



Rules and Regulations of the Medical Staff

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Approved by the Board of Trustees of Baylor Institute for Rehabilitation
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Preamble

The Rules and Regulations of the Medical Staff are established under the authority of the Bylaws of the Medical Staff and shall be administered and amended as provided thereby. For convenience, they shall be referred to as the Rules and Regulations of the Medical Staff.

Section I DEFINITIONS

The following definitions shall apply regarding patient care activities and these Rules and Regulations:

MEDICAL STAFF MEMBER: Unless otherwise expressly limited, any fully licensed physician, dentist, or podiatrist, who is appointed as a member of the Medical Staff of Baylor Institute for Rehabilitation and/or has been granted clinical privileges by the Board of Trustees.

HOSPITAL: means Baylor Institute for Rehabilitation.

HOUSESTAFF: Physicians or dentists who participate in patient care activities at the Hospital as part of postgraduate medical education programs as defined by the Committee on Medical Education. This includes medical students, interns, residents and fellows.

PRACITITIONER: Unless otherwise expressly stated, any fully licensed physician, dentist, or podiatrist, who is appointed as a member of the Medical Staff of Baylor Institute for Rehabilitation and/or has been granted clinical privileges by the Board of Trustees. This may also refer to Housestaff.

ATTENDING PHYSICIAN: The Medical Staff member who admits and is responsible for the overall care of the patient, unless the Medical Staff member transfers the care of the patient by means of a doctor's order to another member of the Medical Staff, shall be known as the Attending Physician. Records, requisitions, and reports shall, at all times, indicate the name of the Medical Staff member who is currently in the role of Attending Physician.

CONSULTANT: A consultant is one who, upon request, provides clinical advice to the Attending Physician in the diagnosis and treatment of the patient's illness or injury.

LICENSED INDEPENDENT PRACITITIONER: Any individual permitted by law and by Baylor Institute for Rehabilitation to provide care, treatment, and services without direction or supervision, within the scope of the individual's license, and consistent with individually granted clinical privileges. For purposes of patient restraint only, a Registered Nurse is designated by Baylor Institute for Rehabilitation as a Licensed Independent Practitioner. (see R 4.3). The RN must be trained in the restraint curriculum designated by Baylor Institute for Rehabilitation.

PHARMACY AND THERAPEUTICS STATEMENT: A statement provided for information to medical or other health practitioners. Pharmacy and Therapeutics statements will generally need only the approval of the Executive Committee.

PHARMACY AND THERAPEUTICS GUIDELINES: General advice on the implementation and monitoring of drug use or distribution practices. Pharmacy and Therapeutics Guidelines must be approved by the Executive Committee.

PHARMACY AND THERAPEUTICS STANDARDS: Specific, detailed advice on issues regarding medication use. These issues are generally complex or controversial and have important patient-care implications. Pharmacy and Therapeutics Standards must be reviewed by legal counsel and sent to the Executive Committee for approval. Adherence to the standards must be reported back to the Executive Committee.

Signature stamps are approved for outpatient use only and not for ~~the~~ use in the inpatient medical record. If used in the inpatient medical record, then the signature stamp must be authenticated with an original signature. Acknowledgments for the use of signature stamps will be filed in Medical Staff Services for those Practitioners who choose to use them. The acknowledgement states that the signature stamp must be in the control of the Practitioner and that they will not allow unauthorized use of the stamp. Signature stamps must include the Practitioner's complete signature and Practitioners are encouraged to include their dictation code number for ease of reference. Opinions requiring medical judgment should be written, or authenticated, only by individuals who have been granted appropriate clinical privileges and by authorized Housestaff members.

R3.3 Reports

R3.3-1 Admission Note

A physician admitting progress record shall be completed at the time of admission, but not later than 24 hours thereafter.

R3.3-2 History Of The Patient

The completion of the admitting history and physical examination shall be the responsibility of the Attending or covering Physician. The history of the patient shall be recorded by an appropriately credentialed member of the Medical Staff, authorized Housestaff, or by an appropriately credentialed physician assistant or advanced practice nurse approved to do so under the conditions outlined in R 3.3-2 (a) and (b).

Appropriately credentialed Physician Assistants and Advanced Practice Nurses approved to perform admission history and physical examinations will be allowed to do so under the following conditions:

- a. Stable patients admitted for elective therapeutic or diagnostic procedure;
- b. Stable patients admitted directly from the physician's office where the admitting physician has previously evaluated them.

A history and physical examination performed under the above conditions must be authenticated and countersigned by the Attending or covering physician within 24 hours.

**Stable: Is defined as a patient who, without concern, could have a therapeutic or diagnostic procedure delayed for 24 hours or more.

Each entry shall be labeled appropriately.

- The Present Illness shall include a listing of the patient's current medical problems, stated in a concise manner to include, when appropriate, assessment of the patient's emotional, behavioral and social status.
- The Past History shall include any previous illnesses, injuries, allergies, or surgery.
- The Review of Systems should include an inventory by body systems. If all systems are not covered, the record should so state.
- The Family History should include illness in the family of the patient, which might contribute to the cause, or development of the present illness.
- The Social History shall include the social history of the patient that might contribute to the cause or development of the present illness or influence care received during the hospitalization or discharge planning.

R3.3-3 Physical Examination

This report shall reflect a comprehensive, current, physical assessment and shall be completed by an appropriately credentialed member of the Medical Staff, authorized Housestaff, or by an appropriately credentialed physician assistant or advanced practice nurse approved to do so under the conditions outlined in R3.3-2 (a)-(b).

Conclusions or impressions drawn from medical history and physical examination are documented.

R3.3-4 Physician Progress Record

This record shall consist of entries by members of the Medical Staff, authorized Housestaff and appropriately credentialed physician assistants or advance practice nurses. Progress notes made by the Medical Staff or Housestaff should give a pertinent, chronological report of the patient's course in the Hospital and should reflect any change in condition and the results of treatment. Progress notes shall be updated at least daily.

R3.3-5 Diagnostic And Therapeutic Orders

These orders shall include those written by Medical Staff members granted appropriate clinical privileges. Telephone or other oral orders given by appropriately credentialed Medical Staff members should be used sparingly and may be accepted and written by a Hospital-employed, licensed nurse, or an appropriately credentialed allied health practitioner. All orders must be documented on approved physician order forms.

A physician agent (preferably RN) may transmit a telephone order to designated Hospital employees. It is the responsibility of Hospital personnel receiving such an order to clarify any questions they may have about the order with the Medical Staff member. Telephone or other oral order designated as "stat" or "urgent" shall be authenticated by the responsible Medical Staff member within 24 hours. Parenteral cytotoxic chemotherapy orders, given via a verbal order, will not be administered until the transcribed order is signed by the Attending Physician. All other telephone or oral orders shall be authenticated by the responsible Medical Staff member by the time of chart completion. "On-call" orders should specify the date of the procedure.

To reduce the possibility of error in interpreting Medical Staff member's orders, they shall be written legibly and preferably appended with the Medical Staff member's name and dictating number. Orders must include the name of the drug, dose, route, frequency, time/date order written and prescribers' signature. Only approved abbreviations shall be used. Abbreviations for drug names will not be accepted. Acceptable drug names include: the complete generic name, the brand name, and the element codes from the periodic table. All orders for a drug dose less than one shall have a zero preceding the decimal amount. A trailing zero shall not be used after a decimal. (e.g., 0.25 shall not be written as 0.250) All orders for microgram amounts shall be clearly written as "microgram" (abbreviations, Greek letters, and other conventions are not to be used) to clearly distinguish from milligrams (mg). All orders for units shall be clearly written as "units" (abbreviations and Greek letters are not to be used).

Questions must be clarified by the Medical Staff member giving the order. Any order questioned by nursing or pharmacy shall be recalculated and checked with the prescribing Medical Staff member and/or Attending Physician. Dose clarifications will be rewritten on the order sheet and signed by the prescriber.

A sample of orders will be audited for compliance and reported to the Executive Committee at least annually. Prescribers who persist in writing orders that are poorly legible or are in violation of this policy will be reported to the Executive Committee for review.

R3.3-6 Consultation Reports

Each Consultation Report shall contain a recorded opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record(s). It may be dictated or written in the Physician Progress Record and shall be labeled as a Consultation Report.

R3.3-7 Reports Of Actions And Findings

These reports include such items as reports of pathology and clinical laboratory examination, radiology examination, medical treatment, and any other diagnostic or therapeutic procedures. All diagnostic and therapeutic procedures shall be recorded and authenticated in the medical record.

R3.3-8 Discharge Entries

At the time of the patient's discharge, the Attending Physician's documentation shall be completed in accordance with these Rules and Regulations to substantiate treatment rendered and to support patient's condition at discharge. Final diagnoses shall be recorded in full, and without the use of either symbols or abbreviations. Where final diagnosis remains uncertain until a laboratory or radiology report is available, the physician shall record on the Attending Physician Summarized Report form that the discharge diagnosis is pending. All relevant diagnoses established by the time of discharge, as well as all operative procedures performed, are recorded, using acceptable disease and operative terminology that includes topography and etiology, as appropriate. Principal Diagnosis should be the condition established after study to be chiefly responsible for admission. Other Diagnoses should include complications and co-morbidities. Principal Operation should be the procedure performed for definitive treatment or the therapeutic procedure most related to principal diagnosis.

R3.3-9 Clinical Resume

The Clinical Resume (Discharge Summary) is the responsibility of the Attending Physician and should concisely recapitulate:

- The reason for hospitalization.
- The significant findings.
- The procedures performed and treatment rendered.
- The condition of the patient on discharge stated in measurable terms compared with the condition on admission and with final discharge diagnoses.
- The specific instructions given to the patient and/or family, as pertinent.

A final progress note may be substituted for the Clinical Resume in the case of patients with problems of a minor nature who require less than a 48-hour period of hospitalization.

The final progress note shall include condition of the patient at the time of discharge and instructions given to the patient and/or family.

When necropsy is performed, a provisional anatomic diagnosis shall be recorded in the medical record within 72 hours, and the complete protocol shall be made part of the record within 60 days unless special studies and/or consultations are necessary and exceed the 60 day limit.

R3.4 Delinquency System

R3.4-1 Procedures

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

R3.5 Surveys of Medical Records

Surveys, audits or reviews of records at the Hospital that do not involve the use or review of patient medical records or other patient-specific health care information shall be subject to clearance by the Chair of the Executive Committee. The requirements set forth in the Bylaws of the Medical Staff concerning the review and approval of research projects must also be met.

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

R4.2 Automatic Stop/Renewal Orders

The Medical Staff delegates to the Executive Committee the responsibility for the development of policies and procedures for renewing/discontinuing medical orders.

R4.3 Use Of Restraints

R4.3-1 General Units

The Hospital believes that patients have the right to be free from restraints of any form that are not medically necessary. Restraints are not used as a means of coercion, discipline, convenience, or retaliation by staff. . Restraint may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

Definitions:

Restraint:

- Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of the patient to move his arms, legs, body or head freely; or
- A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
- A restraint does NOT include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Emergency Restraint: restraint used for the management of violent or self-destructive patient behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.

Non-Emergency Restraint: restraint used to provide for the physical safety of the non-violent or non-self-destructive patient.

A physician initiates the use of restraints through individual physician order (no protocol or standing orders permitted for restraint). Guidelines include:

- (a) the order must be time limited; PRN orders are not acceptable;
- (b) type of restraint to be used is specified in the order
- (c) clinical justification/reason for restraint is stated in the order
- (d) an RN may initiate the use of restraint pending a physician order

- (e.) a physician order must be obtained within 12 hours of initiation of non-emergency restraint; the order must be obtained within one (1) hour of initiation of emergency restraint;
- (f) telephone or verbal orders for restraint must be signed by the physician within 24 hours.
- (g) a new physician order and a physician face-to-face assessment is required every 24 hours while patient is restrained
- (h) A face-to-face assessment by a Licensed Independent Practitioner (LIP) must occur within one (1) hour of the initiation of emergency restraint; the purpose of the assessment is to evaluate the patient's condition and the need for continuation of restraints.
- (i) (l) An order for restraint in emergency situations is limited to 4 hours for adults and 2 hours for adolescents under the age of 17.
- (j) Upon expiration of the original order, a new order must be obtained from a physician.
- (k) A Licensed Independent Practitioner must conduct a face-to-face re-evaluation of the patient in person at least every 8 hours for patients 18 years of age and older and every 4 hours for patients ages 17 and younger.
- (l) A consultation with the patient's Attending Physician must occur as soon as possible (if the restraint is not ordered by the patient's Attending Physician).
- (m) A written modification to the patient's plan of care must occur.

Death Reporting: Each death that occurs while a patient is in restraint, or deaths occurring within 24 hours of the patient being restrained are reported to the Centers for Medicare and Medicaid Services (CMS). Each patient death known to occur within one (1) week after restraint where it is reasonable to assume that use of restraint contributed to the patient's death are reported to CMS.

1. Patient care policies and protocols for the use of restraints are reviewed and approved by the Executive Committee.

R4.4 Standing Orders

Standing orders are approved for use in the Hospital and comply with the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").

All standing orders will be reviewed and approved by the Executive Committee annually.

Section V INFORMED CONSENT

The Attending, covering or consulting Physician will direct the process of informed consent.

It is the Attending Physician's responsibility to:

1. determine the need for informed consent;
2. determine the decision-making capacity of the patient or appropriate surrogate decision maker;
3. explain the proposed treatment or procedure including risks and alternatives; and

4. obtain the patient's (or surrogate decision maker's) consent;

R5.1 "A-List" Procedures

Those treatments/procedures which require disclosure and consent to specific risks and hazards are referred to as "A-List" Procedures" as defined by the Texas Medical Disclosure Panel. Specific disclosure and consent forms are available for "A-List" treatments/procedures. For "A-List" Procedures, performed at Baylor Institute for Rehabilitation or at Baylor University Medical Center, it is the responsibility of the physician performing the treatment/procedure to obtain the patient's (or surrogate decision-maker's) informed consent to the treatment/procedure prior to performing the treatment/procedure by disclosing to the patient (or surrogate decision-maker) the risks and hazards set forth on the specific "A-List" disclosure and consent form and obtaining (or requesting a nurse to obtain) the patient's (or surrogate decision-maker's) signature on the form. Disclosure and Consent forms for all "A-List" procedures may be obtained at the Hospital.

R5.2 Non-"A-List" Procedures

Those treatments/procedures, which do not require disclosure and consent, are referred to as "B-List" procedures as defined by the Texas Medical Disclosure Panel. A generic or "blank" disclosure and consent form (Medical and Surgical Procedures: Form 18688) is available for treatments/procedures not identified as "A-List" Procedures. This form identifies general risks and hazards of treatments/procedures. For treatments/procedures not identified as "A-List" Procedures, but that in the physician's judgment require informed consent, it is the physician's responsibility to obtain the patient's (or surrogate decision-maker's) informed consent prior to performing the treatment/procedure by writing the risks and hazards of the proposed treatment/procedure on the generic disclosure and consent form disclosing such information to the patient (or surrogate decision-maker) and obtaining or requesting a nurse to obtain the patient's (or surrogate decision-maker's) signature on the generic disclosure and consent form or documenting the patient's (or surrogate decision-maker's) informed consent in the Physician's Progress Record.

R5.3 Signatures

Generally, informed consent is obtained by the physician prior to or contemporaneously with the treatment/procedure. If there is a delay in treatment or a change in the patient's condition, physicians are encouraged to repeat the informed consent process. Consent forms may be relied upon for a period of time equal to the earlier of: (i) 96 hours after admission to the hospital or (ii) if the consent form is signed prior to admission to the hospital, 90 days from the date of signature.

Signature should be obtained prior to administration of pre-treatment medication which may cause sedation or confusion, unless delay of the procedure would be significantly hazardous to the patient, or in the opinion of the physician or nurse, the patient has the capacity to exercise judgment. If possible, a consent form should not be signed within 3 hours after administration of such a medication.

For a patient who lacks decision-making capacity, the physician should identify the appropriate surrogate decision maker who may be in order of priority:

1. Court-appointed guardian;
2. Agent with Durable Power of Attorney for Health Care;
3. Patient's spouse (includes common law spouse, i.e., a person who resides with the patient and who along with the patient holds himself or herself out to the public as a married couple);
4. An adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision maker;
5. A majority of the patient's reasonably available adult children;

6. The patient's parents;
7. The individual clearly identified by the patient to act for the patient before the patient became incapacitated;
8. The patient's nearest living relative.

For a patient who possesses decision-making capacity and is able to exercise judgment but is physically unable to sign, a responsible adult may sign for the patient. (This signature confirms that the patient is giving the physician consent for the treatment or procedure.) The responsible adult need not be next-of-kin. Any non-Hospital employee may do so.

For patients who are less than 18 years of age, the parent or legal guardian should sign the consent form. Exceptions are as follows:

1. A patient who is married at any age may sign their own consent forms;
2. A patient who is divorced (not annulled) or widowed under 18 years of age may sign their own consent forms;
3. Unmarried pregnant females may sign for consent of care for any problem related to the pregnancy other than termination of pregnancy;
4. Patient on Active Clinical duty with the military;
5. Patient 16 years of age or older living apart from the patient's parents and managing the patient's own affairs, regardless of source of income.

R5.4 Emergency Situations

If, in the physician's judgment, (i) an adult patient is not able to communicate because of an injury, accident or illness, is unconscious, or otherwise lacks decision making capacity or a minor patient presents without a parent, managing or possessory conservator, or guardian to consent on the minor's behalf, and (ii) the physician believes the patient is suffering from a life-threatening injury or illness, then the patient is deemed to have given implied consent to the emergency treatment/procedure, and the physician may proceed with the treatment/procedure. It is advisable for the physician to document the reason for the emergency treatment/procedure in the Physician's Progress Record.

R5.5 Telephone Consents

If the patient lacks decision-making capacity and the responsible surrogate decision maker is not and will not be present in the hospital to express verbal consent or sign the forms, the physician may obtain consent over the telephone from the surrogate decision maker. The physician should explain the proposed treatment or procedure including the risks and alternatives and should obtain the surrogate's consent over the phone. The physician or nurse must read the consent form to the surrogate and ask if the individual understands and agrees with the form. Telephone consents must have two witnesses; the physician may be the second witness.

Section VI PATHOLOGY

R6.1 Autopsies

Every member of the Medical Staff should seek to secure autopsy permits on appropriate cases. In certain instances, deaths should be initially reported to the Medical Examiner's office for their scrutiny.

Section VII CONTROL OF INFECTIONS

R7.1 Reporting of Infections

It is the duty of the Attending Physician to notify the charge nurse if a particular patient has an infection, which is transmissible within the Hospital.

The physician should specify the diagnosis so that if any measures beyond standard precautions are required, they may be done.

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

The charge nurse should notify the nurse epidemiologist of the name of the patient and the diagnosis.

If any unusual incidence of infections such as wound infections or urinary tract infections are suspected the physician or the nurses should notify the nurse epidemiologist.

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

R7.2 Isolation Procedures

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

Section VIII REQUIREMENTS FOR MEDICAL STAFF MEMBERSHIP

R8.1 General

In addition to the requirements for Medical Staff membership set forth in the Medical Staff Bylaws, the Medical Staff shall have the authority to include in these Rules and Regulations requirements for Medical Staff membership. Any such additional requirements shall be cumulative and not an alternative to the requirements set forth in the Bylaws.

R8.2 Proximity to Medical Center

Pursuant to Section Article III, 3.3-1 (g) of the Medical Staff Bylaws, each member of the Medical Staff in the Active Clinical and Courtesy categories, whether provisional or full staff status, must have a medical office within 25 miles of the Hospital, and be able to travel to the Hospital from place of residence or medical office within one (1) hour during normal driving conditions.

Section IX ALLIED HEALTH PROFESSIONALS

R9.1 ALLIED HEALTH PROFESSIONALS

Allied Health Professionals are not Medical Staff members, and Allied Health Professionals shall not be considered a category of the Medical Staff. Allied Health Professionals shall not have any of the prerogatives or responsibilities of Medical Staff membership.

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

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

R10.1 HOUSESTAFF - INTERNS, RESIDENTS, and FELLOWS

Housestaff participate in the care of patients under the supervision of credentialed members of the Medical Staff. Rotating housestaff are also under the supervision of credentialed members of the Medical Staff per affiliation agreements between BUMC and the sponsoring entities of graduate medical education. The housestaff shall provide care commensurate with the level of training and competence, under the supervision of credentialed members of the Medical Staff. The supervising practitioner will be present or readily available to supervise the housestaff at all times.

All housestaff shall meet the qualifications for resident eligibility as outlined in the Accreditation Council for Graduate Medical Education's Institutional Requirements Section of the *Essentials of Accredited Residencies in Graduate Medical Education*.

The Chairman of the Baylor University Medical Center Graduate Medical Education Committee (GMEC) shall serve as the liaison for communication between the Graduate Medical Education program and the BIR Medical Staff Committees and the Board of Trustees regarding the quality of care, treatment, and services and educational needs of the program. The GMEC Chairman will communicate information to the Program Director regarding these issues at the Hospital. The Residency Program Director shall provide the Designated Institutional Official/MEC Chairman with residency review committee citations to ensure compliance.

The competence of individual Housestaff shall be evaluated on a regular basis by assigned members of the Medical Staff and forwarded to the Residency Program Director. The entity sponsoring the residency program, through its Residency Program Director, shall maintain a confidential record of evaluations.

The entity sponsoring each Graduate Medical Education (GME) program is responsible for the selection of Resident physicians, as well as procedures for discipline and dismissal. Rotating Housestaff must show evidence of professional liability insurance coverage provided by the program and hold a Texas license or an institutional permit.

The Supervising physician or designee is ultimately responsible for completion of a patient's medical record.

Section XI OFFICERS

R11.1 OFFICERS OF THE MEDICAL STAFF

R11.1-1 Identification

The officers of the Medical Staff shall be the Chair and Co-Chair of the Executive Committee.

R11.1-2 Qualifications

- (a) The Chair and Co-Chair of the Executive Committee shall be members of the Active Clinical Category and the Chair shall be the Medical Director of the Hospital.
- (b) The Chair of the Executive Committee shall be appointed by the President of the Hospital, and the Co-Chair shall be appointed by the Chair and the President of the Hospital. The Chair and Co-Chair must be board certified in physical medicine and rehabilitation.
- (c) Officers must remain members in good standing during their term of office. They must have no pending adverse recommendations concerning staff appointment or clinical privileges. Failure to maintain such status shall create a vacancy in the office involved.
- (d) Officers must have constructively participated in Medical Staff affairs, including quality review and peer review activities, possess and have demonstrated an ability for harmonious interpersonal relationships, and be knowledgeable concerning the duties of the office and be willing to discharge faithfully the duties and responsibilities of the position to which the member is appointed.

R11.1-3 Nomination Of At-Large Members Of The Executive Committee

The Executive Committee shall appoint the At-Large Members of the Committee at least thirty (30) days before the end of the calendar year.

R11.1-4 At-Large Members Of The Executive Committee

Four representatives of the Medical Staff at large shall be appointed as At-Large Members of the Executive Committee. Two of these representatives shall be appointed from members in the Active Clinical Staff Category and two shall be appointed from members of the Consulting Category. One of the Consulting Category representatives shall be chosen from the medicine specialties and one from the surgical specialties. The At-Large members of the Executive Committee shall serve staggered two year terms but may serve again after one year.

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

R11.1-7 Term Of Elected Office

The Chair shall serve as long he maintains appointment as Hospital Medical Director. The Co-Chair shall serve for a period of one year, beginning on January 1 and ending on December 31, or until his successor is chosen, unless that officer shall sooner resign or be removed from office.

R11.1-8 Removal Of Officers

The Executive Committee, by a two-thirds vote, may remove the Co-Chair or At-Large Members of the Executive Committee who are found to no longer meet any one or more of the qualifications set forth above, or if the member elected is suffering from a physical or mental infirmity that renders the member incapable of fulfilling the duties of the office. Notice of the meeting at which such action shall be decided must be given in writing to such officer at least ten 10 days prior to the date of the meeting. The member shall be afforded the opportunity to speak prior to the taking of any vote on such removal. The removal shall be effective when approved by the Board of Trustees.

A Chair may only be removed by the President or Board of Trustees after consultation with the Executive Committee. The Chair may be removed from office based upon a failure to maintain status as a member in good standing of the Medical Staff, failure to perform the duties of the office to which elected, or failure to comply with the provisions of Sections 3.3-1, 3.7, and 7.2-1 of the Rules and Regulations. The Chair shall be afforded the opportunity to speak prior to the taking of any vote on removal. Removal of the Chair shall be effective when it has been approved by the Board of Trustees.

R11.1-9 Vacancies

If the office of Chair is vacated during the year due to the Chair's death, disability, resignation, or loss of membership in the Medical Staff, or removal by the President or the Board of Trustees, the Co-Chair is elevated to that office and shall serve as Chair until the President and the Board of Trustees appoint a new Chair. If the office of the Co-Chair is vacated during the year for one of the reasons stated above, the position will remain vacant until the President and the Chair appoint a new Co-

Chair. Vacancies created by At-Large Members' death, disability, resignation, or loss of membership in the Medical Staff, or removal by the President or the Board of Trustees may remain unfilled until the next regular Medical Staff election, or the Executive Committee may schedule a special election for the purpose of filling the vacant position(s).

R11.2 DUTIES OF OFFICERS

R11.2-1 Chair Of The Executive Committee

The duties of the Chair of the Executive Committee shall include, but not be limited to:

- (e) calling, presiding at, and being responsible for the agenda at the Executive Committee;
- (f) serving as a liaison between the Medical Staff and the Board of Trustees. The Chair shall attend meetings of, and communicate Medical Staff matters to, the Board of Trustees;
- (g) reporting to the Medical Staff on actions taken by the Executive Committee;
- (h) serving as an ex-officio member of all other Medical Staff committees without vote, unless his membership in a particular committee is required by the Rules and Regulations;
- (i) interacting with the Administration and Board of Trustees on matters of mutual concern within the Hospital;
- (j) making recommendations for appointment of committee chairpersons and members, in accordance with the provisions of these Rules and Regulations, to all standing and special Medical Staff committees;
- (k) having the right to participate on all Medical Staff committees;
- (l) making known the views, needs, and grievances of the Medical Staff and report on the medical activities of the staff to the Board of Trustees and to the President; and
- (m) being responsible for the organization and conduct of the Medical Staff.

R11.2-2 Co-Chair Of The Executive Committee

The duties of the Co-Chair shall include, but not be limited to:

- (n) assuming all duties and authority of the Chair in the absence of the Chair;
- (o) serving as a member of the Executive Committee; and
- (p) performing such other duties as the Chair may assign or as may be delegated by the Rules and Regulations, or by the Executive Committee.

Section XII COMMITTEES

R12.1 DESIGNATION

R12.1-1 Chairpersons

All committee chairpersons, unless otherwise provided for in the Rules and Regulations, will be appointed by the Board after receiving and considering recommendations from the Chair of the Executive Committee.

All chairpersons shall be selected based on the criteria set forth in the Rules and Regulations for officer positions. Such appointments will be made by the Board at its first meeting after the end of the Medical Staff year, for an initial term of 2 years.

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

R12.1-2 Members

Except as otherwise provided for in the Rules and Regulations, members of each committee shall be appointed every two years by the Executive Committee not more than 10 days after the end of the Medical Staff year, and there shall be no limitation in the number of terms they may serve.

All appointed members may be removed and vacancies filled at the discretion of the Executive Committee.

The President of the Hospital and the Chair of the Executive Committee or his/her respective designees shall be ex-officio members on all committees.

R12.1-3 Types Of Committees

Medical Staff committees shall include but not be limited to, the general meetings of the Medical Staff as a committee of the whole, and meetings of special or ad hoc committees created by the Executive Committee pursuant to this Article. The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Executive Committee to perform specified tasks. Each committee shall have the authority to appoint subcommittees to perform studies on subjects within its jurisdiction.

R12.2 CREATION OF STANDING COMMITTEES

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

Executive Committee. The Rules and Regulations shall be amended as soon as practicable to reflect any Medical Staff committee structure, duties or composition changes approved by resolution.

R12.3 CONFIDENTIALITY OF INFORMATION

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

R12.4 BAYLOR HEALTH CARE SYSTEM BEST CARE COMMITTEE

The Medical Staff shall participate in the Baylor Health Care System Best Care Committee to facilitate the coordination of quality improvement activities in the Baylor Health Care System and to utilize, when appropriate, the resources and recommendations of Best Care Committee as part of the quality assurance and quality improvement of the Medical Staff and Hospital. The Baylor Health Care System Best Care Committee is a special committee of this Medical Staff and its activities, proceedings, documents, reports, information, records and all communications are privileged and confidential pursuant to Article V of the Medical Staff Bylaws.

R12.5 EXECUTIVE COMMITTEE

R12.5-1 Composition

The Executive Committee shall be composed of:

- (q) The Medical Director of the Hospital, who shall serve as Chair
- (r) The Co-Chair
- (s) Four appointed At-Large Members. Two At-Large Members will be appointed representatives of the Consulting Medical Staff, one from a general medicine specialty and one from a surgical specialty, and two At-Large Members will be appointed ~~elected~~ representatives from the Active Clinical Medical Staff.
- (t) The President and/or designee(s) and the Nurse Executive, who shall attend each meeting as non-voting members, and shall serve as liaison officers between the Board of Trustees and the Executive Committee
- (u) The manager or director of Medical Staff Services, who shall attend each Executive Committee meeting as a non-voting member to record the minutes

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

R12.5-2 Duties

The duties of the Executive Committee shall be to:

- (v) represent and to act on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the Medical Staff, subject only to any limitations imposed by the Rules and Regulations;

- (w) receive and to act upon those committee reports as specified in the Rules and Regulations and to make recommendations concerning them to the President and the Board;
- (x) implement policies of the Hospital that affect the Medical Staff;
- (y) review the Medical Staff Bylaws and Rules and Regulations at least annually, and provide recommendations for revisions and updates as may be needed from time to time;
- (z) provide liaison among the Medical Staff, the President and the Board;
- (aa) keep the Medical Staff informed of applicable accreditation and regulatory requirements affecting the Hospital;
- (bb) enforce Hospital and Medical Staff rules in the best interest of patient care and of the Hospital with regard to all members of the Medical Staff;
- (cc) refer situations involving questions of the clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff member to the Medical Care and Evaluation Committee and/or other committees, including the Credentials Committee, as necessary for action and information;
- (dd) be responsible to the Board for the implementation and participation of the Medical Staff in organizational performance improvement activities, as well as the mechanism used to conduct, evaluate, and revise such activities;
- (ee) review the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff at least once a year and recommend such changes as may be necessary or desirable;
- (ff) determine minimum continuing education requirements for appointees to the Medical Staff;
- (gg) review all information available regarding the performance and clinical competence of members of the Medical Staff and, as a result of such review, make recommendations to the Board of Trustees for reappointments or changes in clinical privileges;
- (hh) review the credentials of all applicants and make recommendations to the Board of Trustees for appointment to the Medical Staff and delineation of clinical privileges;
- (ii) be responsible for the mechanism used to review credentials and to delineate individual clinical privileges;
- (jj) be responsible for the mechanism by which Medical Staff membership may be terminated;
- (kk) be responsible for the mechanism for fair-hearing procedures;
- (ll) designate and appoint special or ad hoc committees to assist in carrying out the duties and responsibilities of the Executive Committee;

- (mm) review and implement recommendations of the Baylor Health Care System Best Care Committee for quality improvement, as appropriate to the Medical Staff and Hospital, and report the activities, findings and recommendations of the Baylor Health Care System Best Care Committee to the Medical Staff;
- (nn) review the recommendations of the Credentials Committee as to the credentials and qualifications of all applicants for Medical Staff appointment, reappointment, and clinical privileges;
- (oo) review the recommendations of the Credentials Committee as to the credentials and qualifications of all applicants who request to perform services at the Hospital as Allied Health Professionals;
- (pp) review, as questions arise, all information available regarding the clinical competence and behavior of members currently appointed to the Medical Staff and Allied Health Professionals; and
- (qq) Review and act on, when necessary, information and recommendations from the Baylor University Medical Center Health & Rehabilitation Committee regarding the diagnosis, treatment and rehabilitation of Medical Staff members and Allied Health Professionals who suffer from potentially impairing conditions.

R12.5-3 Meetings

The Executive Committee shall meet at least 6 times each year or more often if necessary to transact pending business. The Medical Staff Services office will maintain reports of all meetings, which reports shall include the minutes of the various committees of the Medical Staff. Copies of all minutes and reports of the Executive Committee shall be transmitted to the President routinely as prepared. Recommendations of the Executive Committee shall be transmitted to the Board with a copy to the President. The Chair of the Executive Committee or his designee shall report to the Board or its applicable committee on all recommendations that the Executive Committee may make.

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

R12.6 MEDICAL CARE EVALUATION COMMITTEE

R12.6-1 Composition

The Medical Care Evaluation Committee of the Medical Staff shall consist of at least three (3) Active Clinical Staff members appointed by the Executive Committee. The Chair of Medical Care Evaluation Committee is appointed by the Executive Committee and is a member of the Active Clinical Staff. The Chair of the Executive Committee and President shall serve as ex-officio members of this committee.

R12.6-2 Duties

The duties of the Medical Care Evaluation Committee include, but are not limited to the following:

- (rr) conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Hospital. The Medical Care Evaluation Committee shall routinely collect information about important aspects of patient care provided in the Hospital, periodically assess this information, and develop objective criteria for use in evaluating patient care. These criteria may include, but are not limited to, procedures performed, outcomes, medication usage, blood usage, medical records, mortality rates, utilization management, meeting attendance and/or risk-management data. Patient care reviews shall include the clinical work performed under the jurisdiction of the Hospital.
- (ss) reviewing and evaluating adherence to Medical Staff policies and procedures, as well as sound principles of clinical practice;
- (tt) submitting written reports to the Executive Committee concerning: (1) review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the Hospital; and
- (uu) making recommendations to the Executive Committee and Board of Trustees regarding equipment and personnel needs of the Hospital.

R12.6-3 Meetings

The Medical Care Evaluation Committees shall meet at least 6 times per year, and as needed to perform duties and functions.

Section XIII MEETINGS

R13.1 MEETINGS

R13.1-1 General Meetings

There may be one or more general meetings of the Medical Staff annually, which shall be called by the Chair of the Executive Committee when it shall be determined necessary or beneficial by the Executive Committee. The agenda and program shall be determined by the Chair of the Executive Committee. Notice of this meeting shall be given to the members at least 30 days prior to the meeting.

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

- (vv) administrative reports from the Chair of the Executive Committee;
- (ww) election of officers when required by the Rules and Regulations;
- (xx) voting on proposed changes to the Rules and Regulations when required by the Rules and Regulations;

- (yy) reports by responsible officers and committees on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the Medical Staff and on the fulfillment of other required Medical Staff functions;
- (zz) old business; and
- (aaa) new business.

R13.1-2 Special Meetings

Special meetings may be called at any time by the Chair of the Executive Committee or upon the written request of 33% of the members of the Active Clinical and Consulting Medical Staff. Such members requesting a meeting shall first consult with the Chair of the Executive Committee as to the purpose and need to call a special meeting. Called special meetings shall be scheduled by the Chair within 30 days after receipt of such request. No later than 30 days prior to the meeting, notice shall be mailed or delivered to the members of the Medical Staff, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

R13.2 COMMITTEE MEETINGS

R13.2-1 Regular Meetings

Except as otherwise specified in the Rules and Regulations, the chairs of committees may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to provide adequate notice of the meeting dates.

R13.2-2 Special Meetings

A special meeting of any Medical Staff committee may be called by the Chair thereof, Executive Committee, or by written request of one-third of the current members, eligible to vote, but not less than three members.

R13.3 VOTING

R13.3-1 Medical Staff Meetings

Except for the Executive Committee and Medical Care Evaluation Committee, the presence of at least two thirds of the Active Clinical Medical Staff shall be required to constitute a quorum. Except as otherwise specified, the action of a majority of the total of those Active Clinical and Consulting Medical Staff members who vote at any regular or special meeting of the Medical Staff shall constitute the action of the Medical Staff. A majority shall be defined as one member over half of the total of those Active Clinical and Consulting Medical Staff members who are present and voting and any members who may have submitted written or electronic ballots.

R13.4 MANNER OF ACTION

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

R13.5 MINUTES

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

R13.6 ATTENDANCE REQUIREMENTS

R13.6-1 Regular Attendance

It is expected that members of the Medical Staff shall be required to attend meetings as follows:

- (bbb) Members appointed to the Executive Committee, other standing committees, or special or ad hoc committees shall be required to attend 50% of the meetings held in a calendar year.
- (ccc) Members of the Active Clinical Staff shall be required to attend at least one meeting of the General Medical Staff each calendar year.
- (ddd) Each member of the Consulting Category, as well as those Practitioners in the Provisional Status shall be required to attend such other meetings as may be determined by the Executive Committee.

R13.6-2 Absence From Meetings

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

R13.6-3 Special Attendance

At the discretion of the chair or presiding officer, individuals other than members and non-voting members may be asked to attend meetings of the Medical Staff or committees. When a member's

practice or conduct is scheduled for discussion at a committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least 7 days prior to the meeting and shall include the time, place, and general indication of the issue involved. Failure of a member to appear at any meeting with respect to which he was given such notice, unless excused by the Executive Committee upon a showing of good cause, shall be a basis for corrective action.

R13.6-4 Conduct Of Meetings

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

R13.6-5 Conflict Of Interest

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

Section XIV GENERAL PROVISIONS

R14.1 ADMINISTRATIVE SUSPENSION OR REVOCATION

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

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

14.1-1 The Administrative Suspension as provided in the Medical Staff Bylaws is as follows:

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

Upon expiration of licensure, DEA, DPS or professional liability insurance the practitioner is immediately prohibited from providing patient care, which includes, but is not limited to: elective and emergency admissions, admission scheduling, consultative and treating privileges, surgery or invasive procedure scheduling, elective anesthesia scheduling, voting and office-holding prerogatives until such document(s) is updated and verified.

B. Failure to Respond to Requests for Information

Practitioners suspended for failure to respond to requests for information related to expiration of licensure, DEA, DPS or professional liability insurance may be prohibited from providing patient care (as defined in section 1.1 above). Failure to respond to other requests for information will be addressed as defined in Section 3.3-5 of the Medical Staff Bylaws.

C. Failure to Complete Medical Records

Practitioners shall be denied scheduling privileges for elective admissions, surgery or invasive procedure and/or elective anesthesia (with the exception of in-house patients), as well as voting and office-holding prerogatives, for failure to complete medical records within twenty-one (21) days from the time the medical records were first made available to the practitioner. In addition, the practitioner's membership and clinical privileges may be suspended for failure to complete medical records for three (3) weeks in a row from availability until such records are completed. Suspended practitioners providing operative procedures on an in-house patient(s) or currently treating an in-house patient(s), may continue to treat that in-house patient(s). Future admission and surgical scheduling will be denied until the practitioner is removed from suspension for failure to complete medical records.

C.1. Extended Leave or Vacation

It is the practitioner's responsibility to notify the Health Information Management Department at the respective facility if

a leave or vacation is planned that exceeds three (3) weeks. In the event the leave extends unexpectedly past three (3) weeks, the Health Information Management Department will initiate the process to file the charts as permanently incomplete.

D. Repetitious Infractions

Practitioners suspended under any definition of administrative suspension will be addressed as defined in Section 3.3-7 (Repetitious Infractions) in the Medical Staff Bylaws.

14.1-2 Notification of Practitioner Suspension or Reinstatement

A. Notification to Suspend

The process for notification to suspended practitioners and appropriate hospital personnel is defined in Medical Staff Services and Health Information Management Policy and Procedures.

B. Notification to Reinstate

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

14.1-3 Reporting to Texas Medical Board for Failure to Complete Medical Records

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

Section XV

AMENDMENT TO THE RULES AND REGULATIONS

The Rules and Regulations of the Medical Staff and department rules and regulation shall be amended as specified in Article XI, Section 6.5 of the Bylaws of the Medical Staff.

New or revised Rules and Regulations shall be published for members of the Medical Staff, and shall be compiled and maintained in a convenient form readily available for reference in Medical Staff Services.

Section XVI

PATIENT CARE POLICIES

In addition to these Rules and Regulations of the Medical Staff, other policies and procedures relating to the provision of patient care may be presented to the Executive Committee for adoption in such areas of the Hospital. New or revised policies and procedures approved by the Executive Committee and Board of Trustees will be communicated to Medical Staff members.

Revisions 5/07, 6/08