

Covenant Children’s Hospital Medical Staff Bylaws

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These bylaws and the Medical Staff Rules and Regulations use the masculine personal pronouns (he, him, his). This is for convenience only and is not intended to exclude females. The Medical Staff is committed to nondiscrimination.

Preamble

Covenant Children’s Hospital is a non-profit corporation organized under the laws of the State of Texas. These Bylaws are adopted in order to provide for the organization of the Medical Staff of Covenant Children’s Hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving quality patient care, treatment, services, and patient safety, and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital’s Board of Directors through the cooperative efforts of the Chief Executive Officer.

The physicians, dentists, and podiatrists practicing in the Hospital shall carry out the functions delegated to the Medical Staff by the Board of Directors in conformity with these Bylaws.

Definitions

For the purposes of these Bylaws and the accompanying Rules and Regulations, the terms referred to will have the following meanings:

1. **Active Medical Staff** means the Active category of the Medical Staff as defined in Article IV of these Bylaws.
2. **Administration** means the President and/or his designees.
3. **Allied Health Professional** (“AHP”) means an individual, other than a licensed physician, oral surgeon, dentist, podiatrist who provides direct patient care, treatment, and services at Covenant Children’s Hospital under a defined degree of supervision by a Medical Staff Member who maintains clinical privileges.
4. **Applicant** means an Inquirer who both: (a) meets the eligibility criteria set out in Section 1.1 of the Rules and Regulations; and (b) is provided an application for appointment to the Medical Staff.
5. **Board** means the Board of Directors of Covenant Children’s Hospital or its designee.
6. **Business Day** means all days other than Saturdays, Sundays, or legal holidays or the equivalent for the Hospital.
7. **Chief Medical Officer** means the Medical Staff Member appointed by the Board to be an active liaison with the Medical Staff, Medical Staff Officers, and Medical Staff Committee Chairs and who shall have other such duties and responsibilities as the Board determines from time to time.
8. **Hospital** means Covenant Children’s Hospital, Lubbock, Texas, including the Board, its members and committees, its president, other officers and employees, all Medical Staff Members, and committees and all authorized representatives of the forgoing.
9. **Inquirer** means a person who: (a) requests in writing an application for appointment to the Medical Staff; and (b) provides evidence of Texas licensure and training requirements for board certification.
10. **Medical Staff** consists of those Members with privileges to attend patients in the Hospital.
11. **Medical Staff Year** means the calendar year.

12. **Member** means any physician, dentist, or podiatrist appointed to, and maintaining membership in, any category of the Medical Staff in accordance with these Bylaws.
13. **Officer** means an officer of the Medical Staff as defined in Article VI of these Bylaws.
14. **Patient** is an individual:
 - a. seeking medical treatment who may or may not be under the immediate supervision of a personal attending physician, has one or more undiagnosed or diagnosed medical conditions, and who, within reasonable medical probability, requires immediate or continuing hospital services and medical care;
or
 - b. admitted to the hospital as a patient.
15. **Practitioner** means a physician (either M.D. or D.O.), dentist or podiatrist.
16. **President** means the individual appointed by the Board of Trustees to act on its behalf in the overall management of the Hospital. The term “President” includes a duly appointed Acting Administrator serving when the President is away from the Hospital.
17. **Specialty Board** means a board that is a member of the American Board of Medical Specialists or a board approved by the American Osteopathic Association, the American Dental Association, or the American Podiatric Association.
18. **Privileges** means the permission granted to a Medical Staff Member or Allied Health Professional, as described in the Hospital bylaws to render specific patient services.

Article I – Name

The name of this organization is the Covenant Children’s Hospital Medical Staff.

Article II – Purpose

The purpose of these Bylaws are: to provide a structure for organizing and governing the Medical Staff, to advance cooperation and cohesion among professionals in the best interest of quality patient care, treatment, services, and to promote a high level of professional performance of Medical Staff Members in a manner that demonstrates Christian concern for all Patients regardless of age, sex, religion, color, national origin, disability, sexual orientation, or economic status.

Article III – Membership

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff of the Hospital is a privilege which will be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth by these Bylaws and associated Rules and Regulations. No practitioner has any right of appointment to the Medical Staff.

Section 2. Qualifications for Membership

1. **Composition:** The Medical Staff will be composed of Practitioners who are selected on the basis of their ability to further the fulfillment of the Hospital’s objectives in quality patient care, treatment, and services. The Hospital will endeavor to maintain a balance among the various specialties required for a regional hospital and referral center. It will also endeavor to provide for systematic admission of outstanding Practitioners in a manner that will assure a continued development of the Medical Staff in future years.

In acting on new applications for Medical Staff membership and clinical privileges, and on applications for changes in clinical privileges or category, consideration must be given to and an explicit finding made concerning the Hospital’s current and projected patient care and teaching needs and the Hospital’s ability to provide the facilities, beds, and support services that will be required if the application is acted upon favorably. In making these required need and ability determinations, consideration will be given to community healthcare needs, present and projected patient mix, actual and planned allocations of physical, financial, and human resources to general and specialized clinical and support services, and the Hospital and Medical Staff’s general and specific goals and objectives as reflected in the Hospital’s short and long range plans.

2. **Qualifications:** The Practitioner will be a graduate of an approved medical, osteopathic, dental, or podiatry school; will hold a current license to practice in the State of Texas; and will comply with the eligibility and other requirements established in these Bylaws and the Rules and Regulations of the Medical Staff. The Practitioner must demonstrate acceptable training, experience, judgment, individual character, current competence, physical and mental capabilities, adherence to the ethics of his profession, and the ability to work harmoniously with others. The practitioner must not have been excluded from the Medicare or Medicaid program.
3. **Exceptions to the above may be made only by the Board with input from the Medical Executive Committee.**

Section 3. Nondiscrimination

Membership and privileges shall not be based upon race, color, religion, sex, national origin, age, disability, or sexual orientation.

Section 4. Conditions and Duration of Appointment

1. Initial appointments and reappointments to the Medical Staff will be made by the Board of Trustees. The Board will act on appointments and reappointments only after there has been a recommendation from the Medical Executive Committee in accordance with the provisions of these Bylaws and associated Rules and Regulations of the Medical Staff.
2. Appointment to the Medical Staff will be for no more than two (2) year intervals.
3. Appointments to the Medical Staff will confer on the Practitioner only such clinical privileges as have been granted by the Board.
4. Initial appointment will be on Provisional Status as described in the Medical Staff Rules and Regulations.

Section 5. Responsibilities of Membership

Each Member will:

1. Direct the care of his patients and will supervise the work of any allied health professionals under his direction;
2. Assist the Hospital in fulfilling its responsibilities for providing charitable care;
3. Act in an ethical, professional, and courteous manner;
4. Treat employees, patients, visitors, and other Medical Staff Members in a dignified and courteous manner;
5. Assume and carry out all functions and responsibilities of membership in the appropriate category as described in these Bylaws and Rules and Regulations, including providing call coverage requirements;
6. Abide by the Medical Staff Bylaws and the Medical Staff Rules and Regulations and by all other lawful standards, policies, and rules of the hospital;
7. Prepare and complete medical and other required records in a timely manner as defined in applicable Rules, Regulations, policies, and procedures for patients the

member admits or in any way provides care, treatment, and services in the Hospital; and

8. Participate in Hospital peer review activities.
9. Abide by all relevant state and federal laws.

Article IV – Categories

Section 1. Active Medical Staff

Qualifications: In addition to the qualifications defined in Article III, Members of this category must:

1. Have primary residence and primary medical practice in Lubbock County, Texas.
2. Participate in the care of at least twelve (12) Hospital patients per year except as expressly waived by the Board with input from the Medical Executive Committee.

Responsibilities:

3. Assume responsibility for emergency service and assigned consultations as described in the Rules and Regulations of the Medical Staff.
4. Contribute to the organizational and administrative affairs of the Medical Staff.
5. Actively participate in recognized Medical Staff functions, including peer review, quality improvement and other monitoring activities, monitoring initial appointees during their provisional period, and other staff functions as designated by the Medical Executive Committee.

Prerogatives:

6. Exercise clinical privileges approved by the Board.
7. Vote and hold office provided that they have been released from Provisional Status as described in the Medical Staff Rules and Regulations.

Section 2. Courtesy Medical Staff

Qualifications: In addition to the qualifications defined in Article III, Members of this category must:

1. Have primary residency and primary medical practice in Lubbock County, Texas.
2. Participate in the care of at least one (1) Hospital patient within each two year reappointment period except as expressly waived by the Board with input from the Medical Executive Committee.

Prerogatives:

3. Exercise clinical privileges approved by the Board with a maximum clinical involvement with twelve (12) Hospital patients annually as defined in the Medical Staff Rules and Regulations.

Section 3. Faculty Medical Staff

Full-time faculty of the Texas Tech University School of Medicine are eligible only for appointment to the Faculty Medical Staff. The Board has sole discretion to decide whether a practitioner qualifies as a full-time faculty member, with input from the Medical Executive Committee. There are three categories of privileges available to Faculty Medical Staff Members:

Instructional Category:

Qualifications: In addition to the qualifications defined in Article III, Members of this category must:

1. Actively participate in instructional programs at the Hospital via supervision of Residents and/or Fellows in their Departments. Instructional programs are determined by and subject to written contractual agreements between the Texas Tech University School of Medicine and the Hospital.
2. Reside in Lubbock County, Texas.
3. Participate in the care of at least one (1) patient contact within each two (2) year reappointment period.

Prerogatives:

4. Exercise clinical privileges approved by the Board.

Consultative Category:

Qualifications: In addition to the qualifications defined in Article III, Members of this category must:

1. Reside in Lubbock County, Texas.
2. Participate in the care of at least one (1) patient contact within each two (2) year reappointment period.

Prerogatives:

3. Consult on a maximum of twelve (12) patients annually.

Consultations may include performing procedures or surgery and actively participating in the care of patients for whom consulted, all within the scope of the privileges granted by the Board.

Active Faculty Category:

Qualifications: In addition to the qualifications defined in Article III, Members of this category must:

1. Reside in Lubbock County, Texas.
2. Participate in the care of at least one patient contact within each two (2) year reappointment period.
3. Possess a specialized expertise that enhances the fulfillment of the Hospital’s mission of caring for patients as determined by the Board with input from the Chief of Staff and Chief Medical Officer.

Responsibilities:

4. Exercise clinical privileges approved by the Board.
5. Assume primary responsibility for emergency service care as described in the Medical Rules and Regulations.

Section 4. House Staff

1. Texas Tech University Health Science Center Residents and Fellows are eligible for this category while participating in programs delineated in the approved affiliation agreements between Texas Tech University Health Science Center and Covenant Health Systems.

Qualifications:

2. The House Staff will consist of residents and fellows appointed to the Texas Tech University Health Sciences Center School of Medicine.

Prerogatives:

3. Exercises clinical privileges to treat any patients under the direct supervision of the Active medical staff or Faculty Instructional medical staff members who are licensed, independent practitioners with appropriate hospital clinical privileges.

Section 5. Honorary Staff

Qualifications:

1. Retired from active Hospital practice; or
2. Outstanding reputation.
3. Honorary Staff Members need not meet the requirements for professional liability insurance.
4. Honorary Staff Members need not be reappointed every two years.

Prerogatives:

5. Full library access and continuing medical education will be provided without charge to Members of the Honorary Staff.

Article V –Allied Health Professionals

Qualifications:

Allied Health Professional (“AHP”) are individuals other than a licensed physician, oral surgeon, dentist, podiatrist who provides direct patient care, treatment, and services at Covenant Medical Center under a defined degree of supervision by a Medical Staff Member who maintains clinical privileges at Covenant Medical Center. AHPs exercise

judgment within the areas of documented professional competence and consistent with the applicable State Practice Act. AHPs are designated by the Board of Directors to be credentialed and provide patient care pursuant to approved clinical privileges. Allied Health Professionals are not eligible for Medical Staff Membership.

AHP’s are independent practitioners licensed by the State of Texas and permitted by Texas State Practice Acts and the Hospital to provide patient services through delineated privileges with supervision by the supervising physician as described in the accompanying Rules and Regulations.

Appointment:

The Board will act on appointments and reappointments to the Allied Health Staff only after there have been recommendations from the Medical Executive Committee in accordance with the provisions of these Bylaws and associated Rules and Regulations of the Medical Staff.

Termination of Privileges:

The Hospital retains the right, upon recommendation of the Chief of Staff or the Medical Executive Committee, to terminate any or all the Allied Health Staff privileges granted. Any Allied Health Professional who has no documented patient contact within the preceding two (2) years will be removed from the Allied Health Staff roster, and all privileges will be terminated.

Article VI – Officers

Section 1. Officers of the Medical Staff

The officers of the Medical Staff will be:

1. Chief of Staff
2. Vice Chief of Staff
3. Immediate Past Chief of Staff

Section 2. Qualifications

Officers must have met the training requirements for board certification in a specialty with a significant focus on the care of children, must be on the Active Medical Staff at the time of nomination and election and must remain so in good standing during their terms of office. Beginning January 1, 2006, physicians who are on Provisional Status will not be eligible for officer positions. Officers should possess leadership and

administrative abilities. Officers may not simultaneously hold leadership positions on other hospital medical staffs.

Section 3. Election of Officers

1. The regular election of Medical Staff Officers will be held every other year at the annual meeting of the Medical Staff. Election will be by voice vote of voting Members present unless secret ballot is requested, in writing, by any voting Member at least seven (7) days prior to voting. All officers will require confirmation by the Board.
2. Nominations will be made by the Nominating Committee as described in the Rules and Regulations. Nominations may also be made from the floor at the time of the annual meeting when accompanied by evidence of the nominee’s qualifications and willingness to be nominated.
3. The Vice Chief of Staff will be the Chief of Staff-Elect and will automatically succeed the Chief of Staff at the completion of the Chief of Staff’s elected term.

Section 4. Term of Office

All officers will serve two (2) year terms. Officers will take office on the first day of the Medical Staff year except that an officer appointed to fill a vacancy will assume office immediately upon appointment.

Section 5. Vacancies in Office

1. A vacancy in the office of the Chief of Staff will be filled by the Vice Chief of Staff.
2. A vacancy in the office of Vice Chief of Staff will be filled by an election which will be conducted in a timely manner.
3. Other vacancies in office will be filled by an appointee of the Medical Executive Committee.

Section 6. Removal from Office

1. An officer may be removed from an office by the Board acting on its own initiative or by a two-thirds (2/3) majority vote of the Active Medical Staff, but no such removal will be effective until it has been ratified by the Board. The process for initiation of a recall by the Medical Staff is addressed in Article XI.
2. Reasons for removal of a Medical Staff officer include, but are not limited to:

- a. Failure to perform the duties of the office in a timely and appropriate manner.
- b. Failure to continuously satisfy the qualifications for office.

Section 7. Duties of Officers

Chief of Staff

1. Act in coordination with the President in all matters of mutual concern within the Hospital.
2. Call, preside at and be responsible for the agenda of all general meetings of the Medical Staff.
3. Serve on the Medical Executive Committee and preside as its Chair.
4. Serve as an ex-officio member of all other committees without vote.
5. Be responsible for the enforcement of these Bylaws and the Rules and Regulations of the Medical Staff, for implementation of corrective action where indicated, and for the Medical Staff’s compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner.
6. Appoint committee members to all standing and special committees, except the Medical Executive Committee.
7. Represent the views, policies, needs, and grievances of the Medical Staff to the Board, to the President and to all others within the Hospital.
8. Interpret the policies of the Board to the Medical Staff and report on the performance and maintenance of quality with respect to the Medical Staff’s responsibility for the provision of quality patient care, treatment, and services.
9. Participate in the organization and coordination of the Medical Staff’s quality improvement programs.
10. Be the spokesperson for the Medical Staff in its external, professional, and public relations.

Vice Chief of Staff

In the absence of the Chief of Staff, the Vice Chief will assume all duties, responsibilities, and authority of the Chief of Staff.

Immediate Past Chief of Staff

The Immediate Past Chief of Staff will serve as a consultant to the Chief and Vice Chief of Staff as requested.

Article VII – Organization as Nondepartmentalized Staff

The Medical Staff will be organized as a nondepartmentalized staff, and all functions and responsibilities will be carried out by the whole except as otherwise defined in these Bylaws.

Article VIII – Committees

Section 1. Medical Executive Committee

Composition:

The Medical Executive Committee (MEC) will be Chaired by the Chief of Staff and will consist of: officers of the Medical Staff; Chairman or a designated pediatric member of the Credentials Committee; Chairman of the Quality Review Committee of the Medical Staff; the Chief Medical Officer; the Medical Director of Quality Management; Section Chief, Pediatrics; a neonatologist; two (2) pediatricians; one (1) representative of family practice; five (5) representatives of other non-pediatric specialties; and two “at-large” members from the Active Medical Staff who will be appointed by the Chief of Staff. Representatives of pediatric subspecialties will be appointed as deemed appropriate by the Chief of Staff. The Chief of Staff of Covenant Medical Center/Covenant Lakeside and the President, or his designees, will attend on an ex-officio basis, without vote. The Chairman of the Board, or his designee, may attend on an ex-officio basis without vote.

Duties:

1. Represent and act on behalf of the organized Medical Staff between medical staff meetings, subject to such limitations as may be imposed by these Bylaws and the Rules and Regulations of the Medical Staff.
2. Coordinate the activities and general policies of the Medical Staff and committees.
3. Receive, coordinate, and act upon committee reports and recommendations.
4. Initiate and implement policies of the Medical Staff.
5. Provide a liaison among the Medical Staff, President, and the Board.

6. Recommend action to the President on matters of a medico-administrative nature.
7. Recommend medical staff structure and membership to the Board.
8. Fulfill the Medical Staff’s accountability to the Board for the overall quality of patient care, treatment, and services in the Hospital and the ongoing monitoring of patient care activities.
9. Ensure that the Medical Staff is kept informed of the accreditation program and status of the Hospital, and take all reasonable steps to ensure compliance with accreditation standards.
10. Review the credentials of all applicants and make recommendations to the Board for Medical Staff membership, category, and delineation of clinical privileges.
11. Review periodically all applications and information regarding the continuing performance and clinical competence of Medical Staff Members and other Practitioners with clinical privileges and as a result of such reviews, to make recommendations for reappointments, category, and delineation of clinical privileges.
12. Review and make recommendations on all applications from Allied Health Professionals, or delegate such responsibility to another committee with approval of the Board.
13. Decide any question concerning interpretation of matters concerning the Medical Staff or these Bylaws, and Rules and Regulations of the Medical Staff, subject to final Board approval.
14. Make recommendations regarding the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for fair-hearing procedures.
15. Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective action when warranted.
16. Report at each general Medical Staff meeting.

Meetings:

The Medical Executive Committee will meet monthly and maintain a permanent record of its proceedings and actions. At the discretion of the Chief of Staff, one Medical Executive Committee meeting may be canceled during a one-year period. The Medical Executive Committee will be required to meet during the month following a canceled meeting.

Section 2. Staff Functions

The Rules and Regulations of the Medical Staff will define the mechanism to be utilized by the Medical Executive Committee in the performance of Medical Staff functions.

Article IX – Medical Staff Meetings

Section 1. Meeting Frequency and Notice

General Medical Staff Meeting:

1. An annual meeting of the general Medical Staff will be held prior to the end of the Medical Staff year. Officers of the Medical Staff will be elected every other year at the annual meeting.
2. A special meeting of the general Medical Staff may be called at any time by the Chief of Staff, and will be called at the request of the Board or the Medical Executive Committee, or upon written request signed by at least ten percent (10%) of the Active Medical Staff. At any special meeting, no business will be transacted except that stated in the notice calling the meeting.

Meeting Notice:

1. Written notice of regular meeting will be mailed to Members at the beginning of the Medical Staff Year. Written or oral notice of special meetings and changes to or cancellations of regular meetings will be not less than three (3) days in advance.
2. Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution

Section 2. Quorum

A quorum will be defined as follows:

1. Medical Staff or committee (other than Medical Executive Committee) meetings: those Members present and voting.

2. Medical Executive Committee meetings: a simple majority of the voting members.

Section 3. Attendance Requirements

Members of the Medical Staff are expected to attend meetings of the Medical Staff.

Section 4. Manner of Action

The action of a majority of its voting members present at a meeting at which a quorum is present will be the action of the Medical Staff or a committee.

Section 5. Robert’s Rules of Order

Robert’s Rules of Order will serve as a guideline at all meetings of the general Medical Staff and Medical Executive Committee meetings.

Section 6. Minutes

1. Minutes of each regular and special meeting of the general Medical Staff or committee will be prepared and will include a record of attendance of members and the vote taken on each matter. Minutes will be signed by the presiding officer.
2. Minutes of committee meetings will be forwarded to the Medical Executive Committee.
3. A permanent file of all minutes will be maintained in the office of Medical Staff Services and will be available for review by Medical Staff Members upon request with exception of minutes generated in connection with peer review or credentialing, which will be available only to those directly involved in the peer review or credentialing process.

Article X – Appointment, Reappointment, and Clinical Privileges

All matters relating to qualifications for appointment; application for or modification of appointment, reappointment, or clinical privileges; investigations; disciplinary proceedings; and hearings are contained in the Rules and Regulations of the Medical Staff.

Article XI – Member Rights

1. In the event a Member of the Medical Staff is unable to resolve a specific issue regarding a rule, regulation or policy with the appropriate Medical Staff

committees, that Member may submit a written request to meet Medical Executive Committee to discuss the issue.

2. Any Member of the Medical Staff has the right to initiate a recall election of a Medical Staff officer. A petition for such recall must be presented and signed by at least ten percent (10%) of the voting Members. Upon presentation of such valid petition, the Medical Executive Committee will, in the case of a Medical Staff officer, schedule a special general Medical Staff meeting for purposes of discussing the issue and, if appropriate, initiate a recall election.
3. Any member of the Medical Staff may call a general Medical Staff meeting by presentation of a petition signed by at least ten percent (10%) of the Active Medical Staff. The Medical Executive Committee will schedule a general Medical Staff meeting for the specific purpose addressed by the petitioners.
4. Any member of the Medical Staff may raise a challenge to any rule, regulation, or policy of the Medical Staff by submission of a petition signed by ten percent (10%) of the Active Medical Staff. Upon receipt of such petition, the Medical Executive Committee will either: (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy; and/or (2) schedule a meeting with petitioners to discuss the issue.
5. Paragraphs 1 through 4 of this Article do not pertain to issues involving disciplinary action, denial, or request for appointment or clinical privileges or other matters relating to individual credentialing actions. Paragraph 6 hereof and the Fair Hearing Plan provide recourse in these matters.
6. Any Practitioner has a right to a hearing pursuant to the Hospital’s Fair Hearing Plan in the event any of the following actions are taken or recommended by the Medical Executive Committee or the Board:
 - a. Denial of initial staff appointment or reappointment.
 - b. Suspension or revocation of Medical Staff membership or privileges, except for automatic suspensions as defined in Section 4, of fourteen (14) days or less.
 - c. Denial of requested appointments to, or advancement in, Medical Staff category, or reduction in category.
 - d. Denial, suspension, revocation, or limitation of the privilege to admit patients or any other clinical privilege, other than limited or emergency privileges.
 - e. Imposition of mandatory consultation requirement, not including any supervision required during provisional appointment.

(See the corrective action process in the Medical Staff Rules and Regulations.)

Article XII – Medical Records

- 1 Entries in the medical record may be made only by individuals authorized to do so as specified in administrative policies. Entries will be made during the regular course of business by those authorized individuals.
 - a) A medical record will be initiated and maintained for every individual assessed or treated. The medical record will incorporate information from subsequent contacts between the patient and the organization.
 - b) The medical record will contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately, and facilitate continuity of care among health care providers. Each medical record will contain at least the following:
 - i) The patient's name, address, date of birth, and the name of any legally authorized representatives;
 - ii) The patient's legal status for patients receiving mental health services;
 - iii) Emergency care provided to the patient prior to arrival, if any;
 - iv) The record and findings of the Practitioner’s assessment of the patient;
 - v) A statement of the conclusions or impressions drawn from the medical history and physical examination;
 - vi) The diagnosis or diagnostic impression;
 - vii) The reason(s) for admission or treatment;
 - viii) The goals of treatment and the treatment plan;
 - ix) Evidence of known advance directive;
 - x) Evidence of informed consent for procedures and treatments for which informed consent is required by organizational policy, Joint Commission standards, and applicable state law;
 - xi) Diagnostic and therapeutic orders, if any;
 - xii) All diagnostic and therapeutic procedures and tests performed and the results;
 - xiii) Test results relevant to the management of the patient’s condition;

- xiv) All operative and other invasive procedures performed using acceptable disease and operative terminology that includes etiology, as appropriate;
 - xv) Progress notes made by the Medical Staff, physicians in training, physician assistants, and nurse practitioners;
 - xvi) All reassessments, when necessary;
 - xvii) Clinical observations;
 - xviii) The patient’s response to the care provided;
 - xix) Consultation reports;
 - xx) Every medication ordered or prescribed;
 - xxi) Every dose of medication administered and any adverse drug reaction;
 - xxii) Each medication dispensed to or prescribed for patient on discharge;
 - xxiii) All relevant diagnoses established during the course of care; and
 - xxiv) Any referrals/communications made to external or internal care providers and to community agencies.
 - xxv) Conclusions at termination of hospitalization;
 - xxvi) Discharge instructions to the patient and family; and
 - xxvii) Clinical resumes and discharge summaries, or a final progress note or transfer summary
- 2 For any acute care patient, a complete medical history and physical examination shall be completed and documented by a practitioner privileged to perform History and Physical’s within twenty-four (24) hours of admission, but prior to a surgery or a procedure requiring anesthesia services. The chart will be considered delinquent if this is not accomplished. This report should include all pertinent findings including a list of tentative diagnoses and a brief management plan. The complete history and physical must include the following: Chief patient complaint, details of the present illness or condition including, when appropriate, assessment of the patient’s emotional, behavioral, and social status, relevant past social and family histories appropriate to the patient’s age, inventory of body systems, physical examination and diagnosis or problem list with a plan of care. If a complete history has been recorded and a physical examination performed within one (1) day prior to the patient’s admission to the Hospital, a reasonably durable, legible copy of these reports may be used in the patient’s Hospital medical record provided these reports were recorded by a Member of the Medical Staff and any significant changes that

may have occurred are recorded in the medical record at the time of admission. If a history and physical exam was performed more than one (1) day or up to and no more than 30 days prior to admission, an interval note is required. An interval note should describe any updated information to reflect the patient’s status at the time of admission. For patients receiving non-inpatient services, an H&P is required prior to the following: Procedures including operative, other invasive, and noninvasive procedures that place the patient at more than minimal risk, and all procedures (invasive and non-invasive) requiring moderate or deep sedation or anesthesia. Examples of outpatient procedures that would not require an H&P would include, but not be limited to, blood and blood product transfusions, bone marrow biopsy and aspiration, and superficial fine needle aspirations. The scope of the H&P when required for non-inpatient services will include: Present illness, pertinent history, allergies, medications, physical examination to include vital signs and relevant clinical findings, impression and planned course of treatment. If a history and physical exam was performed more than one (1) day or up to and no more than 30 days prior to the outpatient procedure, an interval note is required. An interval note should describe any updated information to reflect the patient’s status at the time of the outpatient procedure. A history and physical over 30 days old may not be used.

An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within twenty- four (24) hours of admission or registration, but prior to surgery or procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a practitioner privileged to perform History and Physical’s.

- 3 When the history and physical examination are not in the medical record before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the attending Practitioner states in writing that such delay would be detrimental to the patient.
- 4 The attending physician shall countersign the history, physical examination, and discharge summary when they have been recorded by a member of the house staff.
- 5 A pertinent daily progress note shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.
- 6 A discharge summary shall be completed on any inpatient with a length of stay greater than two days. The clinical resume shall concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and the treatment rendered, and the condition of the patient on discharge. Specific instructions should be given to the patient and/or family including instructions

relating to physical activity, medications, diet and follow-up care. All relevant diagnoses established by the time of discharge, as well as all operative procedures performed, will be recorded using accepted disease and operative terminology that includes topography and etiology as appropriate.

- 7 The medical record of any patient undergoing operative or other invasive procedures and/or anesthesia will include the following:
 - a) Except in life threatening emergencies, the history, physical examination, and preoperative diagnosis must be recorded in the patient’s record prior to any surgical procedure. If not recorded, the operation will be postponed until all data are available.
 - b) Any indicated laboratory and x-ray examinations should be completed and recorded in the medical record or a summary of pertinent findings may be documented in the medical record.
 - c) A preoperative diagnosis prior to surgery, and the attending physician’s and/or surgeon’s documented plan for the operative or invasive procedure.
 - d) The anesthesiologist shall document a pre-anesthesia evaluation to determine the proper anesthetic to be given;
 - e) Handwritten or electronically recorded documentation of the patient’s physiological status during the procedure shall be documented.
 - f) Proper surgical consent shall be obtained prior to the operative procedure except in emergent situations. Risk, benefit, alternative options, and potential complications associated with the procedure shall be discussed with the patient and/or appropriate family members prior to signature of consent. Alternatives to blood transfusion, when blood or blood components are needed, shall be considered. Patients shall be allowed to participate in care decisions and shall provide informed consent.
 - g) Plans of care shall be developed and documented and should include a postprocedure plan and an initial assessment of the patient’s physical, mental, and neurological status and needs.
 - h) Postoperative data including the patient’s vital signs, level of consciousness, medications (including intravenous fluids) received, blood and/or blood components received, unusual events or postoperative complications, including blood transfusion reactions, and management of such events shall be documented.
 - i) Postoperative documentation of the patient’s discharge from the postanesthesia care area by the responsible licensed independent practitioner or according to discharge criteria shall be documented postoperatively.

- j) The operative report, which will be written in the medical record immediately after operative or any other procedure, will describe the name of the procedure, pre and postoperative diagnoses, the technical procedure used, the name of the surgeon, assistants, and the anesthesiologist if in attendance, blood loss, specimens removed, and patient condition and complications, if any;
- 8 A consultation will show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made a part of the patient's record. A limited statement, such as "I concur," will not constitute an acceptable report of consultation. When an attending physician desires another physician to perform a formal consultation, he should document such by an order in the medical record. When the attending physician requests that another physician perform a limited procedure without formal consultation, he should specify such request on the order. When a physician intends mere notification to another physician of the patient's admission, he should specify this intention in the orders.
- 9 The medical record for a patient receiving continuing ambulatory care services will include known significant diagnoses, conditions, procedures, drug allergies, and medications.
- 10 Cancer Staging Form: Each time a pathology report is dictated for a cancer diagnosis, the pathologist will indicate which staging form is to be attached to the pathology report. Pathology Department personnel will ensure that the staging form is attached prior to charting on the patient medical record. Completion of the form will be the responsibility of the physician who performed the procedure, which collected the specimen, establishing a diagnosis of malignancy. If an interventional radiologist or pathologist performed the procedure, completion of the form will be the responsibility of the physician who requested the procedure. Responsibility for completing the form can be transferred to the Medical, Surgical, and/or Radiation Oncologist(s) to whom the patient was referred for completion of staging and treatment planning by providing the name of those individuals if they have privileges at Covenant Medical Center/Lakeside or Covenant Children’s Hospital.

If the patient was referred or chose to complete staging and treatment outside of Covenant Medical Center/Lakeside or Covenant Children’s Hospital, it will be responsibility of the physician who established the diagnosis within Covenant Medical Center/Lakeside or Covenant Children’s Hospital to work with the Tumor Registry Office to obtain that information and complete the staging form. The staging form will be considered to be complete when all blanks are filled in and there is a clinical and pathological stage checked for T – Primary Tumor, N – Regional Lymph Nodes, M – Distant Metastasis, and Stage Grouping. The surgeon will sign and date as well as indicate the physician responsible for follow up and treatment.

Cancer diagnoses which may not prompt a staging form include: Skin cancers (other than melanoma), any metastatic cancers, and/or any secondary surgery to the same site.

If a cancer staging form is completed that is associated with a subsequent surgical procedure, and is deemed more accurate than the initial cancer staging form, then the subsequent cancer staging form will be retained and the initial cancer staging form will be discarded. Staging forms are not required when the patient is not registered in the hospital information system.

- 11 The medical record of any patient receiving an epidural catheter placement will include the following:
 - a) Informed consent for the epidural catheter placement, obtained in the same manner and form as consent for other procedures.
 - b) Documentation of adequate monitoring of the patient’s status with regard to the epidural catheter.
 - c) Daily progress notes by the anesthesiologist who placed the epidural catheter as long as the epidural catheter remains in place.

- 12 Physician responsibilities for moderate sedation (conscious sedation/analgesia) will be as follows:

Preprocedure:

- i) A history and physical should be in the record prior to the procedure on all patients receiving moderate or deep sedation.
- ii) A pre-sedation assessment should be in the record prior to the procedure on all patients to include documentation of:
 - a. Pertinent medical and surgical history
 - b. Personal and family history of sedation/anesthesia complications
 - c. Physical exam of airway, heart and lung, level of consciousness
 - d. Clinical impression or pre-op diagnosis
 - e. Operative and other invasive procedure plan
 - f. Pertinent lab or test results
 - g. Current medications and dosages (inclusive of over the counter medications and herbal supplements, allergies and all past medication reactions)
 - h. Sedation risk assessment (e.g., ASA score)
 - i. Plan for moderate sedation (e.g., IV sedation with monitoring)
- iii) Obtains and documents appropriate informed consent for procedure and sedation

- iv) Communicates the moderate sedation plan to involved care providers

Reassesses the patient prior to administration of sedation and documents that they remain a candidate for the procedure and sedation

Postprocedure:

- i) Document a post procedure / anesthesia note, including pre and post procedure diagnoses, procedure findings, complications, blood loss or specimen removed (if any) and plan of care.

13 Any chart will be delinquent when:

- a. The history and physical are not present within twenty-four (24) hours of admission.
- b. Any portion of the chart is incomplete fifteen (15) days after the date of discharge.

14 A delinquent record, which lacks a history and physical, will be handled separately from all other records. The Director of Medical Records, or his designee, will notify the physician of his suspension from the Hospital. A written notification from the Chief of Staff will follow. The Director of Medical Records will notify the appropriate departments.

15 Any Practitioner with a delinquent chart will be notified by letter from the Quality Review Committee liaison physician. If those records are not completed within seven (7) days, a letter will be faxed from the Chief of Staff notifying the Practitioner of automatic suspension of all Hospital privileges, except for the care of patients presently hospitalized under his care at the time of privileges and the responsibilities for emergency call as assigned on the call schedule.

16 In extenuating circumstances, as determined by the Chief of Staff, suspension may be deferred until the next meeting of the Medical Executive Committee, at which time a decision as to the disposition of the suspension will be made.

17 All notices sent to the Practitioner will indicate the campus(es) where the incomplete medical records are located. If a Practitioner has received a reminder letter for one campus and subsequently acquires past-due records at the other campus, a reaffirmation notice will be sent, reminding the Practitioner of the incomplete records at both campuses. A reaffirmation notice will also be sent if a physician has been suspended for records at one campus and subsequently acquires past-due records at the other campus.

18 Each time a Practitioner enters the Incomplete Chart Room, he will be logged in on a Physician Visit Log. This log will document the following information: (1) the date and time of the visit; (2) the number of incomplete charts assigned to the

Practitioner; (3) the number of charts given to the Practitioner; (4) any reasons why 100% of the records were not available to the Practitioner; and (5) any additional comments. If the Medical Records staff cannot make a record available to a Practitioner, a new available date will be entered into the computer for that record, giving the Practitioner an additional seven (7) days to complete the record.

- 19 Medical records will not be reanalyzed while the Practitioner is in the incomplete Chart Room. Reanalysis will usually be completed within twenty-four (24) hours after the Practitioner completes the records. If the Physician Visit Log indicates that all medical records were made available to the Practitioner, but reanalysis determines that the Practitioner did not satisfactorily complete all items tagged for completion, the Practitioner will be notified, and the Practitioner will be given an additional seven (7) days to complete the records. If the Practitioner was on the suspension list and reanalysis determines that the record has not been satisfactorily completed, the physician will have two (2) days to complete the records. If the physician fails to complete the records within the two (2) day period, the physician’s name will automatically be re-posted to the suspension list.
- 20 When a Practitioner has been on the suspension list for thirty (30) consecutive days, he will receive a one-month reminder letter from the Chief of Staff.
- 21 After forty-five days of continuous suspension, the Chief of Staff will notify the suspended Practitioner that failure to complete the delinquent records within sixty (60) days of continuous suspension will result in referral of the matter to the MEC.
- 22 If a physician does not complete all delinquent medical records within sixty (60) days of continuous suspension, his Medical Staff membership and clinical privileges will be terminated, unless he can provide evidence that extenuating circumstances have prevented completion of the record(s). Such termination will entitle the Member to his procedural rights under the Fair Hearing Plan of these Rules and Regulations.
- 23 A medical record will not be permanently filed until it is completed by the responsible Practitioner or is ordered filed by the Medical Executive Committee.
- 24 A Practitioner's routine pre-printed orders, when applicable to a given patient and ordered by the Practitioner, shall be reproduced in detail on the order sheet of the patient's record, dated, and signed by the Practitioner.
- 25 All orders for treatment shall be in writing. Verbal and telephone orders by staff physicians will be accepted and transcribed when given to qualified designated ward personnel (i.e., a charge nurse or floor nurse - R.N. or L.V.N., nursing supervisor, licensed, registered or certified ancillary personnel pertaining to therapy they are providing, social service personnel pertaining to continuity of care, or a pharmacist). Any order transmitted by phone will be signed by the

designated personnel to whom the order has been given and followed with the physician's authenticated signature.

All verbal and telephone orders must be dated, timed, and authenticated within 48 hours by the prescriber or another practitioner who is responsible for the care of the patient. Covenant Medical Center/Lakeside and Covenant Children’s Hospital employees may take a relayed order from another Covenant Medical Center/Lakeside and Covenant Children’s Hospital employee if the Ordering Practitioner is “scrubbed in” or otherwise indisposed at the time. Orders received by phone should immediately be read back to the staff physician. For receipt of a telephone call regarding a patient’s critical test result, the staff member receiving this critical test results shall read back the name of the patient and the complete test result so as to assure clarity in communication.

- 26 Each clinical entry in the patient's medical record shall be accurately dated and authenticated. Authentication means to establish authorship by written signature, identifiable initials, or approved electronic verification. The use of a rubber stamp signature is not acceptable.
- 27 Written consent of the patient will be required for release of medical information to persons not otherwise authorized to receive this information.
- 28 The ordering physician shall be responsible for authenticating an initial hyperalimentation order. Subsequent orders for changes and adjustments to the hyperalimentation may be recorded in the physician order section of the medical record by the pharmacist. Whenever the attending physician disagrees with these changes, he will mark through and initial the order and document appropriate changes.
- 29 All medical records are the property of the Hospital and may be removed from the Hospital's jurisdiction and safekeeping only in accordance with court order, subpoena or statute, or under the supervision of approved hospital personnel. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee. Medical records may be reviewed only by individuals directly involved in the patient’s care as the attending physician or as a consultant authorized to participate in the patient’s care by the attending physician. Medical records may be reviewed by employees authorized by the Hospital to have access to medical records. Physician employees will also be allowed access to the medical records of their supervising physician. The above guidelines apply to both paper and electronic medical records.
- 30 All Ordering Practitioners must identify themselves and their credentials when talking over the phone with Covenant Medical Center/Lakeside and Covenant

Children’s Hospital employees regarding orders. Covenant Medical Center/Lakeside and Covenant Children’s Hospital employees must include the credentials of the person giving the order when transcribing verbal or telephone orders. Example: V.O. Jane Jackson, N.P.

- 31 A Medical Staff Member may have access to a patient's medical records without patient authorization when:
- a) The physician is currently involved in the care and treatment of the patient (Texas Senate Bill 667; 1996).
 - b) Legal action is pending between the patient whose record is being requested and the physician requesting the record Section 159.003, Texas Occupations Code.
 - c) Review of the medical record is used for Board approved peer or quality review or research.
 - d) An employee or agent of the Hospital may have access to medical records only as a function of patient care or as a review function, subject to the authorization of the President. Federal and state review agencies and the Joint Commission on the Accreditation of Healthcare Organizations may be authorized to review medical records subject to the policies of the President.
 - c) The Hospital chart may not be reviewed by a Medical Staff Member in conjunction with physicians of other hospitals or other medical care institutions. A case presentation without chart review is permissible if the patient's identity cannot be determined.

ARTICLE XIII – Review, Adoption, and Amendment

Section 1. Medical Staff Responsibility

The Medical Staff will have the responsibility to formulate, review annually, adopt, and recommend to the Board Medical Staff Bylaws and amendments thereto, which will be effective when approved by the Board. An annual review process includes the review, adoption, and amendment of the related Rules and Regulations developed to implement various sections of these Bylaws.

Section 2. Adoption and Amendment

- 1. These Bylaws may be amended by a two-thirds (2/3) majority vote of the voting Active Medical Staff. Amendments and ballots will be distributed to eligible voting Active Staff Members, following which such Members will return ballots within thirty (30) days of the date ballots are distributed to Members.

2. Upon receipt of a petition signed by at least ten percent (10%) of the Active Medical Staff Members eligible to vote, the Medical Executive Committee will call a general Medical Staff meeting for the purpose of voting on any proposed amendment(s) specified in the petition. Approval of amendments will require a two-thirds (2/3) majority of the voting Active Medical Staff.
3. Amendments approved by either method described in paragraphs 1 and 2 hereof will become effective when approved by the Board. The Medical Staff Bylaws, Rules and Regulations are not unilaterally amended.
4. The Medical Staff Bylaws, Rules and Regulations, and Policies and the Governing Body Bylaws do not conflict.

Section 3. Rules and Regulations of the Medical Staff

The Medical Executive Committee will recommend to the Board related Rules and Regulations to supplement these Bylaws. Such Rules and Regulations will include, but are not limited to, credentialing, a fair hearing plan, and organization. Upon adoption by the Board, these documents will be incorporated by reference herein and become a part of these Bylaws. All substantive proposed changes to the Rules and Regulations will be distributed to the Medical Staff thirty (30) days in advance of the Medical Executive Committee’s anticipated action. Written comments may be forwarded to the Medical Executive Committee. Any amendments to the Rules and Regulations will be approved by the Medical Executive Committee and the Board.