, if applicable, in accord with Hospital policy. The consent form must be signed prior to the administration of any pre-operative sedation or mind-altering medication. If the patient has received any sedative or mind-altering medication, consent cannot be obtained <u>unless</u> a physician makes an assessment of the patient's capacity for understanding and determines that the patient has the capacity to make health care decisions. This assessment must be documented in the progress notes after which consent shall be obtained.

8.4 Telephone Consent

Telephone consent may be used if the patient lacks the capacity to make health care decisions and the patient's legally responsible representative is only available by telephone. Two responsible parties other than the attending or operating surgeon or anesthesia provider shall be on the telephone to witness the consent. Notation of such shall be included on the consent form along with the signatures of the two parties listening, as well as the exact time of consent. Written confirmation of the telephone consent should be requested and, when received, filed in the medical record.

8.5 Consent by Facsimile Transmission

Unless otherwise provided by Hospital policy, consent may be signed by the patient's legally authorized representative and transmitted to the requesting practitioner and/or anesthesia provider by facsimile if the representative is not available. The representative shall be requested to forward the original of the signed consent form to the Hospital as soon as possible.

SECTION 9: PATIENT CARE SERVICES POLICIES

Appropriate officers, committees and representatives of the Medical Staff and its departments may develop, in coordination with applicable Hospital departments, specific policies for any departments or units and practitioners in those departments or providing services on those units. Policies may address any matters pertaining to patient care or operations, including responsibility for care of patients in the unit, criteria for patient admission to the unit, consultation requirements, admission/discharge/transfer protocols, direction/organization of the unit, authority of the medical director of the unit, special record-keeping requirements, and scheduling of patients. The policies of the various departments and units are subject to the approval of the Medical Executive Committee and CEO.

SECTION 10: HOSPITAL DEATHS AND AUTOPSIES

10.1 Hospital Deaths

10.1.1 Pronouncement

In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner (or physician designee) within a reasonable period of time or the practitioner may authorize pronouncement by two (2) registered nurses on the Hospital's staff pursuant to Hospital policy. The death certificate must be signed by the attending practitioner or other physician practitioner accepting responsibility for certifying the death. It is the responsibility of the attending practitioner to ensure that notice of the patient's death is provided to the family or other authorized representative in an appropriate and timely manner.

10.1.2 Reportable Deaths

Reporting of deaths to the medical examiner's office shall be carried out when required by and in conformance with local law and Hospital policy.

10.1.3 Release of Body

The body may not be released until pronouncement has been documented. In a medical examiner's case, the body may not be released to other than medical examiner personnel or to police officers, except upon the receipt of an appropriate order issued by the medical examiner. All other policies with respect to the release of dead bodies shall conform to local law.

10.2 Autopsies

It is the responsibility of each practitioner to secure autopsies whenever possible. Proper consent for an autopsy shall be in accord with Hospital policy and the attending practitioner shall be notified when an autopsy is being performed. All autopsies shall be performed by a staff pathologist or designee. The provisional anatomic diagnoses must be recorded on the medical record (or the findings communicated to the attending practitioner) within 72 hours and the complete protocol shall be made a part of the medical record within 30 days. These rules do not apply to cases referred to the medical examiner's office.

10.3 Organ Procurement

Practitioners shall assist in complying with Hospital organ procurement protocol in accord with Hospital policy.

SECTION 11: EMERGENCY SERVICES

11.1 Staffing

The Emergency Department will be staffed by qualified staff practitioners. Members of the Emergency Medicine Department are not eligible for admitting privileges.

11.2 Screening and Examination

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

A medical screening may be performed in the ED by either:

a. a licensed physician with clinical privileges granted by the Board; or

b. a licensed nurse practitioner or physician assistant with appropriate advanced training, board certification and clinical privileges granted by the board; or

c. a competent Labor and Delivery nurse. The Labor and Delivery nurse is competent to perform the medical screening examination on the obstetrical patient when the L&D nurse has satisfactorily completed the clinical competency requirements as approved by the Medical Staff; or

d. Registered nurse with appropriate training.

11.3 Responsibility for Patients

While a patient is in the Emergency Department, the patient is the responsibility of the Emergency Department practitioner until another member of the Medical Staff assumes that responsibility or the patient is transferred or discharged from the Emergency Department.

11.3.1 Existing Patient

If a patient who presents to the Emergency Department has an established relationship with a member of the Medical Staff, that practitioner shall be notified in accord with Emergency Department policy. If notified, the practitioner may assume responsibility for the patient's treatment and, if so, shall be responsible to advise the patient of any necessary follow-up treatment, including specialist consultation. Notification of the practitioner shall be documented in the Emergency Department record. Failure of the practitioner to return a telephone call and or page within 30 minutes will be regarded as an inability of the practitioner to be notified.

11.3.2 Follow-up Care

Unless care has been assumed by another practitioner, the Emergency Department practitioner or on-call practitioner who has treated the patient in the Emergency Department shall be responsible to advise the patient of any necessary follow-up treatment, including specialist consultation.

11.4 On-Call Practitioners

11.4.1 Changes in Schedule

Unless specifically exempted by the department, the Medical Executive Committee or the Board, each member of the active clinical and courtesy staffs, when serving as the designated practitioner on-call, will accept responsibility during the time specified by the published schedule for providing care as required by this section to any individual who presents to the Emergency Department requiring treatment and to any patient in any unit of the Hospital referred to the service for which he/she is providing on-call coverage. If there is a conflict with the published schedule, it is the on-call practitioner's responsibility to secure a replacement from the staff who is eligible to take call for that specialty and notify the Emergency Department prior to the scheduled rotation.

11.4.2 Response Time

The designated practitioner on-call is responsible to respond to calls by the Emergency Department and other departments and to comply with the policies and procedures of the Emergency Department and Hospital on specialist availability and coverage. On-call practitioners shall respond by phone or in person within 30 minutes of being called. When requested by the emergency physician to personally evaluate a patient in the emergency department in order to determine if the patient has an emergency medical condition or to stabilize an

emergency medical condition, the on-call practitioner shall see the patient in an appropriate time frame as determined by the emergency physician. On-call practitioners who fail to respond to a call within 30 minutes shall be reported to the appropriate department and may be subject to corrective action.

11.5 Use of Emergency Department

If a staff member wishes to see his patient in the Emergency Department, he must make arrangements within one hour of the patient's arrival to the Emergency Department to see the patient or the patient will then be managed by the Emergency Department practitioner. Regardless of the practitioner's arrangements, the patient shall be provided an appropriate medical screening examination for the presence of an emergency medical condition as provided in Section 11.2 above.

SECTION 12: TREATMENT PRACTICES

12.1 Ethics Committee

The Ethics Committee shall be available for consultation with any practitioner, Hospital staff, patient or family member, in accord with Hospital policy. Any questions regarding procedures or conflict between a practitioner or Hospital staff and a patient and/or the patient's legally authorized representative or family may be referred to the Ethics Committee for review and advice.

12.2 Religious Beliefs

Unless medically contraindicated, each patient's religious or specific beliefs shall be accommodated as reasonably practical. If such beliefs adversely impact or may adversely impact the medical care, such as to place the life of a patient in danger, the CEO (or designee) shall be contacted.

SECTION 13: STANDARDS OF CONDUCT

13.1 Policy

It is the policy of the Hospital and the Medical Staff that all practitioners and other individuals within the Hospital be treated courteously, respectfully, and with dignity. To that end, the Hospital and the Medical Staff require all practitioners to conduct themselves in a professional and cooperative manner in the Hospital and related facilities and at all times while engaged in Hospital or Medical Staff affairs.

13.2 Complaints

Any individual may report disruptive or potentially disruptive conduct of a practitioner to the appropriate department chair, President of the Medical Staff or CEO, or as otherwise provided by Hospital policy. Complaints shall be handled in accord with Hospital policy and the Medical Staff Bylaws.

SECTION 14: MEDICAL DISASTER PLAN

All attending practitioners shall be subject to the Hospital's Medical Disaster Plan and specifically agree to relinquish distribution and disposition of their inpatients during the period of a disaster to the President of the Medical Staff or his/her physician designee. During a medical disaster, the President may order the discharge of patients.

SECTION 15: REPORTING OF INCIDENTS AND SENTINEL EVENTS

15.1 Reporting

Each member of the medical staff has a duty to report timely any variance/incident or sentinel event. Report may be made to the President of the Medical Staff, Risk Manager, Director of Quality Management or as outlined in the Medical Center Administrative Policy Manual. The report is timely if made as soon as is practical after the occurrence, taking into account the patient’s immediate need for care, and the need for intervention to prevent further adverse events.

15.2 Definitions:

15.2.1 Incident:

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

15.2.2 Sentinel Event

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

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

- The event has resulted in an unanticipated death or major permanent loss of

function, not related to the natural course of the patient's illness or underlying condition*; or

- The event is one of the following:
    - Patient Suicide
    - Unanticipated death of a full-term infant
    - Infant abduction or discharge to the wrong family
    - Rape
    - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
    - Surgery on the wrong patient or wrong body part

***Further definition and clarification of illness and/or underlying condition is available in the administrative policy, with the Risk Manager or Department of Health Care Improvement**

SECTION 16: NAME

The physicians, dentists and podiatrists authorized to practice in the Baylor Medical Center at Irving shall be referred to as "The Medical Staff of Baylor Medical Center at Irving."

SECTION 17: REQUIRMENTS FOR SURGERY

Whenever possible, all elective surgical cases should be posted by 3 PM the day before surgery (or by 4:30 PM Friday for surgery on Monday). All cases in non-blocked rooms will be posted on a "first come" basis. Only the surgeon or someone from his office can post the case. Heart rooms have no release time. Orthopedic blocks release 24 hours prior to block. All other blocks release 48 hours prior to the block. Block utilization will be reviewed quarterly by the OR Subcommittee. Block utilization of less than 50% will be subject to loss of block or a decreased block time, at the discretion of the OR Subcommittee.

At the time of posting, all procedures for that case are to be posted and listed in order that they will be done. 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, as that may result in delay to other physicians and their patients. Anticipated length of surgery is also required at time of posting. Names of assistants should also be listed and any need for additional scrub personnel.

The surgery schedule will begin at 7:30 AM (this is designated as room time, not "cut" time). If the surgeon does not wish to begin at 7:30 AM, the case may be tentatively scheduled for a later start, but will be subject to delay if other surgery can be scheduled in order to facilitate completion of the entire surgery schedule.

Surgical procedures may be scheduled as far in advance as necessary. The time on the OR schedule is reserved for the patient rather than the surgeon. If a procedure is canceled, the OR reservation is lost and the next patient scheduled may be moved to that time. If this

occurs in a surgeon's block time, he may add another procedure or move succeeding procedures up.

Cases that arise after 3 PM that are not emergent, yet need to be done the following day, may be added to the following day's Want List by OR personnel or the Nursing Supervisor.

Procedures added to the Want List will be designated as elective, urgent or emergent. If an emergent case needs to supersede a case already on the Want List, it will be the emergent surgeon's responsibility to speak with the surgeon ahead of him on the want list in order to "bump" the case or any other scheduled case.

The Anesthesiologist will discuss the anesthesia risks with the patient and obtain consent. 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 the "List A". The physician should document that risk/benefits/alternatives have been explained and the patient agrees with treatment planned.

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 the patient chart prior to entering the 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 (unless the VTE Risk Assessment form is utilized), 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. An H&P performed within the last 30 days may be used. However, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Updates related to changes in patient condition need to be annotated on the H&P or in the progress notes. If there are no changes, there must be documentation of such and the statement must be dated, signed and timed.

The surgeon should be present in the OR at the scheduled start time. The patient will not be moved to the OR table prior to the staff seeing the surgeon. If the surgeon is not present 15 minutes after the scheduled time, the physician will be documented as a late start. Three occurrences of documented late 7:30 AM starts in a consecutive three month period will result in loss of scheduling 7:30 AM cases for a 90-day period. Cases that have already been posted will be allowed to remain as scheduled. The OR will be responsible for documenting late starts, and the information will be forwarded to the OR Subcommittee for action. 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 any physicians affected as well as appropriate operating room staff. In addition, the surgeon should notify the nursing unit and patient of his delay.

For any procedure in which the patient will benefit, there shall be a qualified assistant scrubbed and present that is capable of protecting the patient in the event of incapacity of the surgeon until a qualified surgeon can be summoned to complete the case. The primary operating surgeon shall determine the level and number of assistants required (e.g., qualified RNFA, PA, surgeon, or other qualified physician) commensurate with the following parameters:

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

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. Physicians performing procedures are responsible for the pre-op and post-op (beyond recovery) anesthesia testing orders. Anesthesiologists are responsible for these orders from intra-op through the recovery room.

Admission orders for same day surgery include the following list and must be faxed to the fax server by 6 (six) PM the day prior to the scheduled procedure. Want list cases will not be started until the same criteria are met.

Admit to Outpatient DSU
Admit to AM Admit
Admit to Outpatient DSU—23 hrs obs
Diagnosis
Planned procedure
Allergies
Consent signed and witnessed
VTE assessment and order (type and timing)
Beta blocker pre-op or continuation
Labs, blood glucose, pregnancy test, etc.
Antibiotic order
Other medication orders

Post-op orders (at a minimum) will include the following:

Discharge to___
Admit to 23 hr obs
Discharge when patient meets DSU discharge criteria
Activities including driving restrictions
Diet

Dressing or wound care instructions, including shower or hygiene
Drain care
Nursing orders
Discharge medication and completed UML
Appointment follow up instructions
Call if Tem>101.5

An immediate post-op note must be documented containing the following elements:

(e) Surgeon
(f) Assistant(s)
(g) Anesthesiologist
(h) Procedure
(i) Findings
(j) Final Diagnosis
(k) Specimens
(l) EBL
(m) Complications
(n) Condition

SECTION 18: PURPOSES AND RESPONSIBILITIES OF MEDICAL STAFF

18.1 Purposes

The purpose of the Staff is to:

18.1.1 develop an organizational structure, reflected in Bylaws, Manuals and other related protocols, which adequately defines responsibility, authority and accountability of each component of the Staff;

18.1.2 provide a mechanism for accountability to the Board, through defined Staff components, for the appropriateness of the patient care services, professional and ethical conduct, and education and research activities of each practitioner;

18.1.3 promote a high level of professional performance of practitioners and allied health professionals through the appropriate delineation of clinical privileges and through review and evaluation of their performance;

18.1.4 provide a liaison with the Board and a means by which the Staff can formulate recommendations for the Hospital's policy-making and planning processes, and through which such policies and plans are communicated to and observed by each practitioner on the Staff; and

18.1.5 assist the Board in fulfilling its legal and accreditation responsibilities.

18.2 Responsibilities

To affect the purposes enumerated above, it is the obligation and responsibility of the Staff to:

18.2.1 participate in the Hospital's quality management, utilization review and risk management programs by conducting all required and necessary activities for assessing and improving the effectiveness and efficiency of medical care provided in the Hospital;

18.2.2 make recommendations to the Board concerning appointments and reappointments to the Staff, including Staff category and department assignments, clinical privileges and corrective action;

18.2.3 maintain sound professional practices and an atmosphere conducive to the diagnosis and treatment of illness, education and research;

18.2.4 develop or participate in and monitor the Staff's education and training programs and research activities;

18.2.5 develop, administer and recommend amendments to these Bylaws and the ancillary Manuals;

18.2.6 endorse compliance with the Bylaws and Manuals and with Board and Hospital Bylaws, rules and policies;

18.2.7 participate in the Board's short and long range planning activities, assist in identifying community health needs and suggest to the Board appropriate institutional policies and programs to meet those needs; and

18.2.8 exercise the authority granted by these Bylaws as necessary to fulfill the foregoing responsibilities in a proper and timely manner.

18.3 Board and Administration Support.

When the Staff and practitioners are assisting the Board in fulfilling the Hospital's and Board's legal responsibilities and accreditation requirements by performing the duties and responsibilities set forth in these Bylaws, the Board, through the CEO, shall make available to the Staff appropriate administrative and legal support services. The CEO may provide any notice required by these Bylaws or a Manual from a Staff officer, department or committee chair, or department or committee.

SECTION 19: MEDICAL STAFF STRUCTURE

19.1 Officers

The officers of the Medical Staff shall be the President, the President-Elect, the Vice-President, the Past President, and the Secretary-Treasurer.

19.1.1 Qualifications

Officers must be members of the active Staff at the time of their nomination and election and must remain in good professional and ethical standing during their term of office. Because of the peer review responsibilities, the officers shall have demonstrated competence in their fields of practice and ability to direct the medico-administrative aspects of Staff activities. Officers must have demonstrated appropriate interpersonal relationships with Staff members and Hospital Staff, and have indicated a willingness to accept the responsibilities of the office. A practitioner may not hold two offices concurrently or serve simultaneously as an officer and department chair.

19.1.2 Term and Election

The term of office is one medical staff year. One may be eligible for re-election with a maximum of two consecutive terms. The procedures for election, vacancies, resignation and removal of officers are set forth in the Medical Staff Organizational Manual.

19.2 Committees

The Staff may utilize committees, both standing and special, to accomplish its functions. All committee members and chairs, other than for the Medical Executive Committee, shall be appointed by the President from either active or associate Staff members unless otherwise provided in these Bylaws. The CEO shall appoint any non-Staff members. Only Staff members may vote, except as may otherwise be provided within the Bylaws or on appointment. Each committee may adopt policies and procedures for carrying out its duties, and may delegate one or more functions to a subcommittee. The composition, duties, meeting frequency, and other procedural requirements for Staff committees, as well as mandated representatives on Board or Hospital committees, are set forth as follows:

19.2.1 Medical Executive Committee

The Medical Executive Committee is authorized to act for the organized staff in the intervals between organized staff meetings. The Medical Staff Executive Committee includes physicians and may include other licensed independent practitioners. All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the Executive Committee. The majority of voting members are fully licensed physicians actively participating in the Hospital.

19.2.2 Representation on Board or Hospital Committees

Functions and responsibilities that require participation, but not direct oversight, by the Staff may be discharged by Staff or department officers, departments or members appointed by the President to Board or Hospital committees

established to fulfill those functions and responsibilities. The Staff shall be represented in any Board or Hospital deliberation affecting the discharge of Staff responsibilities.

19.3 Departments

The Staff shall be departmentalized by clinical specialties, with each department a separate organizational component of the Staff. The departments may be modified by the Medical Executive Committee subject to Board approval. The Medical Executive Committee may also recommend the establishment of sections within departments.

19.3.1 Functions

The department shall fulfill administrative and quality management functions as detailed in this Manual. Each department shall have a chair and vice-chair. The functions of the departments and the duties of the officers, as well as procedures for election, vacancies, resignation, and removal, are as set forth in this Manual.

19.3.2 Assignment to Departments.

Each practitioner shall have a primary affiliation with the department that most closely reflects his/her professional training and experience and the clinical area in which his/her practice is concentrated. A practitioner may be granted clinical privileges in more than one department, with his/her exercise of those clinical privileges subject to the requirements of that department and the authority of that department chair.

19.4 Meetings

19.4.1 **Staff:** An annual meeting of the Staff shall be held at least once each medical staff year. At this meeting, the retiring officers and committees shall make available such reports as may be desirable and the results of officer elections for the next year shall be announced. Special Staff meetings may be called at any time by the President and shall be called at the written request of the Board, the Medical Executive Committee, or ten percent (10%) of the members of the active Staff.

19.4.2 **Department:** Departments shall meet at least quarterly and otherwise as necessary to accomplish department functions. Meetings may be called by the department chair (or any section chief), the President or by one-third (1/3rd) of the department's active Staff members.

19.4.3 **Committee:** Standing committees shall meet at least monthly, unless otherwise specified. Special meetings may be called by the committee chair, the

President or by at least two (2) voting members of the committee. Special committees and subcommittees shall meet as required by the committee chair.

19.4.4 Attendance Requirements:

a. Practitioners may be required, at the discretion of the committee or department chair, to attend any department or committee meeting at which their patient care or conduct will be discussed or for any other reason, provided the practitioner receives at least ten (10) days prior written notice. The practitioner may not be accompanied by an attorney at the meeting. A failure to comply, by the practitioner's attendance, shall constitute a failure to respond to requested information as outlined in 3.3-5 of the Bylaws.

19.4.5 Meeting Procedures: Notice, quorum, minutes, action, and agenda requirements for meetings are as set forth in this Manual. The CEO (or designee) may attend any Staff, department or committee meeting.

19.5 Medical Peer Review Committee Status.

Each committee (whether Staff, department or a subcommittee) and department, as well as the Staff when meeting as a whole, shall be constituted and operate as a medical peer review committee or professional review body, as such terms are defined by law, and is authorized by the Board to: engage in professional review activity; evaluate health care services, including evaluation of the qualifications of practitioners and allied health professionals and the health care services they provide; and evaluate the merits of complaints relating to practitioners, allied health professionals or other individuals providing health care services in the Hospital. Members of the committee, department or Staff shall act as members of and on behalf of the medical peer review committee or professional review body when performing a function or responsibilities of the committee, department or Staff.

SECTION 20: GENERAL

Section sets out the general requirements for the structure of the Staff. The following sets forth the specific duties and procedures applicable to Medical Staff and department officers, committees and departments, and requirements for meetings. The definitions in the Bylaws are applicable to this Manual.

SECTION 21: OFFICERS

21.1 Duties

21.1.1 President. The President of the Staff shall serve as the chief administrative officer of the Staff and shall be a physician. The President's duties shall be to:

a. act in coordination and cooperation with the CEO and the Board in all matters of mutual concern within the Hospital;

b. call, preside at and be responsible for the agenda of all general and special meetings of the Medical Staff;

c. serve as a voting member and the chair of the Medical Executive Committee, a voting member of the Professional Relations and Joint Conference Committees, and an ex officio member of all other Medical Staff committees;

d. is responsible for the enforcement of Bylaws and Manuals, for the implementation of sanctions when indicated, and for the Medical Staff's compliance with procedural safeguards when an adverse recommendation has been made against a practitioner;

e. impose emergency corrective action when indicated;

f. make appointments to all standing and special Staff committees (except for the Medical Executive Committee, the Board, or hospital committees requiring Staff representation, unless otherwise provided in the Bylaws or the Hospital's Bylaws;)

g. represents the views, policies, needs and grievances of the Staff and Medical Executive Committee to the Board and to the CEO;

h. receive and interpret the policies of the Board to the Staff and report to the Board on the performance, maintenance and quality with respect to the health care services provided by the Staff;

i. be the spokesperson for the Staff in its external professional and public relations; and

j. perform such other duties as required by the Bylaws.

21.1.2 President-Elect. The President-Elect shall be a voting member of the Medical Executive Committee, Professional Relations Committee and Joint Conference Committee, and shall be authorized to perform the duties of the President in his/her absence. He/she shall observe and participate in the functions of the Staff in preparation for serving as the President and perform such other duties as may be assigned by the President.

21.1.3 Vice President. The Vice President shall be a voting member of the Medical Executive Committee, Professional Relations Committee and Joint Conference Committee, and shall perform such other duties as may be assigned by the President.

21.1.4 Secretary/Treasurer. The Secretary/Treasurer shall be a voting member of the Medical Executive Committee, Professional Relations Committee and Joint Conference Committee. He/she shall ensure that accurate minutes are maintained for all meetings and that correspondence to the Staff is attended to, and perform such other duties as ordinarily attend this office.

21.1.5 Past President. The Past President shall be a voting member of the Medical Executive Committee, Professional Relations Committee and Joint Conference Committee. He/she shall also serve as the chair of the Nominations Committee and shall perform any other duties requested by the President.

21.2 Nomination and Election of Officers.

The President attains office by automatic succession from the office of President-Elect, as does the Past President from the office of President. The other officers shall be elected by the active Staff members by mail ballot immediately prior to the annual Staff meeting, as provided below.

21.2.1 At least sixty (60) days before the annual Staff meeting, the Nominations Committee shall select at least one (1) candidate for the position of President-Elect, posting the nominations at the medical staff office at least six (6) weeks before the Staff meeting.

21.2.2 Nominations may also be made by petition signed by at least twenty-five (25) active Staff practitioners and filed with the Nominations Committee at least thirty (30) days prior to the annual Staff meeting. These nominations shall be posted at the medical staff office upon filing if candidacy is accepted by the nominee.

21.2.3 At least twenty (20) days prior to the annual Staff meeting, a written ballot shall be sent to all eligible voting practitioners. All completed ballots that are returned to medical staff office, either by hand-delivery, electronically, or postmarked at least seven (7) days prior to the date of the annual Staff meeting, shall be counted.

21.2.4 The candidate receiving a majority of the votes returned shall be elected and the results announced at the annual Staff meeting. If there are three (3) or more candidates and no candidate receives a majority, successive mailed ballots shall be conducted with the name of the candidate receiving the fewest votes eliminated with each successive ballot.

21.3 Term of Office

The term of office is one (1) year, with officers assuming office on the first day of the medical staff year following their election or appointment, except that an officer elected to fill

a vacancy assumes office immediately upon election. Each officer serves until the 31st day of December of that year and until a successor is elected, unless he/she sooner resigns or is removed from office.

21.4 Resignation and Removal

Officers may resign by submitting a written resignation to the Medical Executive Committee and Board. Removal of an officer may be initiated on written petition of at least ten percent (10%) of the members of the active Staff and a subsequent two-thirds (2/3rds) affirmative vote of the returned mail ballots, provided that at least fifty percent (50%) of the active Staff vote. Removal shall be immediate but must be ratified by the Board to become final. The Board may remove any officer, but only after consultation with the Medical Executive Committee to include presentation of the specific reasons for the removal. Grounds for removal of an officer shall include but not be limited to, failure to remain a member in good standing of the medical staff or inability or unwillingness to perform the duties and responsibilities of office as described in Section 20.0 – 20.1.5. Resignation or removal shall not affect the practitioner's Staff appointment or privileges.

21.5 Vacancies

A vacancy in the office of President shall be filled by the President-Elect. A vacancy in the office of President-Elect shall be filled by a special election using the procedures in section 20.2 above. A vacancy in the office of past President shall be filled by the prior past President. If he/she is unavailable or unwilling to serve, the President shall appoint an active Staff practitioner to fulfill the duties of the past President, with the exception of membership on the Medical Executive Committee, and the successor shall serve for the balance of the remaining term.

21.6 Training

Newly elected officers shall attend medical Staff leadership seminars arranged by the CEO at hospital expense.

SECTION 22: COMMITTEES

22.1 General

The Medical Executive Committee may establish, eliminate or merge standing or special Staff committees, change or add to the functions of a Staff committee, or assign a committee function to the Staff as a whole, unless otherwise provided by the Board. The standing committees are set out below. Special committees may be established to accomplish specific functions and shall terminate upon fulfillment of those functions. For standing committees, the term is one (1) year to begin on the first day of the medical staff year. All committees shall maintain written minutes reflecting any actions or recommendations and shall report to the Medical Executive Committee.

22.2 Medical Executive Committee

21.2.1 Composition. The membership of the Medical Executive Committee shall be as set forth as follows:

Voting Members:
President
President- Elect
Vice President
Secretary/Treasurer
Past President
All Department Chairs and/or Vice Chairs
Chair of JQIC
Chair of MSQIC
Chair of Membership & Credentials

Non-Voting Members:
Chair of Infection Control
Radiology Physician Representative
Pathology Physician Representative
Hospital President
Hospital Vice President (s)
Board Representative
Medical Staff Services Representatives
Health Care Improvement Representatives

22.2.2 Duties. In addition to the duties described in the Bylaws, the duties of the Medical Executive Committee shall be to:

a. Be subject to such limitations as may be stated in the Bylaws, and serve as a liaison between the Staff, CEO and Board;

b. coordinates the activities and general policies of the various departments and implement policies of the Staff not otherwise the responsibility of the departments;

c. recommends action to the CEO on matters of medically related administrative matters;

d. makes recommendations on hospital management matters to the Board through the CEO;

e. fulfills the Staff's accountability to the Board for the review of health care rendered to patients in the Hospital;

f. provide for the preparation of all meeting programs, either directly or through delegation;

g. promote professionally ethical conduct and competent clinical performance on the part of all members of the Staff, including the initiation of and/or participation in corrective or review measures when warranted;

h. report at each Staff meeting; and

i. perform such other duties as required by these Bylaws or requested by the Board.

Quality Management Duties of Medical Executive Committee. The Medical Executive Committee shall approve a plan for improving organization performance, review the reports of the Joint Quality Improvement Committee and the Medical Staff Quality Improvement Committee, and initiate corrective action procedures when indicated. The Medical Executive Committee may request reports from Staff or hospital committees, departments and others as needed. Recommendations will be reported to the CEO and to the Board, through the Joint Conference Committee, by the President or by the CEO. A report of Medical Executive Committee action shall be forwarded to the Joint Quality Improvement Committee from which the recommendation originated within sixty (60) days.

22.2.3 Meetings. The committee shall meet at least ten (10) times per year.

22.3 Membership and Credentials Committee

22.3.1 Composition. This committee shall consist of an active Staff representative from each department and additional members or agents as necessary. The chair of this committee shall not be a current chair of any Department. This individual shall be a voting member of the Medical Executive Committee.

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22.3.2 Duties. The duties of the committee shall be to:

a. coordinates and approves the establishment of minimum or threshold criteria for clinical privileges by departments, ensuring appropriateness and consistency for privileges available in more than one department;

b. review and investigate the qualifications of practitioners seeking Staff appointment and make recommendations for appointment and delineation of clinical privileges; and

c. review and investigate the qualifications of allied health professionals and make recommendations on delineation of clinical privileges.

22.3.3 Meetings. The committee shall meet at least every other month.

22.4 Pharmacy and Therapeutics Committee

22.4.1 Composition. This committee shall consist of at least ten (10) Staff members, of whom a pharmacist who will be a voting member of the committee.

22.4.2 Duties. The practices and procedures of the pharmacy, dispensing or administration of drugs, and all use of diagnostic testing materials within the Hospital shall be subject to monitoring and review by this committee. The committee will address pharmacologic and professional aspects of drugs and the pharmacy, as well as administrative and fiscal matters pertaining to the pharmacy and the dispensing of drugs.

a. The review of practices and procedures shall include routine collection and assessment of information to improve the use of drugs and resolution of problems in their use, and monitoring and evaluation of selected drugs that present significant risks, that have been designated by infection control, or that are frequently prescribed drugs. The review will be based upon objective criteria utilizing current knowledge, clinical experience and relevant literature.

b. This committee shall respond to requests by the Staff or the pharmacist for the addition or removal of drugs to the formulary and the restriction of use of any drug.

c. All instances of significant drug reactions shall be reviewed by this committee, which will file a report of each case with the Medical Executive Committee.

22.4.3 Meetings. The committee shall meet at least quarterly.

22.5 Professional Relations Committee

22.5.1 Composition. This committee shall consist of the five (5) officers of the Staff.

22.5.2 Duties. The duty of this committee shall be to consult on and attempt to resolve matters of professional conduct and relations between Staff members or between Staff members and hospital employees.

22.5.3 Meetings. The committee shall meet as needed on request of the President.

22.6 Cancer Committee

22.6.1 Composition. The committee is multi-disciplinary and configured according to the Standards of the American College of Surgeons, Commission on Cancer. Membership shall include at least one (1) medical staff member from general surgery, medical oncology, diagnostic radiology, radiation oncology, and pathology. A Cancer Liaison Physician is also required and may be from one of the required physician specialties. Non-physician members shall include at least

one cancer program administrator, oncology nurse, social worker, certified tumor registrar, quality management professional, hospital administration, and oncology coordinator. Other medical or hospital representatives shall serve as ex-officio members.

22.6.2 Duties. The committee is responsible for planning, initiating, stimulating and assessing all cancer-related activities in the Hospital. The committee shall:

a. supervises the cancer registry and provides an annual report to the Staff summarizing the data from the registry and any pertinent information, problems or policy changes;

b. serves as registry physician-advisor(s);

c. evaluates the quality of cancer care through the patient care evaluation program and assesses the effectiveness of the program;

d. ensure access to consultation in all cancer-related fields through multi-disciplinary physician attendance at conferences; and

e. ensures that cancer conferences include major cancer sites yearly and are primarily patient-oriented and prospective.

22.6.3 Meetings. The committee will meet at least quarterly, with documentation of the policy-advisory function, and will have monthly educational meetings open to the Staff.

22.7 Practitioner Health Committee

22.7.1 Composition. This committee shall consist of five (5) Staff members, to include at least one member with stature in the community, one in substance abuse recovery and one with specialized knowledge of impairment issues.

22.7.2 Duties. The committee shall identify cases of practitioner impairment as early as possible and oversee control and rehabilitation of the impaired practitioner.

22.7.3 Meetings. This committee shall meet as needed.

22.8 Nominations Committee

22.8.1 Composition. This committee shall consist of the President, President-Elect and the past five (5) Presidents of the Staff, with the current Past President serving as chair.

22.8.2 Duties. The committee shall be responsible for nominating candidates for Staff office.

22.8.3 Meetings. The committee shall meet as needed.

22.9 Bylaws Committee

22.9.1 Composition. The committee shall consist of at least five (5) Staff members selected from Past Presidents. The chair of this committee shall not be a current chair of any Department. This individual shall be a voting member of the Medical Executive Committee

22.9.2 Duties. The committee shall conduct an annual review of the Bylaws and recommend amendments to the Medical Executive Committee.

22.9.3 Meetings. The committee shall meet at least once each year.

22.10 Joint Quality Improvement Committee

22.10.1 Composition: This committee shall consist of at least one active Staff member from the majority of the departments chosen from the department leadership, the Medical Directors of Special Care and Infection Control, the Physician Advisor for the Utilization Management Program and other medical staff representatives appointed by the President of the Medical Staff, the Hospital President and/or his designee, the Director of Quality Management, the Vice President of Patient Care Services as well as hospital representatives the CEO deems appropriate, with the majority of the committee being Medical Staff members. All appointees will be voting members. The Chair of the Committee will be a voting member of the Medical Executive Committee.

22.10.2. Duties: The committee shall receive and review the quality management activities and processes of the Staff and hospital departments and shall follow the purposes and regulations as outlined in the Plan for Improving Organization Performance and report the results to the CEO and Medical Executive Committee.

22.11 Medical Staff Quality Improvement Committee (MSQIC)

22.11.1 Composition: This committee shall be a standing committee consisting of one member from each medical staff department, appointed by the department chair, representatives from the Quality Management Department and administrative representatives designated by the President of the Hospital. The chair of this committee shall not be a current chair of any Department. This individual shall be a voting member of the Medical Executive Committee

22.11.2 Duties: This committee will provide oversight of peer review activities of the medical staff. It will report quarterly to the Medical Executive Committee peer review activities of each department and physicians for which a Quality Improvement Plan (QIP) has been initiated. The committee shall review all pending quality index levels assigned by the Department Quality Assurance Subcommittees and assign a final level to each pending quality index, in accord with the Medical Staff Peer Review Plan, Medical Staff Policy

Number MS 021.

22.12 Ethics Committee

The committee shall consist of a minimum of six physicians who have an interest in Ethics. Members from Social Services, the Chaplaincy program, Nursing, Administration, Quality Management, and as appropriate, a member representing the public shall also participate.

22.13 Infection Control Committee

22.13.1 Composition: This committee consists of voting members which include a Medical Director for Infection Control who will as Chair, and members of the Medical Staff as appointed by the Medical Executive Committee. Non-Voting members are to include: Infection Control Practitioner, Employee Health Nurse, Director Healthcare Improvement, Hospital President, Chief Nursing Officer, Director of Surgery and Women's Services. Representatives from other departments of Medical Center involved in infection evaluation and control may be invited on a consultative basis.

22.13.2 Duties:

a. Develop a hospital-wide infection control program and maintain surveillance over the program,
b. Develop a system for reporting, identifying, and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytical review of such data, and follow-up activities.
c. Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques,
d. Recommend educational activities for Medical Staff members and for Medical Center employees to maintain awareness of the potential problems of infection and to emphasize the importance of strict adherence to techniques of preventing the spread of infection,
e. Develop written policies defining special indications for isolation requirements,
f. Act upon recommendation related to infection control received from the Medical Executive Committee, departments and other committees,
g. Review antibiotic sensitivities of organisms specific to this facility,
h. Initiate and coordinate any control measure or studies for the immediate protection of patients or personnel and recommend measures for prevention and control of infection.

22.13.3 Meetings and Reporting Structure:
The committee shall meet as often as necessary at the call of its Chairman but at least quarterly. It shall maintain a confidential record of its proceedings and shall report to the Medical Executive Committee.

22.14 Representation on Hospital and Board Committees

22.14.1 Joint Conference Committee. The membership of the Joint Conference Committee shall include the five (5) Staff officers and additional practitioners appointed by the President as necessary to ensure an equal number of Staff and Board members on the committee.

SECTION 23: DEPARTMENTS

23.1 Designation

The Staff shall be departmentalized as follows:

Anesthesiology

Emergency Medicine

Family Practice

Internal Medicine: Physical Medicine and Rehabilitation, Infectious Diseases, Cardiology, Pulmonology, Gastroenterology, Endocrinology, Neurology, Psychiatry, Radiology, Dermatology, Medical Oncology and Hematology, and Radiation Oncology.

Internal Medicine: Internal Medicine with **Radiology Section**

The function of the section shall be to perform the functions assigned to it by the Department Chair of the Internal Medicine Department. Such functions may include, without limitation, patient care reviews, evaluation of patient care practices, credentials review and clinical privilege delineation and continuing education programs. The section shall transmit regular reports to the Department Chair on the conduct of its assigned functions.

The Section may elect a Section Chair. Sections may meet as frequently deemed necessary.

Internal Medicine: **Cardiovascular Section**

The function of the section shall be to perform the functions assigned to it by the Department Chairs of the Internal Medicine and Surgery Departments as a multi-disciplinary section. Such functions may include, without limitation, patient care reviews, evaluation of patient care practices, credentials review and clinical privilege delineation and continuing education programs. The section shall transmit regular reports
to the Department Chairs on the conduct of its assigned functions.

The Section may elect a Section Chair. Sections may meet as frequently deemed necessary.

Obstetrics/Gynecology: Obstetrics, Gynecology, Gynecological Oncology, and Perinatology

Orthopaedics: Orthopedics with Podiatry Section
The functions of each section shall be to perform the functions assigned to it by the Department Chair of the respective department. Such functions may include, without limitation, patient care reviews, evaluation of patient care practices, credentials review and clinical privilege delineation and continuing education programs. The section shall transmit regular reports to the Department Chair on the conduct of its assigned functions.

The Section may elect a Section Chair who will serve with vote in the respective department. Sections may meet as frequently deemed necessary.

Pediatrics: Pediatrics and Neonatology

Surgery: General Surgery, Neurological Surgery, Urology, Thoracic Surgery, Plastic Surgery, Surgical Oncology, Ophthalmology, Otorhinolaryngology, Oral and Maxillofacial Surgery, and Pathology. The Department of Surgery will oversee the surgical management and quality assurance of spinal surgery by all hospital practitioners.

Surgery Department: **Surgery** with **Cardiovascular Section**

The function of the section shall be to perform the functions assigned to it by the Department Chairs of the Internal Medicine and Surgery Departments as a multi-disciplinary section. Such functions may include, without limitation, patient care reviews, evaluation of patient care practices, credentials review and clinical privilege delineation and continuing education programs. The section shall transmit regular reports to the Department Chairs on the conduct of its assigned functions.

The Section may elect a Section Chair. Sections may meet as frequently deemed necessary.

23.2 Functions

23.2.1 General. The functions of each department shall be to:

a. establishes minimum or threshold criteria for clinical privileges in the department that are applicable to all practitioners and allied health professionals requesting or exercising those privileges;

b. monitors its members' adherence to clinical standards, policies, procedures, and practices in accord with the Hospital's Plan for Improving Organizational Performance.

c. establish, implement and enforce, subject to Medical Executive Committee and Board approval, an appropriate specialty on-call roster to provide services to patients who present to the emergency department and as otherwise required by the Board;

d. provide an inter-specialty and interdepartmental forum for matters of clinical concern and for resolving clinical issues involving its members' activities and the activities of other patient care and administrative services;

e. develops consistency in standards, policies, procedures and practices within the department and across any of its constituent sections;

f. review and investigate quality management, utilization review and risk management data from the department Quality Management Committee and make recommendations, or take action as appropriate, to the Staff and hospital committees;

g. provide clinical support and continuing education relevant to the practice of its members; and

h. performs such other duties as required by the Medical Executive Committee.

23.2.2 Department Quality Management Committee. Each department shall also establish a Quality Management Committee as a subcommittee of the department. The number of members shall be appropriate to the size of the department and the volume of work, with a minimum of three (3) members and not to exceed fifteen (15) members. The members shall be appointed by the department chair with representation from as many department specialties as is practical and to include any section chairs. Representatives from other specialties may be appointed by the department chair as members or agents on an ad hoc basis. The department chair shall chair the committee and the vice-chair shall be a member. The committee shall meet at least quarterly and its duties shall be to:

a. review and investigate patient care evaluations of quality and appropriateness and conduct monitoring activities, including invasive procedures, blood usage, drug usage and medical record reviews;

b. review utilization data provided by the Utilization Management Program.

c. review and take action as indicated on nosocomial data provided by the Infection Control Committee.

d. review the quality, completeness, accuracy, and timeliness of medical records based on accepted professional standards;

e. makes recommendations based on results of review to promote improved care and develop clinical policy and report to the department and Quality Management Committee;

f. coordinate the care provided by practitioners and allied health professionals within the department with the care provided by other patient care and administrative services; and

g. performs such other duties as required by these Bylaws or requested by the department chair, Medical Executive Committee or Joint Quality Improvement Committee.

23.4 Actions and Policies

The department shall maintain minutes of all meetings to include any findings, recommendations and actions. Subject to the approval of the Medical Executive Committee and the Board, each department will formulate its own written policies and procedures for the conduct of its affairs and the discharge of its duties.

23.4 Department Officers

23.4.1. Qualifications. Each department shall have a chair and vice-chair who shall be active Staff practitioners at Baylor Medical Center at Irving and physician members of the department in good standing and possess sound judgment and appropriate administrative skills. The chair of each department shall be certified by an appropriate specialty board. The chair shall be assisted by the vice-chair in fulfilling his/her duties and the vice-chair may perform any of the chair's duties in his/her absence.

23.4.2. Duties. The duties of the chair shall be to:

a. assumes responsibility for professional and administrative duties within the department ensure that the department fulfills its functions and report regularly to the Medical Executive Committee;

b. serve as a member of the Medical Executive Committee, providing guidance on the overall medical policies of the System and making specific recommendations and suggestions regarding the department in order to improve quality patient care;

c. maintains authority over and monitors, through the quality management plan, the professional performance of practitioners and allied health professionals with clinical privileges in the department;

d. be responsible for enforcement of the Staff Bylaws, Manuals and hospital policies and requirements within the department, implementation within the department of actions taken by the Medical Executive Committee or Board, and compliance with legal and accreditation requirements;

e. review and investigate the qualifications and competence of practitioners and allied health professionals who have satisfied the established criteria to exercise clinical privileges and make recommendations to the Membership and Credentials Committee on delineation of clinical privileges;

f. imposes emergency corrective action if indicated and provide for alternate practitioner coverage or consultation when needed;

g. participate in administrative matters pertaining to the department and coordinate with other patient care and administrative services;

h. presides at department meetings;

i. respond to contact by other patient care and administrative services regarding concerns or conflicts with the Staff, a practitioner or an allied health professional assigned to the department, or department policies;

j. coordinates teaching, education and research programs within the department;

k. prepare reports on the department as may be requested by the Medical Executive Committee, CEO or Board; and

l. performs such other duties as required by these Bylaws or requested by the Medical Executive Committee.

M. oversees the implementation of the actions of the department

23.4.3. Election and Term. The department chair attains office by automatic succession from the office of vice-chair unless the department votes in the existing department chair for an additional term(s). The vice-chair shall be elected on a mailed ballot by a majority of the returned ballots from active Staff members assigned to the department, subject to approval of the Medical Executive Committee and the Board. The term of office is one (1) year.

23.4.4. Resignation and Removal. A department chair or vice-chair may resign by submitting a written resignation to the Medical Executive Committee. Removal of a chair may be accomplished on written petition of ten percent (10%) of the active Staff practitioners assigned to the department and a subsequent two-thirds (2/3rds) affirmative vote of the returned mail ballots, provided that at least fifty percent (50%) of the active Staff practitioners in the department vote. Removal shall be immediate but must be ratified by the Board to become final.

23.4.5. Vacancies. Vacancies shall be filled by a special election in accord with section 4.4.3 above.

SECTION 24: MEETINGS

24.1 Notice

24.1.1. Staff Meetings. At least ten (10) days prior written notice of the annual meeting shall be provided to active Staff practitioners. For special meetings, practitioners shall be provided with at least three (3) days prior written notice.

24.1.2 Department and Committee Meetings. Regular meetings for which a schedule has been set at a prior meeting shall not require prior notice. Written or oral notice of special meetings shall be provided to all practitioners assigned to the department or committee at least three (3) days prior to the meeting.

24.1.3 Effect and Waiver. Written notice is deemed effective upon deposit in the U.S. mail, postage prepaid, addressed to the practitioner's office address as recorded in the medical staff office, or upon hand delivery or electronic transmission to the practitioner's office. Attendance at a meeting constitutes a waiver of any objection to the adequacy of notice.

24.2 Quorum

The quorum for a department or committee meeting shall be the chairperson, or designee, and any voting physician members assigned and present. For any Staff meeting a quorum shall be any active staff practitioners assigned and present. All actions taken by departments or committees shall be subject to approval by the Medical Executive Committee.

24.3 Voting

Unless otherwise provided in this Manual or the Bylaws, the action of a majority of the voting members at a meeting at which a quorum is present shall be the action of the Staff, department or committee. Mailed or electronically sent ballots may only be used for Staff votes on officers and Bylaws adoption or amendment, or department votes on chairs. Action by a department or committee may be taken without a meeting by unanimous consent in writing, signed by each voting member.

24.4 Agenda and Procedure

The President, department chair or committee chair shall establish the agenda for each Staff, department or committee meeting. No business may be transacted at a special meeting except that stated in the notice of the meeting. The latest edition of Robert's Rules of Order shall be used to establish procedures, except that the chair of a department or committee may vote. In the event of a conflict between the Bylaws or this Manual and Robert's Rules of Order, the Bylaws or Manual shall control.

24.5 Record

The Secretary/Treasurer or department or committee chair shall ensure that minutes of each meeting are prepared that include a record of the attendees and the business transacted. The minutes shall be signed by the Secretary/Treasurer or chair and approved by a majority of the members present at the next meeting.

SECTION 25: ALLIED HEALTH PROFESSIONALS

25.1 Application Requirements.

Applications for clinical privileges for Allied Health Professionals shall be provided only to individuals in disciplines or categories that have been approved by the Board as listed on Attachment 2 and who can document current licensure, registration or certification, as well as required professional liability insurance. The Allied Health Professional shall be provided with a copy of the Bylaws and the accompanying Manuals. Individuals who are not eligible to receive an application shall not be entitled to any procedural rights of review in connection with such ineligibility.

25.2 Criteria for Clinical Privileges.

Prior to offering or granting clinical privileges to an Allied Health Professional, each department must recommend, in writing, the minimum or threshold qualifications and criteria for exercise of the privileges. Qualifications and criteria may relate to training, experience, specialty or sub-specialty certification and other pertinent factors. Recommended qualifications and criteria must be approved by the Membership and Credentials Committee, the Medical Executive Committee and the Board, must be reviewed at least every two (2) years, and shall form the basis for clinical privileges recommendations.

25.3 Application Form.

The application forms for initial clinical privileges and renewal shall be approved by the CEO, or designee, after consultation with the Medical Executive Committee, and shall require substantially the same information as Staff applications for practitioners.

25.4 Credentialing

Applications from Allied Health Professionals shall be processed in accord with the credentialing procedures used for practitioners The required letters of recommendation must include names of at least three (3) practitioners or other health care professionals who have personal knowledge of the applicant's qualifications based on observation within the past three (3) years of the applicant's professional performance over a reasonable period of time (preferably in the acute care hospital setting) and who will provide specific written comments upon request. In the event of an adverse recommendation, the allied health professional shall not be entitled to the procedural rights of review set out in the Medical Staff Bylaws or otherwise afforded to practitioners, but shall be afforded the right to an interview as set out in section 24.6 below. The Membership and Credentials Committee and Medical Executive Committee may delegate the credentialing functions for Allied Health

Professionals to subcommittees. Allied Health Professionals shall be subject to the requirements of the Bylaws and accompanying Manual except as provided in section 24.6 below.

25.5 Corrective Action.

Allied Health Professionals shall be subject to the corrective action procedures used for practitioners except as provided below. In the event of an adverse recommendation, the professional shall not be entitled to the procedural rights of review set out in the Medical Staff Bylaws or otherwise afforded to practitioners, but shall be afforded the right to an interview as set out in section 24.6 below.

25.6 Procedural Rights of Review

Notwithstanding any provisions in the Bylaws or this Manual to the contrary, Allied Health Professionals shall not be entitled to the procedural rights of review afforded to practitioners by the Bylaws. In the event of an adverse recommendation pertaining to an Allied Health Professional, the allied health professional shall be informed by the CEO, or designee, of the recommendation by special notice and shall have thirty (30) days to submit a written request for an interview with the Medical Executive Committee or Board (or a subcommittee), whichever issued the adverse recommendation.

25.6.1 The interview shall be scheduled within thirty (30) days of receipt of a timely request and shall be held by the Medical Executive Committee or Board or a subcommittee. The Allied Health Professional may submit any information prior to or during the interview pertaining to his/her qualifications to exercise the clinical privileges being requested. The allied health professional may not be accompanied by an attorney. The interview is not a hearing and none of the procedural rules for hearings or as set forth in the Staff Bylaws shall apply.

25.6.2 The Medical Executive Committee or Board may change their recommendation as a result of the interview and, if so, shall give the Allied Health Professional special notice of the decision.

ATTACHMENT 2

Approved list of Allied Health Professionals:

Advance Practice Nurse:
  Nurse Practitioner and Clinical Nurse Specialist
Certified Registered Nurse Anesthetist
Clinical Technician (orthopedics, surgery)
Physician Assistant
Certified Perfusionist
Certified Pathology Assistant

Registered Nurse or Licensed Vocational Nurse
Surgery Technician
First Assist
Psychologists
Scribes