

Covenant Children’s Hospital Medical Staff Rules and Regulations

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For the purposes of these Rules and Regulations, capitalized terms shall have the same meaning as defined in the Medical Staff Bylaws.

Section 1 Credentialing

1 Application Eligibility

An application for appointment to the Medical Staff and/or for clinical privileges will be provided to an Inquirer who meets the following eligibility criteria:

- a) Graduate of an approved medical, osteopathic, dental or podiatry school;
- b) Licensed to practice medicine, dentistry, or podiatry in the State of Texas (or New Mexico, for Practitioners in New Mexico sites, including Community Health Outreach Children's Dental Clinical practitioners in New Mexico). A Practitioner holding a Faculty Temporary License may only apply to sections in which there is a current residency affiliation agreement between Covenant Health System and the Texas Tech University Health Sciences Center;
- c) Is certified by or has completed the training requirements for Specialty Board certification by a Specialty Board as defined in the Medical Staff Bylaws. A general dentist must have successfully completed a one-year ADA approved (hospital based) general practice residency. This requirement does not apply to general dentists whose privileges will be limited to the mobile dentistry unit. A podiatrist must have successfully completed a two year surgical podiatric residency;
- d) Practices a specialty which has not been closed by the Board; and
- e) An Inquirer will be notified if he does not meet the eligibility criteria. Failure to meet such criteria will not entitle the Inquirer to any procedural rights under the Fair Hearing Plan except as related to nondiscrimination as set forth in Article III, Section 3, of the Medical Staff Bylaws.

2 Application Process

- a) *Form:* The application will be approved by the Medical Executive Committee and will, at a minimum, require the applicant to provide or disclose the following:
 - i) The Applicant's professional qualifications, including all degrees granted, programs completed, and Specialty or Subspecialty Board certification or

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recertification;

- ii) An accounting of all time periods from the beginning of medical school;
- iii) Licensure and narcotic/controlled substances registrations, if applicable, including evidence of current state licensure. A Practitioner holding a Faculty Temporary License (applying to sections in which there is a current residency affiliation agreement between Covenant Health System and the Texas Tech University Health Sciences Center) may utilize the TTUHSC Institutional DPS and DEA registration(s);
- iv) Professional liability insurance of at least \$200,000 per occurrence and \$600,000 aggregate, including the names of the present insurance carrier and all previous insurance carriers for the past five years;
- v) Professional liability action involving the Applicant (for the past ten years and all final judgments or settlements);
- vi) The Applicant's voluntary resignation or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or any such action which may be pending;
- vii) Whether the Applicant's membership in local, state, or national professional societies or license to practice any profession in any jurisdiction, or narcotic/controlled substances registration has ever been the subject of pending or completed action involving denial, revocation, suspension, termination, reduction, limitation, probation, nonrenewable, or voluntary relinquishment;
- viii) Whether any current felony criminal charges are pending against the Applicant and whether there have been any past charges, including their resolution;
- ix) Details of any prior or pending government agency or third party payer proceeding or litigation challenging or sanctioning the Applicant's patient admission, treatment, discharge, charging, correction, or utilization practices, including, but not limited to, Medicare and/or Medicaid fraud and abuse proceedings and convictions;

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- x) Complete names and addresses of all institutional affiliations since completion of postgraduate education, including all hospitals, corporations, military assignments, or government agencies; and
 - xi) Complete names and addresses of three (3) peer references who have reasonably current experience in observing and working with the Applicant over a reasonable period of time, and who can provide reliable information regarding current clinical competence, professional qualifications, ethical character, and ability to work with others.
- b) *Applicant's Responsibilities:* The Applicant shall have the burden of providing a completed application. Upon conditional offer of Medical Staff Membership, the applicant shall also have the burden to produce adequate information for proper evaluation of his current competence, character, ethics, and other qualifications, for resolving any questions or doubts about such qualifications, and for supplying additional information or clarification as requested. In addition, the practitioner will be required to have a photograph identification badge made by the Human Resources department at Covenant Medical Center. The practitioner's badge or other form of identification shall be worn/available at all times when attending patients on hospital property.
- i) *Receipt of an application:* An application will not be deemed complete nor finally received until: all references, licensures, education, and qualifications have been verified; applicable forms are fully answered, signed and dated; and all additional information has been provided which might be requested by Medical Staff Services.
 - ii) An Applicant's misrepresentation or omission will be cause for rejection of the application, or corrective action if the misrepresentation or omission is discovered at a later date.
 - iii) The applicant may be notified that the application will expire and become void, and no further processing will take place, if the Applicant fails to provide requested information within forty-five (45) days of a documented request.
- c) *Applicant's Attestations:* By applying for appointment to the Medical Staff, each Applicant thereby:

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- i) Signifies his willingness to appear for interviews in regard to the application;
- ii) Authorizes the Hospital to consult with members of the medical staff of other hospitals with which the Applicant has been associated and with others who may have information bearing on pertinent aspects of his application;
- iii) Consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his: professional qualifications and competence to carry out the clinical privileges requested; and professional and ethical qualifications; all records and documents that may be material to his physical and mental health status as they relate to the Applicant's ability to exercise requested clinical privileges;
- iv) Releases from any liability the Hospital and all of its representatives, including its Medical Staff, for their acts performed in good faith and without malice in connection with processing the application and evaluating the Applicant and his credentials;
- v) Releases from any liability all individuals and organizations who provide information to Hospital representatives, in good faith and without malice, concerning his competence, character, ethics, physical and mental health, emotional stability, and other information regarding qualifications for Medical Staff appointment and clinical privileges, including information which may be otherwise privileged or confidential;
- vi) Agrees to promptly notify Medical Staff Services within seven (7) days of the revocation or suspension of his professional license by any state, of his loss of staff membership or privileges at any hospital or other health care institution, or the entry of a judgment against the Applicant based upon a malpractice cause of action; and proceedings, investigation, litigation or sanctioning by governmental agency or third-party payor; any felony criminal charge; and
- vii) Signifies that he has received the Bylaws, Rules and Regulations of the Medical Staff and agrees to be bound by the terms thereof in all matters relating to consideration of his application, without regard to whether the Applicant is admitted to membership, receives privileges, and regardless of the

category of membership.

- viii) The consents, authorizations, releases, rights, privileges, and immunities which are applicable to application for initial appointment shall also be applicable to application for reappointment, additional privileges, and change in status or category.
- d) *Submission of Application:* The Applicant will submit the application, fully answered, and accompanying materials to Medical Staff Services.
- e) *Verification:* Medical Staff Services will collect pertinent documentation and verify information about the Applicant's licensure, specific training, experience, felony criminal charges, if any, and current competence with information from the primary source(s) whenever feasible. Upon completion of the verification process, the file, or a summary of the Applicant's file, will be presented to the applicable Department Chair for review.
- f) *Interview:* The Applicant may be notified to schedule a personal interview if requested by the Department Chair or the Credentials Committee. In the event of such an interview, the results will be documented in the Applicant's file by the individual conducting the interview.
- g) *Department Chair Review:* The Department Chair, or his designee, with the advice of the Section Chief, as needed, will review the application file, and all related materials, with consideration of the Applicant's qualifications for Medical Staff membership and the clinical privileges requested. The Credentials Chair will forward credentials file to the Credential Committee within twenty-one (21) days of receipt of the completed file.. In the event that the Department Chair is unable to properly evaluate the application, the Department Chair will inform the Credentials Committee.
- h) *Expedited Review:* On receipt of the completed Applicant's file and the findings of the Department Chair, the Credentials Committee Chairman will review the file. If there are no questionable issues or adverse actions documented in the application file, the Credentials Committee may recommend approval of the application by expedited review to the Medical Executive Committee. In such expedited review, the Medical Executive Committee will review the file and may recommend approval of the application to the Quality and Patient Safety Committee of the Board of Directors. The Applicant's file will be submitted for review by the two

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members of the Quality and Patient Safety Committee of the Board of Directors; the Chairman of the Quality and Patient Safety Committee of the Board of Directors, as the designated representative of that committee, and one additional member of the Quality and Patient Safety Committee of the Board of Directors who is a voting member of the Board. Chief of Staff will review and sign the approved credential file.

The reviewers will give consideration to the Applicant's licensure, current competence, training, experience, and ethics, and make recommendations concerning Medical Staff category and clinical privileges.

- i) If the Quality and Patient Safety Committee of the Board of Directors recommends approval; the Applicant's file will be submitted for review by the Chairman of the Board or his designee.
- ii) Approval by the Chairman of the Board, or his designee, result in an offer of Medical Staff Membership conditional upon the Applicant's showing that he does not have a condition which would represent a significant current risk of substantial harm to his patients and/or others, or that if the practitioner does have such a condition, this risk could be reduced or eliminated by reasonable accommodation. Such an offer will include a designation of the Department assignment, category of membership, and the clinical privileges the Applicant may exercise.
- iii) If approved, the President shall notify Medical Staff Services and the practitioner.
- iv) In the absence of a positive recommendation by any of the above Medical Staff or Board representatives, the application will reviewed in accordance with the Standard Review process.
- v) An Applicant is ineligible for the expedited process if at the time of appointment, or if since the time of reappointment, any of the following has occurred:
 1. Applicant submits an incomplete application;
 2. There is a current challenge or a previously successful challenge to licensure or registration;

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3. The Applicant has voluntarily resigned or been involuntarily terminated from medical staff membership at another organization;
 4. The Applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges;
 5. The Applicant has had three or more professional liability suits or any single settlement of greater than \$500,000; however, if any one or more suits have been dismissed without payment, the Applicant may be eligible for expedited review in the absence of any of the other reasons for ineligibility as outlined in this section;
 6. There has been a final judgment adverse to the Applicant in a professional liability action; or
 7. Information is present that suggests the Applicant may not meet the quality and /or ethical standards of the Medical Staff.
 8. The Applicant has been convicted of or pleaded guilty or nolo contendere to a felony.
- i) *Standard Review*: An Applicant's file that is not recommended for expedited review will require review by each of the following committees at their next regular meetings to examine the evidence of the Applicant's current competence, licensure, training, experience, and ethics to evaluate his qualifications for the Medical Staff category and the clinical privileges requested:
- i) The Credentials Committee shall take action on the completed application no later than ninety (90) days after the date on which the completed Applicant's file is finally received by the Credentials Committee, and its findings and recommendations will be forwarded to the Medical Executive Committee. Action may include a recommendation for approval, recommendation for disapproval, or decision to further investigate.
 - ii) The Medical Executive Committee will act upon receipt of an Applicant's file and recommendations from the Credentials Committee with-in 60 days.
 - (1) A recommendation will be forwarded to the Board at its next regular meeting.

- (2) An adverse recommendation will entitle the Applicant to the hearing rights provided in the Fair Hearing Plan of these Rules and Regulations. No such adverse recommendation will be forwarded to the Board until after the Applicant has exercised or has been deemed to have waived his procedural rights provided in the Fair Hearing Plan.
 - (3) The Medical Executive Committee may request additional information from various Committees and from the Applicant before it makes a recommendation to the Board.
- j) *Board Review:* For any file not approved by the Expedited Review Process, the Quality and Patient Safety Committee of the Board of Directors will review the file at its next regularly scheduled meeting and will make recommendations to the Board. The Board will act no later than sixty (60) days after date on which the recommendation of the Quality and Patient Safety Committee of the Board of Directors is received. The Board will review a list of files approved by Expedited Review at its next regularly scheduled meeting.
- i) After considering the Applicant's file, the Board shall either:
 - (1) Make an offer of membership; or
 - (2) Make an adverse recommendation.
 - (a) If the Applicant has had a hearing or has waived his procedural rights and the Board's recommendation is adverse, the Board's decision will be final.
 - (b) If the Applicant has not had a hearing, has not waived his procedural rights, and the Board's recommendation is adverse, the Applicant will be afforded the right to a hearing as provided in the Fair Hearing Plan.
 - (c) At its next regular meeting after an Applicant's rights under the Fair Hearing Plan have been exhausted or waived, the Board will act on the matter. A decision to appoint will include a designation of the Department assignment, category of membership, and the clinical privileges the Applicant may exercise.

- (3) The President shall notify the Applicant, in writing, of the Board's final action, including the reason(s) for denial or restriction of privileges, not later than the twentieth (20th) day after the date on which final action is taken.

3 Reapplication Following Adverse Decision

- a) An Applicant who has received a final adverse credentialing decision regarding appointment, reappointment, or the denial, termination, or restriction of clinical privileges will not be eligible to reapply for membership or for the privileges in question for a period of two (2) years following the final adverse decision.
- b) Prior to receiving an application for appointment to the Medical Staff, following a final adverse decision, the Inquirer must submit evidence sufficient to demonstrate that the basis for the prior adverse action no longer exists. After having satisfied the Board, or its appointed committee, that the basis for the earlier action no longer exists, then such Inquirer will be furnished with an application, and the reapplication will be processed as an initial application. If there is litigation pending between the practitioner and the Hospital involving the Applicant's credentials or other Medical Staff matters, the practitioner will be ineligible to receive a Medical Staff application.

4 Provisional Status

- a) All initial appointments and privileges will be provisional for a period of one (1) year.
- b) At the end of one year, the Credentials Committee Chairman will evaluate the Member's eligibility for release from provisional status and will include consideration of the following without limitation:
 - i) A quality review profile obtained from the Quality Management Department;
 - ii) Any observation information available; and
 - iii) Any other pertinent information available or requested by the Credentials

Committee Chairman.

- c) The Chairman of the Credentials Committee will review the supporting documentation and may recommend the Member's release from provisional status utilizing the expedited review provided in Item 2.i. of this Section.
- d) If a request for release from provisional status is not recommended for approval by expedited review, the request will be considered utilizing the Standard Review process described in Item 2.j. of this Section.
- e) Provisional status may be extended for one (1) additional year if there is insufficient information available for the Member's release from provisional status.
- f) Denial of a Member's release from provisional status will result in termination of his Medical Staff membership and privileges. A Practitioner whose membership and privileges are so terminated will be entitled to the procedural rights provided in the Fair Hearing Plan.

5 Reappointment

- a) All appointments, except provisional, are for a period not to exceed two years. Appointments will expire on the last day of the month in which the Member's birthday occurs.
- b) The reappointment of a Medical Staff or Allied Health Staff Member and the category and clinical privileges to be granted upon reappointment will be based upon consideration of all pertinent information, including but not limited to the following:
 - i) The Applicant's current state licensure;
 - ii) The Applicant's professional performance, current competence, and judgment, as indicated in part by the results of quality review activities;
 - iii) The Applicant's clinical and/or technical skills, as indicated in part by the results of quality review activities;

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- iv) Continuing medical or professional education which relates at least in part to the clinical privileges requested;
 - v) Previously successful or currently pending challenges to any licensures or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration;
 - vi) Involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges or provider status at any health care entity; or proceedings, investigation, litigation or sanctioning by governmental agency or third-party payor; any felony criminal charges since the last reappointment, including their resolution; and
 - vii) Any involvement in a professional liability action since the last reappointment, including, but not limited to, final judgments or settlements involving the Applicant;
 - viii) The Applicant's ethics and conduct;
 - ix) The Applicant's compliance with the Hospital Bylaws and the Bylaws, Rules, and Regulations of the Medical Staff;
 - x) The Applicant's maintenance of professional liability insurance in the required amount; and
 - xi) The Applicant's volume of professional activity in the Hospital, and his professional relationships with other Staff Members and Hospital employees.
 - xii) Two peer recommendations are required when sufficient practitioner specific data is not available.
- c) *Submission of Reappointment Application:* At least ninety (90) days prior to the end of the Member's appointment period, the Member will submit a written application to Medical Staff Services and specifically request the Medical Staff category, and clinical privileges sought. Failure without good cause to timely return such application, fee, and all information required for assessment of his current competence, qualifications, and eligibility for reappointment will constitute a resignation of Staff membership at the expiration of the Member's current term. Although all privileges will terminate upon such resignation, if the Member

submits a complete application for reappointment within ninety days of such resignation, the complete application for reappointment will be processed as a reappointment application in accordance with these Rules and Regulations. However, privileges will be reinstated only after processing and final approval of the reappointment application. Any practitioner requesting privileges more than ninety (90) days following resignation will be deemed an Inquirer.

- d) *Verification:* Upon receipt of the application for reappointment, Medical Staff Services will verify pertinent information as described in 2.f. of these Rules and Regulations and will obtain a quality profile and any other information relevant to the Member's application.
- e) *Review:* Upon completion of the verification process, the reappointment application will be submitted to the Credentials Committee Chairman for review and evaluation. The Credentials Committee Chairman's assessment will be forwarded with the reappointment application for review in accordance with Item 2.g-j. of this Section.

6 Clinical Privileges

- a) Every Practitioner practicing at the Hospital by virtue of Medical Staff membership or otherwise, shall in connection with such practice, be entitled to exercise only those clinical privileges granted to him by the Board.
- b) Every application for Medical Staff or Allied Health Staff appointment and reappointment must contain a request for the clinical privileges desired by the Applicant. The evaluation of such requests will be based upon the following verified information:
 - i) The Applicant's current state licensure;
 - ii) The Applicant's education, training, and experience;
 - iii) The Applicant's demonstrated current competence and references;
 - iv) The Applicant's ability to perform the privileges requested;
 - v) Professional liability action involving the Applicant (for the past five years

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and all final judgments or settlements);

- vi) Previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration;
 - vii) Involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges or provider status at any health care entity;
 - viii) Other relevant information, including an appraisal by the Department Chair of the Department in which privileges are sought; and
 - ix) Quality assessment and improvement activities and/or peer references when appropriate.
 - x) Any felony criminal charges since the last reappointment, including their resolution
- c) The Applicant shall have the burden of establishing his qualifications for and competence to exercise the clinical privileges requested.
 - d) Applications for clinical privileges will be processed in the same manner as applications for appointment and reappointment.
 - e) Each clinical department will make recommendations to the Credentials and Medical Executive Committees regarding professional criteria for clinical privileges. The Department Chair may elicit the input of the appropriate sections.
 - f) Criteria for granting privileges that cross specialty lines will be consistent for all specialties. Such criteria will be developed with input from representatives of all involved specialties and recommended to the Credentials and Medical Executive Committees.
 - g) Practitioners requesting privileges to supervise physician assistants and nurse practitioners must accept the standards of practice outlined by the Texas State Board of Medicine Examiners for Physician Assistants and the Board of Nurse Examiners for Nurse Practitioners and at reappointment demonstrate competence

in the ability to supervise the Physician Assistant or Nurse Practitioner.

- h) As new procedures emerge, the Department Chair, with input from all applicable specialties, will provide recommendations concerning the following issues to the Credentials Committee:
 - i) The clinical validity of the procedure;
 - ii) Whether the new procedure differs from existing privileges to the extent that additional privileges should be required;
 - iii) The criteria for training and experience for granting privileges to perform the procedure, when additional privileges are recommended.
 - iv) No individual may be considered for additional privileges for a new procedure until the Credentials Committee has received the above recommendations from the Department Chair and has adopted criteria for granting such privileges.

7 Change of Staff Status or Category

- a) A Member may request modification of his staff category or Department assignment by submitting a written request to Medical Staff Services. Such requests will be processed in substantially the same manner as provided in Item 2.g-j. of this Section.

8 Determination of Active or Courtesy Category

- a) Patient contacts will be monitored for Members of the Active Medical Staff at the time of reappointment. Failure to participate in the care of at least twelve (12) Hospital patients per year will result in automatic transfer to Courtesy Medical Staff Category unless the requirement is expressly waived by the Board.
- b) Patients will be monitored for Members of the Courtesy Medical Staff and Faculty Medical Staff, Consultative Category. Upon verification that such a Member has reached the maximum allowable patients in a staff year, his privileges will automatically convert to Active Medical Staff or Faculty

Medical Staff Active Category.

9 Leave of Absence

- a) A leave of absence from the Medical Staff without loss of Medical Staff membership will be limited to a period of up to one year. Under special circumstances a leave of absence may be extended for an additional year following approval of the Medical Executive Committee and the Board. Further extensions may be granted by the Board only for a Practitioner on active military duty.
- b) A leave of absence is ordinarily granted for reasons of health, military service, or further education. Written request for a leave of absence will be forwarded to the Chief of Staff with a copy to the President. Each request for leave of absence will be evaluated on an individual basis by the Medical Executive Committee, with final decision by the Board. No decision on a leave of absence will be subject to a review or give rise to a right to any hearing.
- c) While on leave of absence, the Practitioner's privileges and prerogatives will be suspended.
- d) Upon return from leave of absence, the Practitioner must submit a written request for reinstatement with a summary of his activities during the leave and any additional information that may be requested by the Medical Executive Committee. Following a leave of absence for reasons of health, the Practitioner will also provide documentation of his physical and mental ability to practice the privileges requested.

10 Definition and Monitoring of Clinical Involvement with a Patient

- a) For the purposes of the Medical Staff Bylaws, Article IV, Categories, clinical involvement with a patient is defined as the following:
 - i) Admissions including observation, outpatient surgery, and cancer center;
 - ii) Procedures or operations;
 - iii) Assisting in operations;

- iv) Consultations;
- v) Writing progress notes;
- vi) Verbal or written physician's orders on inpatients, observation patients, outpatient surgery patients, or cancer center patients;
- vii) Interpretations (as applied to radiographic, pathologic, or other ancillary tests); and
- viii) Personally attending patients in the emergency room.

When a physician is notified of a patient's admission only for courtesy reasons, this does not constitute clinical involvement with a patient.

11 Temporary Privileges

- a) Upon receipt of a fully answered application, Temporary privileges for new applicants may be granted while awaiting review and approval by the Board upon verification of the following: all required references, current licensure, current DEA, current DPS, relevant training or experience, current competence, ability to perform the privileges requested, NPDB response, complete application, no current or previously successful challenge to licensure or registration, no subjection to involuntary termination of medical staff membership at another organization, no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges. The President or his designee, with input from the Chief of Staff, Department Chair, Credentials Committee, and Chairman of the Quality and Patient Safety Committee of the Board of Directors may grant temporary privileges in one of the following circumstances:
 - i) *To Treat Specific Patients:* Privileges may be granted to an appropriately licensed Applicant who desires to provide services to one or more specified patients. Such privileges may be granted for a period of up to thirty (30) days (subject to renewal for successive periods of up to thirty (30) days) but in no event for longer than the period during which such patients are receiving services at the Hospital.
 - ii) *During Locum Tenens:* Privileges may be granted to an Applicant

who meets the general eligibility requirements for Medical Staff membership, with the exception of requirement for primary residency in Lubbock County, who is serving as Locum Tenens for a Medical Staff Member who desires to provide services to the patients customarily served by the absent Member, when such Member is the sole provider of his specialty in his service area or otherwise unable to arrange appropriate coverage of his patients due to unresolvable circumstances as determined by the Medical Executive Committee. In an emergency situation, the Chief of Staff may determine the appropriate need for Locum Tenens pending final approval by the Medical Executive Committee at its next regular meeting. Locum Tenens privileges may be granted for a period of up to thirty (30) days (subject to renewal for successive periods of up to thirty (30) days but in no event for longer than the period of the Locum Tenens. Locum Tenens must apply for Provisional Staff Status if aggregate time exceeds 120 days in a given year.

iii) *To provide coverage in a hospital-based specialty:* Privileges may be granted to an Applicant who meets the general eligibility requirements for Medical Staff membership and who desires to serve as a member of a hospital-based specialty Section (the Sections of Radiology, Pathology, Anesthesiology, Emergency Medicine, Urgent Care, Neonatology, and Pediatric Intensivists) in order to provide coverage on a temporary basis, if the Section is inadequately staffed. The Chief of Staff, in consultation with the Section Chief, shall make a determination of the need for the Applicant's services, pending final approval by the Medical Staff Executive Committee at its next regularly scheduled meeting. These privileges may be granted for a period of up to ninety (90) days, subject to renewal for successive periods of up to ninety (90) days each, but in no event for a period longer than 120 days.

iv) *To fulfill an important patient care, treatment, and/or service need:* Privileges may be granted to an Applicant who meets the general eligibility requirements for Medical Staff membership in order to provide coverage on a temporary basis to fulfill an important patient care, treatment, and/or service need. The Chief of Staff, in consultation with the appropriate Department Chair and Chief Medical Officer, shall make a determination of the need for the Applicant's services, pending final approval by the Medical Executive Committee at its next regularly

scheduled meeting. These privileges may be granted for a period of no more than (120) days.

- v) *To provide continuity of care for patients of regional physicians.* Regional physicians must be in good standing on the active staff at a managed, leased or affiliated hospital of the Covenant Health System. Regional physicians may participate in the care of patients at Covenant Medical Center with the permission of the Attending Physician. Regional physicians may not admit or discharge patients. Regional physicians must be credentialed by Covenant Medical Center.

The Credentials Committee based on demonstration of training and competency may recommend limited privileges to the Governing Board. Additionally, privileges may be granted to the regional physicians who meet the general eligibility requirements for Medical Staff membership (Section 1. Rules and Regulations), with the exception of the requirements for primary residency in the Lubbock County. Regional physicians must be licensed to practice medicine in the state of Texas and must have current professional liability coverage (\$200,000-\$600,000) for procedures and medical care performed in Texas. It will be the responsibility of the supervising physician to document the participation and completion of procedures or related information of regional physician.

Regional physicians may refer patients to the hospital for procedures and may also participate in the pre-procedure and post-procedure care of such patients while hospitalized as long as the Attending Physician is an active member of the Covenant Medical Center staff, in the same specialty, with the same privileges and in good standing with Covenant Medical Center.

These Temporary Privileges may be granted for specific patients for periods of up to 60 days, subject to renewal for successive periods of 60 days, not to exceed 120 days.

- b) The awarding of Temporary Privileges is a wholly discretionary power to be exercised only when the fully completed application provides proof of the Applicant's licensure and professional liability insurance coverage, and only to provide an adequate basis for a tentative judgment concerning the competence, reliability, ethical standing, and other qualifications of the Applicant.

- c) The privileges requested may be awarded in part or in whole, shall be exercised under the supervision of the Chief of Staff, and may be subject to other special requirements of supervision and/or reporting.
- d) The Applicant acknowledges that he has been informed of the Medical Staff Bylaws and these Rules, and Regulations and agrees to abide by them.
- e) Refusal of the President to award Temporary Privileges shall not give rise to any right of review.
- f) After consideration of the advice of the Medical Executive Committee, or Chief of Staff, the President may summarily revoke the Temporary Privileges upon discovery of any fact or event which casts a reasonable doubt upon the Practitioner's adherence to the conditions governing his Temporary Privileges. This action of revocation shall not give rise to any right of review or any other right or other procedural process. If the revocation occurs, the Chief of Staff will assign to another Practitioner the responsibility for the care of patients affected by this action until they are discharged from the Hospital.

12 Disaster Privileges

The President, his designee, or the Chief of Staff may grant disaster privileges When the Emergency Management Plan has been implemented and the Medical Staff is unable to handle the immediate patient needs. This will ensure a mechanism for physicians, affiliate health staff, and allied health staff, who are not members of the Covenant Medical Center/Lakeside Staff nor possess Covenant Medical Center/Lakeside privileges, to be allowed to work at Covenant Medical Center/Lakeside during a "disaster".

When the Emergency Management Plan is no longer needed, all disaster privileges will immediately terminate. The patient shall be assigned to an appropriate member of the Medical Staff.

- a) At a minimum, a volunteer practitioner to be considered eligible to act as licensed independent practitioner must provide a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

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- 1) Current hospital photo card
- 2) Current license with valid photo ID issued by a state, federal, or regulatory agency
- 3) Current ID that certifies the physician is a member of a state or federal disaster medical assistance team
- 4) Presentation by a current hospital or medical staff member who can vouch for the physician's identity.

The verification process of the credentials and privileges of individuals who receive disaster privileges, including primary source verification of licensure, will begin as soon as the immediate situation is under control. This privileging process is identical to the process established under the medical staff bylaws for granting temporary privileges to fulfill an important patient care need. The disaster privileges will terminate as soon as the emergency management plan has been deactivated.

In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required timeframe; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

- b) Oversight of these physicians will be provided by the Chief of Staff, Medical Staff Officers, Department Chairs, or Section Chiefs to assure appropriate medical care is provided to patients. The oversight of professional performance of volunteer practitioners who receive disaster privileges will consist of direct observation, monitoring, and clinical record review. The Medical Staff Officers will make the decision to continue the disaster privileges every 72 hours.

13 Emergency Privileges

- a) In an emergency situation, any Member, to the degree permitted by his license and without any of the limitations imposed by these Rules and Regulations, may do all within his capabilities to advance the best interests of the patient, using every facility of the Hospital necessary, including calling for any consultation necessary

or desirable.

When an emergency situation no longer exists, such Member must request the privileges necessary to continue to treat the patient if desired. In the event such privileges are denied or he does not desire to request such privileges, the patient will be assigned to an appropriate Member of the Medical Staff.

- b) For the purposes of this Section, an emergency is defined as a condition in which serious or permanent harm would result to a patient or in which the life or limb of a patient is in immediate danger and any delay in administering treatment would add to that danger.
- c) A Member utilizing emergency privileges must subsequently provide a written report to the Chief of Staff delineating the circumstances of the emergency.

14 Telemedicine Privileges

- a) Telemedicine is the practice of medicine at the Hospital by a person who is physically located outside the Hospital and, through the use of any medium, including an electronic medium, performs an act that is part of a patient care service initiated at the Hospital, including the reading of an x-ray examination, that would affect the diagnosis or treatment of the patient.

A physician who provides telemedicine services to a Hospital patient must have privileges as a member of an appropriate category of the Medical Staff.

- b) A physician who provides telemedicine services to a Hospital patient must be licensed to practice medicine in the State of Texas and must meet all other qualifications for membership on the Medical Staff, with the exception of requirement for primary residency in Lubbock County and DPS Registration.

15 House Staff

- a) The House Staff will consist of residents and fellows appointed to the Texas Tech University Health Sciences Center School of Medicine.
- b) Resident and Fellows will be under the direct supervision of the supervising/admitting/attending physician and will have privileges consistent with their current level of residency training and limited to the delineated privileges of supervising/admitting/attending physician. While performing patient care

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responsibilities, Residents and Fellows will, at all times, be under direct supervision of the Active Faculty, Faculty Instructional or Active Staff members who are licensed, independent practitioners with appropriate hospital privileges including the privilege to supervise Residents and/or Fellows. The supervising/admitting/attending physician must countersign the history, physical examination, discharge summary, and all orders when recorded by a member of the House Staff. Medical Staff members may write patient care orders on patients who are cared for in part by a resident or fellow. Departmental assignment, privileges, prerogatives, responsibilities and all other matters relating to each House Staff practitioner shall be governed by the policies of the Hospital, the Medical Staff Bylaws, these Rules and Regulations, all contractual agreements with Covenant Health System, and by the affiliation agreement between the Hospital and the Texas Tech University Health Sciences School of Medicine

- c) Members of the House Staff shall not be eligible to admit, vote, or hold office in the Medical Staff organization. The activities of the House Staff shall be included in the review and evaluation of the quality of clinical care. Problems identified as a result of this review and evaluation will be the responsibility of the supervising physician of the House Staff member. Responsibilities delegated by the medical staff to residents and fellows are consistent with the educational and experiential levels of the individual intern, resident, or fellow as described in the House Staff procedure manual.
- d) Failure of a member of the House Staff to perform his assigned duties or to abide by applicable procedures of the Medical Staff Bylaws, or the Rules and Regulations shall be reported to the House Staff practitioner's supervising physician, the Director of Medical Education or the Chief of Staff for appropriate action.
- e) Malpractice insurance for the House Staff will be provided for by the TTUHSC Professional Malpractice Self-Insurance Plan in accordance with the affiliation agreement between TTUHSC School of Medicine and Covenant Health System pertaining to House Staff rotation to participating institution (Covenant).

16 Covenant Fellowships

- a) Covenant Fellows will be participants in a Covenant Health System fellowship that is not affiliated with Texas Tech University Health Sciences Center. These fellows shall be of 12 month duration and can be renewed.

- b) These fellows may be regional physicians must be in good standing on the active staff at a managed, leased or affiliated hospital of the Covenant Health System. Regional physicians may participate in the care of patients at Covenant Medical Center with the permission of the Attending Physician. Regional physicians may not admit or discharge patients. Regional physicians must be credentialed by Covenant Medical Center.

The Credentials Committee based on demonstration of training and competency may recommend limited privileges to the Governing Board. Additionally, privileges may be granted to the regional physicians who meet the general eligibility requirements for Medical Staff membership (Section 1. Rules and Regulations), with the exception of the requirements for primary residency in the Lubbock County. Regional physicians must be licensed to practice medicine in the state of Texas and must have current professional liability coverage (\$200,000-\$600,000) for procedures and medical care performed in Texas. It will be the responsibility of the supervising physician to document the participation and completion of procedures or related information of regional physician.

Regional physicians may refer patients to the hospital for procedures and may also participate in the pre-procedure and post-procedure care of such patients while hospitalized as long as the Attending Physician is an active member of the Covenant Medical Center staff, in the same specialty, with the same privileges and in good standing with Covenant Medical Center. If requested, regional physicians can see additional patients of the Attending Physician as well.

- c) Departmental assignment, privileges, prerogatives, responsibilities, and all other matters relating to each Covenant Fellow shall be governed by the policies of the Hospital, the Medical Staff Bylaws, these Rules and Regulations, and all contractual agreements with Covenant Health System.
- d) Covenant Fellows shall not be eligible to vote or hold office in the Medical Staff organization, but may serve on committees at the discretion of the Chief of Staff.
- e) The activities of Covenant Fellows shall be included in the review and evaluation of the quality of clinical care in keeping with Hospital policies and these Rules and Regulations.

Section 2 Allied Health Professionals

1 Categories

- i) Allied Health Professionals are 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 Rules and Regulations. This category will include, but not be limited to the following and they will go through the Medical Staff credentialing process.
 - a) Audiologists;
 - b) Cardiovascular pump perfusionists;
 - c) Clinical psychologists;
 - d) Licensed professional counselors;
 - e) Marriage and family counselors;
 - f) Nurse practitioners/advanced nurse practitioners;
 - g) Orthotists;
 - h) Physician's assistants;
 - i) Prosthetists;
 - j) Psychiatric social workers;
 - k) Surgical first assistants

- ii) Affiliate Health Professionals – Physician Employees are under the direct supervision of the supervising physician to provide patient services through written duties and responsibilities approved by the Medical Staff. This category will include, but not be limited to the following and they will go through the Medical Staff and Human Resources Department process. The Affiliate Health Professionals shall not be entitled to the procedures set forth in the Fair Hearing Plan.
 - a) Registered Nurses;
 - (a) Licensed Vocational Nurses;
 - (b) Surgical Technicians;
 - (c) Medical Assistants;

2 Supervision

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- a) All Allied Health Professionals and Affiliate Health Professionals must operate under the supervision or direction of a licensed attending physician, dentist, or podiatrist with clinical privileges on the Medical Staff. Physician will execute an acknowledgement that he is completely responsible for all actions/procedures of his employee while at Covenant Medical Center/Lakeside.
- b) Nurse practitioners and physician's assistants must receive privileges for any activity that requires supervision and those privileges must also be held by their supervising physician.
- c) Nurse practitioners and physician's assistants may only be supervised by members of the medical staff who have specific privileges for supervision of the nurse practitioner or physician assistant.

3 Qualifications

- a) Allied Health Professionals must meet the following minimum criteria for the category for which they are applying:
 - i) Audiologists
 - (1) Documented verification of a M.A. degree in Audiology or certification by the American Speech/Language Association; and
 - (2) Documented verification of current Texas licensure in audiology.
 - ii) Cardiovascular Pump Perfusionists
 - (1) Board Certified by the American Board of Cardiovascular Perfusionists, and maintain same once granted; and
 - (2) Graduate of an accredited training program in open heart surgery with a thorough background in sterile technique, perfusion physiology, monitoring equipment, and a general understanding of the commonly performed cardiac surgical procedures.

- iii) Clinical Psychologists
 - (1) Documented verification of graduation from an accredited doctorate program in psychology;
 - (2) Documented verification of certification by the Texas Board of Examiners of Psychologists; and
 - (3) If the clinical psychologist is to operate an independent practice, documented verification of licensure for independent practice in the state of Texas.
- iv) Licensed Professional Counselors
 - (1) Documented verification of a graduate program in an accredited doctorate program; or Master's Degree clinical related field with current clinical membership in the American Association of Licensed Professional Counselors.
 - (2) Documented verification of licensure as a professional counselor.
- v) Marriage and Family Counselors
 - (1) Documented verification of a graduate program in an accredited doctorate program; or Master's Degree with current membership in the American Association of Family and Marriage Counselors.
 - (2) Documented verification of licensure as a marriage and family counselor.
- vi) Nurse Practitioners
 - (1) Documented verification of completion of a nurse practitioner program and completion of the requirements specified by the Texas State Board of Nurse Examiners or proof of current certification of the nurse practitioner in the appropriate area of practice by a national or state organization, whose certification examination has been recognized by the Texas State Board of Nurse Examiners.
 - (2) Documented verification of licensure as a nurse practitioner by the Texas

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State Board of Nurse Examiners.

(3) Current basic cardiopulmonary resuscitation certification.

vii) Orthotists

(1) Documentation of having met the eligibility criteria for certification by the American Board for Certification in Orthotics and Prosthetics or the Board for Orthotist Certification.

viii) Physician's Assistants

(1) Documented verification of licensure by the Texas Medical Board and certification by the National Commission on Certification of Physicians Assistants. Practitioners who have recently completed training and have not yet taken the certification examination will only be eligible for temporary privileges. Such temporary privileges may be advanced to standard privileges upon successful completion of the next certification examination offered by the Commission. Such temporary privileges will automatically terminate if the Practitioner does not satisfactorily complete the next certification examination offered.

(2) Current basic cardiopulmonary resuscitation certification.

ix) Prosthetists

(1) Documentation of having met the eligibility criteria for certification by the American Board for Certification in Orthotics and Prosthetics.

x) Psychiatric Social Workers

(1) Documented verification of licensure as a psychiatric social worker.

xi) Surgical First Assistants

(1) Graduate of accredited school of nursing or surgical technology;

(2) Documentation of nursing licensure if R.N. or L.V.N.;

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- (3) Documentation of current certification if a surgical technician;
 - (4) Current basic cardiopulmonary resuscitation certification; and
 - (5) Documentation of competency.
- xii) Other Qualifications for All Categories
- (1) Letter of recommendation from at least three references who know of the Applicant's professional experience and competence.
 - (2) Documented evidence of continuing education relative to the Applicant's area of specialty during the past two years.
 - (3) Documented evidence of professional liability insurance of at least \$200,000 per occurrence and \$600,000 aggregate.

4 Application

- a) An application for Allied Health Professional status and clinical privileges will be provided to an Allied Health Inquirer who meets the minimum eligibility criteria defined in Item 3 of this Section.
- b) Upon receipt of a completed application, Medical Staff Services will process the application in accordance with Section 1 of these Rules and Regulations.
- c) Terms of appointment will not exceed two years.
- d) Application for reappointment will be in accordance with Section 1 of these Rules and Regulations.

5 Assignment

- a) Each Allied Health Professional will be assigned to the Department appropriate to his occupational or professional training.
- b) Attendance at Department meetings will not be required.

6 Review of Nurse Practitioners (Advanced Practice Nurses)

The Chief Nursing Officer will review and make recommendations for approval for the initial appointment and reappointment of Nurse Practitioners.

Section 3 National Practitioner Data Bank

1 Federal and state law requires the hospital to report certain information to the National Practitioner Data Bank and to the Texas Medical Board. The Hospital designates Medical Staff Services to report to and query information from the National Practitioner Data Bank.

2 Reporting to the Data Bank

- a) The Hospital must report certain adverse actions it has taken against the clinical privileges of a physician or dentist. The following actions must be reported:
 - i) A professional review action that adversely affects a physician's or dentist's clinical privileges for a period longer than thirty (30) days. The term professional review action means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients) and which affects (or may affect) adversely the clinical privileges, or membership, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action.
 - ii) Acceptance of the surrender or restriction of clinical privileges while the physician or dentist is under investigation by the Hospital relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding.

- b) The Hospital may report such adverse actions when taken against the clinical privileges of health care practitioners other than physicians and dentists (e.g. physician assistants or nurse practitioners).
 - c) Adverse actions involving censures, reprimands, or admonishments will not be reported.
 - d) Reportable actions must be based on reasons relating to professional competence or professional conduct which affects or could adversely affect the health or welfare of a patient. Matters not related to the professional competence or professional conduct of a Practitioner will not be reported to the Data Bank.
- 3 Querying from the Data Bank
- a) The Hospital must request information from the Data Bank as follows:
 - i) At the time a physician, dentist, or other health care practitioner applies for membership on the Medical Staff or Allied Health Staff, or for clinical privileges at the Hospital.
 - ii) Every two years concerning any physician, dentist, or other health care practitioner who is a Member of the Medical Staff or Allied Health Staff, or has clinical privileges at the Hospital.
 - iii) At the time physician applies for additional privileges.
 - b) The Hospital may request information from the Data Bank as follows:
 - i) At any other time it deems necessary.
 - ii) With respect to professional review activity.

Section 4 Corrective Action

1 Types of Corrective Action

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- a) For purposes of corrective action, "practitioner" shall include physicians, dentists, podiatrists and Allied Health professionals.

- b) Adverse actions are those which involve a reduction, suspension, or revocation of a practitioner's clinical privileges, or a suspension or revocation of his Medical Staff membership. Adverse Actions shall constitute grounds for a hearing and shall entitle the Practitioner to the procedural rights provided in Section 5 of these Rules and Regulations. Adverse Actions are reportable under the Health Care Quality Improvement Act and the Texas Medical Practice Act where the Adverse Action adversely affects the clinical privileges of a physician for a period longer than thirty (30) days, if such action is based on professional competency or conduct:
 - i) Denial of Medical Staff Membership;
 - ii) Denial of requested advancement in Medical Staff Membership status or category;
 - iii) Denial of Medical Staff reappointment;
 - iv) Revocation of Medical Staff Membership and/or termination of clinical privileges;
 - v) Denial of requested clinical privileges;
 - vi) Involuntary reduction of current clinical privileges for a period of more than fourteen (14) days;
 - vii) Summary suspension of Medical Staff Membership and/or clinical privileges for a period of more than fourteen (14) days;
 - viii) Assignment to Medical Staff Member of a proctor/consultant who must grant approval before medical care is provided;
 - ix) Any professional review action or recommendation adversely affecting (as such term is defined in Section 11151 (1) of the Health Care Quality Improvement Act or as used in Section 151.001, et. seq., of the Texas Occupations Code, known as the Texas Medical

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Practice Act) any Applicant or Medical Staff Member;

- x) Denial or termination of clinical privileges due to a Practitioner's physical or mental health condition that poses a significant current risk of harm to his patients or to others, when such risks cannot be satisfactorily reduced or eliminated by reasonable accommodation.
- c) Non-adverse actions are those that do not entail a reduction, suspension, or revocation of the practitioner's clinical privileges except as otherwise specified in the Bylaws or Rules and Regulations. The following actions or recommended actions shall be deemed Non-Adverse Action, shall not constitute grounds for a hearing or entitle the Practitioner to the procedural rights provided in Section 5 of these Rules and Regulations, and shall not be reportable under the Health Care Quality Improvement Act or the Texas Medical Practice Act:
- i) Informal Counseling;
 - ii) Issuance of a letter of warning, admonition or reprimand;
 - iii) Imposing terms of probation or a requirement for consultation;
 - iv) Proctorship and/or supervision during a defined evaluative period, but approval by the proctor is not required before medical care is provided;
 - v) One hundred percent (100%) review of the Medical Staff Member's practice if the Member is permitted to make determinations about the patient's treatment course without the agreement of any consulting physician;
 - vi) Supervision of the Medical Staff Member's practice which requires concurrent review or frequent discussion with the supervising physician;
 - vii) Requirement of continuing education.
 - viii) Requirement that the Medical Staff member must obtain retraining in a particular specialty or procedure;

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- ix) Requirement that another physician be present during operative or invasive procedures;
- x) Placement on provisional status as a contingency of reappointment;
- xi) Appointment of an Investigatory Panel, or ad hoc committee;
- xii) Conducting a review or investigation into any matter;
- xiii) Formulation and presentation of any report of any ad hoc committee to the President, Chief of Staff, Medical Executive Committee, or Board;
- xiv) Requirement that the Medical Staff member must obtain retraining in a particular specialty or procedure;
- xv) Temporary suspension for a period of fourteen (14) days or less;
- xvi) Automatic suspensions for a period of fourteen (14) days or less imposed in accordance with Section 4.5.
- xvii) Making of a request or issuance of a directive to an Applicant or Medical Staff Member to appear at an interview or conference before the Credentials Committee, any ad hoc committee, an investigatory committee, the Medical Executive Committee, the Board, or any other professional review body in connection with any review or investigation prior to a proposed adverse recommendation or action;
- xviii) Denial of or refusal to accept a pre-application for initial appointment or application for reappointment to the Medical Staff (a) where the information is incomplete; (b) where the information reflects that the Applicant does not meet the minimum objective requirements for appointment or reappointment; or (c) where the Applicant is requesting clinical privileges in a Department, subspecialty or service in which the number of medical staff appointees has been limited in accordance with the Bylaws or Rules and Regulations;

- xix) Automatic termination of privileges and membership as provided by the Bylaws or these Rules and Regulations;
- xx) The following changes in medical staff classification: (a) a change from active staff to courtesy staff for failure to meet the patient care requirements set forth in the Bylaws or Rules and Regulations; or (b) any other change in category resulting from the failure of the Medical Staff Member to meet the minimum objective criteria for a specified category; or (c) any professional review recommendation or action not adversely affecting (as such term is defined in Section 11151 (1), of the Health Care Quality Improvement Act or as used in Section 151.001, et. seq., of the Texas Occupations Code, known as the Texas Medical Practice Act) any Applicant or Medical Staff member, or which is not based upon a subjective determination of the professional competency or conduct of the Applicant or Medical Staff Member.
- xxi) Accommodation for a mental or physical health condition to reduce or eliminate the risk that the Practitioner's condition will cause a substantial risk of harm to his patients or to others.
- xxii) Recommendation for termination of medical staff membership and privileges for suspension for delinquent medical records if the Medical Staff Member completes their medical records prior to the Quality and Patient Safety Committee of the Board of Directors meeting and acting on the Medical Executive Committee recommendation. If the Practitioner completes their delinquent medical records by 8:00 a.m. the day of the Quality and Patient Safety Committee of the Board of Directors meeting, the Medical Executive Committee action will be automatically rescinded.

2 Grounds for Corrective Action

- a) Corrective action may be initiated when there is reliable information that the character, professional, or ethical qualifications or conduct of a Medical Staff Member or Allied Health Professional would in reasonable probability adversely affect the patient care or the proper operation of the Hospital, and the grounds for

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such specifically include, but are not limited to:

- i) Failure to perform in accordance with accepted professional and clinical standards of medical, dental, or podiatric practice;
- ii) Serious or repeated breaches of professional ethics;
- iii) Material misrepresentations, falsehoods, or omissions in any application or other document used in connection with the evaluation of any request for or change in Medical Staff membership, category, or clinical privileges, regardless of when discovered;
- iv) Conviction of or plea of guilty or nolo contendere to any felony when such would reasonably be expected to have an adverse effect on the Member's fitness to care for patients or on the proper operation of the Hospital;
- v) Loss of professional licensure or other corrective or disciplinary action imposed by licensing authorities in any jurisdiction, when such reflects upon the Member's current fitness or ability to practice medicine, dentistry, or podiatry;
- vi) Conduct or behavior, including disruptive conduct which, in reasonable likelihood would adversely affect patient safety or care or interfere with the proper operation of the Hospital;
- vii) Repeated or serious breaches of the Medical Staff Bylaws or these Rules and Regulations or of Hospital Bylaws or policies;
- viii) Dishonest, unethical, or immoral conduct, when such would reasonably be expected to have an adverse effect on the well-being of the Hospital patients or on the proper operation of the Hospital; or
- ix) Other acts, omissions, or conduct which are specifically made grounds for corrective action elsewhere in these Rules and Regulations.
- x) Breach of confidentiality in the peer review and/or credentialing process
- xi) Failing to follow procedures to prevent wrong site, wrong procedure, wrong person surgery in accordance with the Universal Protocol for Preventing

Wrong Site, Wrong Procedure, Wrong Person Surgery (“Universal Protocol”)

- b) In determining whether adequate grounds for corrective action exist, the Board, the Medical Staff, and any Committee or officer thereof, may consider all credible evidence and facts relevant thereof, and shall not be limited to the examination of any particular incident or event, or to incidents or events occurring within the Hospital.

3 Request for Corrective Action

Any request for corrective action must be submitted to the Chief of Staff in writing and signed. The request must be supported by reference to the specific activities or conduct which constitute the grounds for the request, and may be initiated by:

One or more members of the Medical Executive Committee;

Any Department Chair;

The Chair of any standing Committee;

Any senior administrative executive; or

One or more members of the Board.

4 Initial Review / Informal Counseling

Upon receipt of a written Request for Corrective Action, the Chief of Staff and the Department Chair wherein the practitioner has privileges shall review the Request for Corrective Action, review any pertinent records, consult with the involved Practitioner and determine whether the matter is (1) unfounded, or (2) has merit but can be resolved through a Counseling Memorandum in a counseling meeting. Consultations may occur in person or by telephone as necessary. Failure by the Practitioner to cooperate with the informal consultation and counseling process may result in discipline in accordance with these rules. One or more representatives of Administration and/or the Medical Staff may attend the reviews and consultations to assist the Chief of Staff and the Department Chair at the discretion of the Chief of Staff as part of the initial peer review.

Potential Conflicts

If the Chief of Staff or Department Chair feels that he or she has a conflict of interest, the two of them shall decide upon an alternate person to serve in this capacity and shall notify the designated Medical Staff Member in writing of the Medical Staff Member's responsibilities and duties for the initial review.

Unfounded Complaints

If the Chief of Staff and the Department Chair find the complaint unfounded, they shall prepare a written Memorandum stating that the complaint is unfounded and that the matter is concluded. This Memorandum will be sent to the practitioner by messenger or certified mail; return receipt requested.

Counseling Meeting

If the Chief of Staff and the Department Chair find the complaint has merit but can be resolved through a Counseling Memorandum, the Chief of Staff and the Department Chair shall have the authority and responsibility to make written recommendations to the Practitioner in a Counseling Memorandum. The Practitioner shall review and sign the Counseling Memorandum during the counseling meeting in the presence of the Chief of Staff and Department Chair, who shall both sign a statement on the Memorandum that the Practitioner has read such Memorandum. One or more representatives of Administration and/or the Medical Staff may attend the counseling meeting at the discretion of the Chief of Staff. The Chief of Staff shall document the information from the counseling meeting and forward it to the President to be placed in the Practitioner's peer review file. Neither the counseling meetings nor any consultations with the Practitioner shall constitute a hearing. These meetings and consultations shall be informal and preliminary in nature. The procedural rights provided in Section 5 of these Rules and Regulations shall not apply to the informal counseling process, and attendance of legal counsel shall not be permitted.

Ad-Hoc Committee

If:

- a) The Chief of Staff and the Department Chair find the complaint has merit but cannot be resolved by a Counseling Memorandum;
- b) The Chief of Staff and the Department Chair do not agree on whether the

- complaint is unfounded or has merit;
- c) The Chief of Staff and the Department Chair do not agree on the recommendations to be made to the practitioner;
- d) The Chief of Staff or the Department Chair is not satisfied with informal counseling or with the results of such counseling;
- e) The Practitioner refuses to sign the Counseling Memorandum; or
- f) The Practitioner refuses to stop an undesirable act, behavior, or procedure or to perform a duty or an obligation,

the Chief of Staff shall immediately appoint an Ad Hoc Fact Finding Committee composed of Members of the Medical Staff to investigate the matter and follow the procedures as set forth in "Formal Investigation," below.

5 External Peer Review

- a) External peer review of a Practitioner's medical records or other documents may be conducted upon approval of the Chief of Staff, to (1) assess a Practitioner's application or reapplication for privileges, or (2) when quality monitoring has identified a potential problem. External Review can be used during the corrective action procedures at the Initial Review / Informal Counseling stage (Section X), Ad Hoc Committee stage (Section X), or Formal Review stage (Section X) the Chairman of the Credentials or
- b) The Chief of Staff or the Chief Medical Officer President, or their designee will obtain an objective and bonded peer reviewer, who is board certified in the specialty to be reviewed. Location of the reviewer will be through a reputable firm that provides such services. The President will be notified of the request.
- c) Documented results of external peer review will be maintained in the applicable Practitioners peer review file in Medical Staff Services and will be confidential, as described in Section 15 of these Rules and Regulations. Copies of these documents will be made only when needed in connection with Sections 4 and 5 of these Rules and Regulations.
- d) The above rules are not applicable to external review obtained in the direct provision of patient care for routine quality control measures, such as second opinions on pathology specimens.

6 Formal Investigation

If the request for corrective action is not resolved in the initial review process of the previous section, the Chief of Staff shall immediately appoint an Ad Hoc Fact Finding Committee to investigate the matter. The Ad Hoc Fact Finding Committee shall be composed of at least three Members of the Active Medical Staff and one of such Members shall be designated chairperson by the Chief of Staff. The Chief of Staff is authorized to act on behalf of the Medical Executive Committee to authorize the investigation.

The Practitioner against whom corrective action has been requested shall be informed of the general nature of the complaint against him and that an Ad Hoc Fact Finding Committee has been appointed to investigate the matter. The Practitioner shall provide information to the Ad Hoc Fact Finding Committee upon request and shall cooperate with the investigation. Failure or refusal by the Practitioner to provide requested information or to cooperate with the investigation may result in an adverse recommendation.

The Practitioner shall have an opportunity for an interview with the Ad Hoc Fact Finding Committee prior to the Committee making its report to the Medical Executive Committee. At such interview, the Practitioner shall be allowed a reasonable opportunity to discuss, explain or refute the grounds for the request. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rights provided in "Fair Hearing Plan" of these Rules and Regulations shall apply. Legal counsel will not be permitted to attend this interview. A written record of such interview shall be made by the Ad Hoc Fact Finding Committee and shall be included with its written report to the Medical Executive Committee.

The Ad Hoc Fact Finding Committee may, but is not obligated to, review medical files or other documents and conduct interviews with witnesses.

Within forty-five (45) days after the receipt of the Request for Corrective Action by the Chief of Staff, the Ad Hoc Fact Finding Committee shall make written report of its investigation to the Medical Executive Committee. This report shall include any recommendation of the Ad Hoc Fact Finding Committee with specific reference to the Practitioner's activities or conduct and the reasons and bases for such recommendation. Any dissenting views must also be reduced to writing, supported by reasons and references, and transmitted with the report. The Practitioner shall be furnished a copy of such report by messenger or certified mail, return receipt requested

at the time such report is furnished to the Medical Executive Committee.

If the Ad Hoc Fact Finding Committee has not concluded its investigation within forty-five (45) days, the Ad Hoc Fact Finding Committee shall report its findings, if any, to the Medical Executive Committee for consideration of further action. The Medical Executive Committee shall have the authority to dismiss the investigation if an adequate showing of cause for continuing the investigation is not provided at the end of forty-five (45) days.

7 Medical Executive Committee Review

Within fourteen (14) business days following receipt of the report from the Ad Hoc Fact Finding Committee with a recommendation which could result in the reduction or suspension of clinical privileges, the Medical Executive Committee shall convene and take action upon the report and any recommendation. If the Ad Hoc Fact Finding Committee's report includes a recommendation that would involve a reduction or suspension of clinical privileges, a change in category, or suspension or expulsion from the Medical Staff, the Practitioner shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rights provided in Section 5 of these Rules and Regulation shall apply. Legal counsel shall not be permitted at this appearance. A written record of such appearance shall be made by the Medical Executive Committee.

The Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including (without limitation) the following:

- i) to reject or modify the recommendation of the Ad Hoc Fact Finding Committee;
- ii) to issue a verbal warning, a letter of admonition or a letter of reprimand;
- iii) to impose terms of probation or a requirement for consultation;
- iv) to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained;
- v) to recommend that a category of clinical privileges be suspended or revoked
or
- vi) to recommend that the Practitioner's Medical Staff membership be suspended or revoked.

The Practitioner shall be notified promptly, in writing (by messenger or certified mail, return receipt requested) of the recommendation of the Medical Executive Committee, including a statement of the reasons for the action with specific reference to the Practitioner's activities or conduct.

Any recommendation by the Medical Executive Committee which is listed in Section 5.1.b. shall entitle the Practitioner to procedural rights provided in Section 5 of these Rules and Regulations and the written notice to the practitioner shall appraise him of these rights in accordance with the notice requirements of Section 5.4.

8 Board Review and Final Action

After the Medical Executive Committee has taken final action on the Request for Corrective Action, and after the practitioner has exhausted or waived all applicable procedural rights, if any, the matter shall be forwarded to the Board for final action. The Board shall comply with all requirements of the Fair Hearing Plan, if applicable, including those requirements found in Section 5 of these Rules and Regulations. If the Fair Hearing Plan is not applicable, the Board will review the matter and either approve, modify or reverse the Medical Executive Committee's action or recommendation. The President shall then promptly notify the practitioner, in writing (by messenger or certified mail, return receipt requested) of the Board's final action, including the reasons therefore.

9 Summary Suspension

- a) Whenever the professional competence or conduct of a Staff Member may result in imminent danger to the life, health, or safety of any individual, the Chief of Staff shall have the authority to summarily restrict or suspend all or any portion of the clinical privileges of a Practitioner. Summary suspension or restriction shall become effective immediately upon imposition and the Staff Member shall be given immediate verbal notice of the suspension. Verbal notice shall be followed by written notification of the summary suspension or restriction to the Staff Member (by messenger or certified mail, return receipt requested) and to the Department Chair, President, and to the Medical Executive Committee. The summary suspension or restriction shall remain in effect until resolved by the procedures specified in this Section.

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- b) Within five (5) Business Days of the effective date of the summary suspension, the Medical Executive Committee shall meet to review and consider the action. Upon request of either the Medical Executive Committee or the affected Staff Member, the Staff Member shall attend the meeting of the Medical Executive Committee and make a statement concerning the issues under review on such terms and conditions as the Medical Executive Committee may impose. In no event shall any meeting of the Medical Executive Committee, with or without the affected Staff Member, constitute a hearing under the Bylaws, these Rules and Regulations, or the Fair Hearing Plan, nor shall any procedural rules apply except those designated by the Medical Executive Committee. The affected Staff Member's failure, without good cause, to attend any Medical Executive Committee meeting upon request shall constitute a waiver of his rights to a hearing under the Bylaws and these Rules and Regulations. The Medical Executive Committee may take action to approve the summary suspension or restriction, may take action to terminate the summary restriction or suspension, or may recommend that the suspension or restriction be modified or continued.

- c) Following the Medical Executive Committee's meeting, the affected Staff Member shall promptly be sent written notice of the action and recommendation of the Medical Executive Committee. The Chief of Staff shall send this notice to the Practitioner (by messenger or certified mail, return receipt requested). The notice shall contain the following:
 - i) The specific action and recommendation of the Medical Executive Committee, with the reasons therefore;

 - ii) The extent to which the Practitioner's clinical privileges have been suspended or restricted;

 - iii) A statement advising the Practitioner that he or she has the right to request a hearing on any proposed adverse action by making a written request for a hearing to the President (by messenger or certified mail, return receipt requested) within thirty (30) days of the receipt of the notice from the Chief of Staff;

 - iv) A statement advising the Practitioner that failure to request a

hearing constitutes a waiver of such rights and an acceptance of the suspension or restriction; and,

- d) Any recommendation by the Medical Executive Committee which is listed in Section 5.2.b. shall entitle the affected Practitioner to the procedural rights provided in Section 5 of these Rules and Regulations and the written notice to the Practitioner shall apprise him of these rights in accordance with notice requirements of Section 5.2.a. the terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the Board. Where the Medical Executive Committee recommends termination of the summary suspension in conjunction with the imposition of corrective action not listed in Section 5.2.b., the Practitioner shall not be entitled to the procedural rights provided in Section 5.

10 Automatic Suspension

- a) License

An action of by the state revoking, canceling or suspending a practitioner's license shall automatically suspend all of his clinical privileges. A state action placing a practitioner on probation will result in altering the terms of the practitioner's clinical privileges to the extent necessary to meet the terms of the probation. Whenever a Medical Staff Member's license expires, his clinical privileges will be suspended automatically until there is evidence of a licensure renewal. Medical Staff Members so affected shall not be entitled to the procedural rights afforded in Section 5 regarding such automatic action.

- b) Restriction

Whenever a Medical Staff Member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges that the Practitioner has been granted at the Hospital that are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such licensing or certifying authority's action becomes effective throughout its duration.

c) Sanctions

An action by the Centers for Medicare & Medicaid Services (CMS) excluding a practitioner from Medicare, Medicaid or any other Federal health care programs shall automatically suspend the practitioner's medical staff membership and clinical privileges. Such suspension shall remain in effect until the practitioner's medical staff membership and clinical privileges either are terminated as provided herein or the practitioner provides evidence acceptable to the hospital's Board of Directors confirming he no longer is excluded from such Federal health care program.

d) Drug Enforcement Agency (DEA) Number or State Controlled Registration (DPS)

An action by the Drug Enforcement Agency or by the State Controlled Registration (DPS) revoking or suspending a practitioner's registration number automatically divests the practitioner of his right to prescribe medications covered by the registration number, effective on the date notice is actually received by the hospital and continuing throughout the term specified by the DEA or DPS.

Whenever a Medical Staff Member's DEA or DPS certificate expires, the practitioner will be asked to sign a waiver stating he agrees not to prescribe, dispense or administer any type of controlled substances until there is evidence of registration renewal. If the practitioner chooses not to sign the medication waiver, his clinical privileges shall be suspended automatically. Medical Staff Members so affected shall not be entitled to the procedural rights afforded by Section 5 regarding such automatic action.

e) Medical Records

Temporary medical records suspension in the form of a practitioner's privileges to admit patients to the hospital or to schedule procedures within the hospital effective until delinquent medical records are completed, shall be imposed in conformity with the Rules and Regulations of the Medical Staff. This medical record suspension will be an internal and administrative suspension that will not be reported to the National

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Practitioner Data Bank. The Practitioner shall be notified in writing of the imposition of automatic suspension in accordance with these Rules and Regulations of the Medical Staff, and such notice shall identify the specific delinquent medical records. Suspension shall remain in effect until the medical records have been completed. If the delinquency has not been corrected with sixty (60) days of the imposition of the suspension, the Chairperson of the Quality Review Committee shall present the matter in writing to the Medical Executive Committee as grounds for corrective action as delineated in Section 8.14 of these Rules and Regulations.

f) Failure to Provide Documentation

Medical Staff membership and clinical privileges shall be automatically suspended whenever a Practitioner fails to provide documentation to the Medical Staff Office of licensure, narcotic registration, professional liability or proceedings, investigation, litigation or sanctioning by governmental agency or third-party payor or other documentation required by the Medical Staff policies/procedures and these Rules and Regulations.

g) Professional Liability Insurance

Failure of the Practitioner to maintain professional liability insurance in the amount required by these Rules and Regulations shall result in the suspension of all of the Practitioner's Medical Staff or allied health privileges.

a) Failure to Satisfy Special Appearance Requirement

A Medical Staff Member who fails, without good cause, to appear at a meeting scheduled for the purpose of discussing the Practitioner's practice or conduct which the Medical Staff Member is required to attend, automatically shall be suspended from exercising all clinical privileges, or such portion of clinical privileges as may be specified in the meeting. Alternatively, such failure may be the basis for a request for corrective action or other discipline under the Bylaws or these Rules and Regulations.

Procedure

i) The President shall cooperate with the Chief of Staff in enforcing

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all automatic suspensions. The Chief of Staff shall notify the Practitioner in writing (by messenger or certified mail, return receipt requested) of any automatic suspension, and of referral of the matter to the Medical Executive Committee for corrective action recommendation.

- ii) The Medical Executive Committee shall consider the matter at its next regularly scheduled meeting and make a written recommendation, which shall include the reasons for the recommendation with a specific reference to the Practitioner's activities or conduct. The Practitioner shall be sent written notice of the Medical Executive Committee's recommendation immediately (by messenger or certified mail, return receipt requested). This paragraph does not apply to automatic suspensions of less than fourteen (14) days.
- iii) Any recommendation by the Medical Executive Committee which is listed in Section 5.1.c shall entitle the affected Practitioner to the procedural rights provided in Section 5 of these Rules and Regulations, and the written notice to the Practitioner from the Medical Executive Committee shall be in accordance with the notice requirements of Section 5.4. The terms of the automatic suspension as sustained or modified by the Medical Executive Committee shall remain in effect pending a final decision by the Board. Where the Medical Executive Committee recommends termination of the automatic suspension in conjunction with the imposition of corrective action not listed in Section 5.2.b., the Practitioner shall not be entitled to the procedural rights provided in Section 5.

11 Temporary Suspension

a) Criteria

A Medical Staff Member is subject to immediate temporary suspension, without a prior request for corrective action, grievance, or other discipline, whenever: (1) the Medical Staff Member willfully disregards or grossly violates the Bylaws or these Rules

and Regulations; (2) his conduct requires that immediate action be taken to protect the welfare of any patient where the failure to take such action may result in imminent danger to the health of any individual; or (3) the Medical Staff Member has failed to follow procedures to prevent wrong site, wrong procedure, wrong person surgery in accordance with the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person ("Universal Protocol"); or (4) the conduct of the Medical Staff Member materially disrupts the operation of any department or unit of the Hospital. Upon the occurrence of one or more of these conditions, the Chief of Staff shall have the authority to impose a temporary suspension or restriction of all or any portion of the clinical privileges of the Medical Staff member. Such temporary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that may be taken with respect to the affected member, but is not a complete professional review action in and of itself. Such temporary suspension shall become effective immediately upon imposition, and shall remain in effect no longer than fourteen (14) days during which an investigation will be conducted to determine the need for a professional review action.

b) Notice of Temporary Suspension

The Chief of Staff shall give prompt verbal notice to the suspended individual. Verbal notice shall be followed by written notification of the temporary suspension to the Affected Practitioner (by messenger or certified mail, return receipt requested) and to the Medical Executive Committee and President. This notice shall specify the extent to which the affected practitioner's clinical privileges are suspended or restricted, and the reason for the temporary suspension.

c) Legal Status of Suspension

- i) Such temporary suspension:
- ii) Is an interim administrative step to maintain the status quo until an investigation can be conducted;

- iii) Is not a punitive measure;
- iv) Is not reportable to the National Practitioner Data Bank as a temporary suspension shall remain in effect no longer than thirty (30) days; and
- v) Does not give the Practitioner the right to a hearing or appeal of such temporary suspension.

Appointment of Investigatory Panel

The Medical Executive Committee shall promptly appoint an ad hoc Investigatory Committee to review the temporary suspension and conduct an investigation to determine the need for professional review action against the Practitioner. The Investigatory Committee shall be composed of not less than three (3) Members of the Medical Staff, none of which shall be in direct economic competition with the Practitioner.

Investigation by Committee

Within five (5) Business Days after the Investigating Committee has been appointed, said Committee shall conduct an investigation and give a written report and recommendation to the Medical Executive Committee with respect to the reasons and basis for the temporary suspension. The Practitioner shall be sent a copy of the written report and recommendation (by messenger or certified mail, return receipt requested).

Review by Medical Executive Committee

- i) Within three (3) Business Days of receiving the report and recommendation of the Investigatory Committee, the Medical Executive Committee shall consider the matter and make written recommendations with specific reference to the Practitioner's conduct or activities.
- ii) The Medical Executive Committee may recommend to terminate the temporary suspension in all respects. The Practitioner shall be sent written notice of the Medical Executive Committee's recommendation and the

comprise the full extent of the Member's privileges. Such termination shall not be considered Adverse Action unless the Practitioner is terminated for reasons relating to the professional character, competence, ethics, or performance.

c) Savings Clause

No provision above is intended to deprive any Practitioner of any rights under applicable law, including (without limitation) the Health Care Quality Improvement Act or the Texas Medical Practice Act. Nothing above shall be construed to deprive a Member of any applicable hearing or appeal rights under the Bylaws, these Rules and Regulations, or applicable law.

Section 5 Fair Hearing Plan

1 General Provisions

a) Definitions

- i) Adverse Action means corrective action taken or recommended by the Medical Executive Committee, the Board, or another professional review committee or officer specified in the Bylaws or these Rules and Regulations, which may prevent or restrict the Applicant, Medical Staff Member or Allied Health Professional from receiving or exercising Medical Staff appointment or clinical privileges. Adverse Action includes those actions listed below in Section 5(2)(b) of these Rules and Regulations. Adverse Action entitles the Affected Practitioner to the hearing and appellate review procedures set forth below.
- ii) Non-Adverse Action means corrective action taken or recommended by the Medical Executive Committee, the Board, or another professional review committee or officer specified in the Bylaws or these Rules and Regulations, which may place restrictions or conditions concerning the Medical Staff appointment and exercise of clinical privileges of the Applicant or Medical Staff Member. Non-Adverse Action includes those actions listed below in Section 5(2)(a). Non-Adverse Action shall not entitle the Affected Practitioner to the hearing review procedures set forth below.

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iii) Affected Practitioner means an Applicant or a Medical Staff member who is named in a recommendation or action for corrective action.

b) Exhaustion of Remedies

i) In all cases in which Adverse Action is taken or recommended, the Applicant or Medical Staff Member must exhaust the remedies afforded by the Bylaws and Rules and Regulations, before resorting to legal action. For purposes of this Section, the term Medical Staff Member may include Applicant as applicable under the circumstances.

c) Right to Hearing

i) When any Medical Staff Member receives notice of a recommendation for Adverse Action by the Medical Executive Committee, he shall be entitled to a hearing before a hearing committee established by the Medical Executive Committee as set forth below. When the Medical Staff Member is entitled to a hearing at both Covenant Children's Hospital and Covenant Medical Center / Covenant Lakeside on the same issue, a joint hearing committee may be appointed.

ii) When any Medical Staff Member receives notice of a decision by the Board for Adverse Action, and this decision is not based on a recommendation for Adverse Action by the Medical Executive Committee which entitles a Medical Staff Member to a hearing, he shall be entitled to a hearing by a hearing committee appointed by the Board.

2 Grounds for Hearings

a) Non-Adverse Actions

i) Except as otherwise specified in the Bylaws or Rules and Regulations, the following actions or recommended actions shall be deemed Non-Adverse Action, shall not constitute grounds for a hearing, and shall not be reportable under the Health Care Quality Improvement Act or the Texas Medical Practice Act:

ii) One hundred percent (100%) review of the Medical Staff Member's practice if the Member is permitted to make determinations about the patient's treatment

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- course without the agreement of any consulting physician;
- iii) A proctor is assigned to supervise the Medical Staff Member, but approval by the proctor is not required before medical care is provided;
 - iv) Supervision of the Medical Staff Member's practice which requires concurrent review or frequent discussion with the supervising physician;
 - v) Requirement of continuing education;
 - vi) Requirement that the Medical Staff member must obtain retraining in a particular specialty or procedure;
 - vii) Requirement that another physician be present during operative or invasive procedures;
 - viii) Placement on provisional status as a contingency of reappointment;
 - ix) Appointment of a Grievance Committee, Investigatory Panel, or ad hoc committee;
 - x) Conducting a review or investigation into any matter;
 - xi) Formulation and presentation of any report of any Grievance Committee of ad hoc committee to the President, Chief of Staff, Medical Executive Committee, or Board;
 - xii) No hearing if temporary suspension for a period of fourteen (14) days or less;
 - xiii) Automatic suspensions for a period of fourteen (14) days or less imposed in accordance with Section 4.5.
 - xiv) Making of a request or issuance of a directive to an Applicant or Medical Staff Member to appear at an interview or conference before the Credentials Committee, any ad hoc committee, an investigatory committee, the Grievance Committee, the Medical Executive Committee, the Board, or any other professional review body in connection with any review or investigation prior to a proposed adverse recommendation or action;

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- xv) Denial of or refusal to accept a pre-application for initial appointment or application for reappointment to the Medical Staff (a) where the information is incomplete; (b) where the information reflects that the Applicant does not meet the minimum objective requirements for appointment or reappointment; or (c) where the Applicant is requesting clinical privileges in a Department, subspecialty or service in which the number of medical staff appointees has been limited in accordance with the Bylaws or Rules and Regulations;
- xv) Automatic termination of privileges and membership as provided by the Bylaws or these Rules and Regulations;
- xvi) Issuance of a letter of warning, admonition, or reprimand;
- xvii) Informal counseling;
- xviii) The following changes in medical staff classification: (a) a change from active staff to courtesy staff for failure to meet the patient care requirements set forth in the Bylaws or Rules and Regulations; or (b) any other change in category resulting from the failure of the Medical Staff Member to meet the minimum objective criteria for a specified category; or (c) any professional review recommendation or action not adversely affecting (as such term is defined in Section 11151 (1), of the Health Care Quality Improvement Act or as used in Section 151.001, et. seq., of the Texas Occupations Code, known as the Texas Medical Practice Act) any Applicant or Medical Staff member, or which is not based upon a subjective determination of the professional competency or conduct of the Applicant or Medical Staff Member.
- xix) Accommodation for a mental or physical health condition to reduce or eliminate the risk that the Practitioner's condition will cause a substantial risk of harm to his patients or to others.
- xx) Recommendation for termination of medical staff membership and privileges for suspension for delinquent medical records if the Medical Staff Member completes their medical records prior to the Quality and Patient Safety Committee of the Board of Directors meeting and acting on the Medical Executive Committee recommendation. If the Practitioner completes their delinquent medical records by 8:00 a.m. the day of the Quality and Patient Safety Committee of the Board of Directors meeting, the Medical Executive Committee action will be automatically rescinded.

b) Adverse Actions

- i) The following actions or recommended actions shall be deemed Adverse Action, shall constitute grounds for a hearing and shall be reportable under the Health Care Quality Improvement Act and the Texas Medical Practice Act where the Adverse Action adversely affects the clinical privileges of a physician for a period longer than thirty (30) days, if such action is based on professional competency or conduct:
- ii) Denial of Medical Staff Membership;
- iii) Denial of requested advancement in Medical Staff Membership status or category;
- iv) Denial of Medical Staff reappointment;
- v) Revocation of Medical Staff Membership and/or termination of clinical privileges;
- vi) Denial of requested clinical privileges;
- vii) Involuntary reduction of current clinical privileges for a period of more than fourteen (14) days;
- viii) Summary suspension of Medical Staff Membership and/or clinical privileges for a period of more than fourteen (14) days;
- ix) Assignment to Medical Staff Member of a proctor/consultant who must grant approval before medical care is provided;
- x) Any professional review action or recommendation adversely affecting (as such term is defined in Section 11151 (1) of the Health Care Quality Improvement Act or as used in Section 151.001, et. seq., of the Texas Occupations Code, known as the Texas Medical Practice Act) any Applicant or Medical Staff Member;
- xi) Denial or termination of clinical privileges due to a Practitioner's physical

or mental health condition that poses a significant current risk of harm to his patients or to others, when such risks cannot be satisfactorily reduced or eliminated by reasonable accommodation.

b) Exception to Hearing Right

i) Contract

(1) The clinical privileges and Medical Staff Memberships of Members who are directly under contract with the Hospital in a medico/administrative capacity or in closed departments shall be subject to termination in accordance with the terms of their contracts, and such Medical Staff Member shall not be entitled to the procedural rights as specified in the Bylaws or Rules and Regulations, except to the extent that the Member's medical staff membership or clinical privileges which would otherwise exist independent of the contract are to be limited or terminated, or except where the limitation or termination is for reasons pertaining to the Member's professional conduct which could be reasonably deemed to be a threat to patient safety or pertaining to the quality of care provided by the Medical Staff Member. Whenever all of a contract practitioner's clinical privileges are terminated or suspended, that practitioner's Medical Staff Membership shall be deemed terminated or suspended.

ii) Closed Staff or Exclusive Use Departments

(1) The hearing rights as specified in the Medical Staff Bylaws or these Rules and Regulations, including the Fair Hearing Plan, do not apply to an Applicant or Medical Staff Member whose application for clinical privileges was denied on the basis that the privileges sought by the Applicant or Medical Staff Member are granted only pursuant to the Closed Staff or Exclusive Use policy. However, such physicians shall have the right to request that the Board review the denial, and the Board shall have the discretion to determine whether to review such request and, if it decides to review such request, to determine whether the physician may personally appear before and/or submit a statement in support of his position to the Board.

3 Procedural Safeguards

- a) All hearings shall be in accordance with the Procedural Safeguards set forth in the Bylaws and Rules and Regulations to assure that the affected Practitioner is accorded the rights to which he is entitled.

4 Notice of Adverse Recommendation or Action

Notice of a recommendation by the Medical Executive Committee or decision by the Board for Adverse Action shall be sent promptly to the Practitioner by the President, shall be in writing, shall be sent (by messenger or certified mail, return receipt requested) and shall state the following:

- a) That the Adverse Action concerning the Practitioner has been either recommended or decided;
- b) The reasons for the recommendation or initiation of Adverse Action, with specific reference to the Practitioner's activities;
- c) That the Practitioner has the right to request a hearing on the proposed Adverse Action by making a written request to the President (by messenger or certified mail, return receipt requested) for a hearing within the following time period:
 - i) Within thirty (30) days of receipt of the written notice concerning all Adverse Actions except for actions of suspension (hereafter referred to as Unexpedited Hearing); and
 - ii) Within three (3) Business Days of receipt of the written notice of an Adverse Action of suspension (hereafter Expedited Hearing);
- d) That the failure to request a hearing constitutes a waiver of such right; and
- e) A summary of the rights and conduct of the hearing.

5 Request for Hearing and Notice

- a) Waiver
 - i) The Failure of a Practitioner to request a hearing to which he is entitled by these Rules and Regulations, within the time and in the manner herein

provided, shall be deemed a waiver of the Practitioner's right to such a hearing to which he might otherwise have been entitled on the matter. When the waived hearing relates to an adverse recommendation of the Medical Executive Committee, such recommendation shall thereupon become and remain effective against the Practitioner pending the Board's decision on the matter. When the waived hearing relates to an adverse recommendation by the Board, such recommendation shall thereupon become and remain effective against the Practitioner as a final decision of the Board. In either of such events, the President shall promptly provide written notice to the affected Practitioner of such individual's status (by messenger or certified mail, return receipt requested).

b) Notice of Hearing

- i) Upon receipt by the President of a timely request for a hearing from a Practitioner entitled to same, the Chief of Staff shall schedule and arrange for such hearing and shall notify the Practitioner of the scheduled time, place, and date of the hearing. This notice must be provided (by messenger or certified mail, return receipt requested). The date for an Unexpedited Hearing shall not be less than thirty (30) days from the date of receipt of the request for hearing. The hearing date for an Expedited Hearing shall be as soon as arrangements may reasonably be made, but not later than fourteen (14) days from the date of receipt of such Practitioner's request for hearing.
- ii) The notice of hearing shall state the following:
 - (1) The place, time, and date of the hearing;
 - (2) A list of witnesses, if any, the Hospital expects to testify at the hearing; and
 - (3) The acts or omissions with which the Practitioner is charged, a list of specific or representative charts being questioned, and/or other reasons or subject matter that was considered in making the recommendation or decision for Adverse Action.
 - (4) The Practitioner must submit a list of witnesses, if any, expected to testify, on his behalf not later than fourteen (14) days prior to an Unexpedited Hearing and three (3) days prior to an Expedited Hearing.

6 Establishment of Hearing Committee

a) Medical Executive Committee Recommendation

- i) When a hearing is requested pursuant to a recommendation of the Medical Executive Committee, the Medical Executive Committee shall, in its sole discretion, direct that the hearing be held before one of the following:
 - (1) Before an arbitrator appointed by the Chief of Staff who is acceptable to the Practitioner and Hospital; or
 - (2) Before a hearing officer appointed by the Chief of Staff who is not in direct economic competition with the Practitioner; or
 - (3) Before a hearing committee appointed by the Chief of Staff and composed of not less than five (5) members of Medical Staff who are not in direct economic competition with the Practitioner, and who have not actively participated in consideration of the recommendation or action under review; however, knowledge of the matter shall not preclude a Member from serving as a member of the hearing committee. The Chief of Staff shall designate one committee member as chairperson. Members of the hearing committee must be present when the hearing takes place, and no member may vote by proxy;
 - (4) Before a hearing committee appointed by the Chief of Staff composed of no fewer than three (3) independent peer reviewers from outside the Medical Staff, who are not in economic competition with the Affected Practitioner. The Chief of Staff shall designate one reviewer as chairperson.
 - (5) When the affected Practitioner is an Allied Health Professional and a hearing committee is to be held, as described in paragraph (3) or (4), a majority of the hearing committee will be comprised of Allied Health Professionals who are not in direct economic competition with the Affected Practitioner.

b) Board Action

- i) When a hearing is requested pursuant to an action of the Board, the Board

shall direct that a hearing be held before a hearing committee composed of at least three (3) persons not in direct economic competition with the Affected Practitioner to include at least one (1) Medical Staff Member. The two non-physician members of the hearing panel should be members of the Board, and the Medical Staff Member of the hearing panel is not required to be a member of the Board. The Board shall designate one of the members as Chairperson.

- ii) When a hearing is requested based on an adverse decision of the Board that is contrary to the recommendation of the Medical Executive Committee, the Board shall appoint a hearing committee to conduct a hearing and shall designate one of the members of this committee as Chairperson. At least one representative from the Medical Staff shall be included on this Committee.

7 Procedures for Hearing

a) Hearing Officer

- i) The Chief of Staff, in his sole discretion, may appoint a hearing officer to preside at the hearing. The hearing officer may be the designated Chairperson or an attorney qualified to preside over a quasi-judicial hearing. If appointed, the hearing officer shall have the following duties:
 - (1) To determine the role of attorneys, if any, present at the hearing;
 - (2) To determine the order of procedure for presenting evidence;
 - (3) To ensure proper decorum in the hearing is maintained;
 - (4) To ensure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in a professional, efficient and expeditious manner;
 - (5) To make rulings on all questions which pertain to matters of procedure or the admissibility of evidence;
 - (6) To take such discretionary action as seems warranted by the circumstances if the hearing officer determines that either side is not proceeding in a professional, efficient, or expeditious manner;

- (7) To determine whether to schedule a mandatory pre-hearing conference with the attorneys for both parties independent;
- (8) To participate in the deliberations of the hearing committee and, if applicable, to serve as a legal advisor to the hearing committee; however, unless appointed as a member of the hearing committee, the hearing officer may not vote.

b) Failure to Appear

- i) The personal presence of the Affected Practitioner shall be required at the hearing. An Affected Practitioner who is determined by the hearing committee, arbitrator or hearing officer, as applicable, in the sole discretion of such individual or committee to have failed to appear and proceed at the hearing without good cause, shall be deemed to have waived his rights in the same manner as provided in Section 5(5)(a) of these Rules and Regulations, and to have accepted the recommendation or decision for Adverse Action, and the same shall thereupon become and remain in effect as provided therein.

c) Postponement or Recess

- i) Once a request for a hearing is initiated, postponements and extensions of time beyond the times permitted in the Fair Hearing Plan may be permitted by the hearing committee, or the hearing officer acting upon its behalf, on a showing of good cause.
- ii) The hearing officer may, without special notice, recess the hearing and reconvene the same for the convenience of the participants for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, within a reasonable time which is convenient to its members, conduct its deliberations after all other individuals have been excluded. Upon completion of deliberations, the hearing shall be adjourned.

d) Record of the Hearing

- i) A reporter shall make a record of the hearing proceedings. The cost of the attendance of the reporter, if any, shall be borne by the Hospital, but the cost of

the transcript, or copies thereof, if any, shall be borne by the party requesting it.

e) Procedural Rules

- i) Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Fair Hearing Plan. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely upon in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The arbitrator, hearing officer or members of the hearing committee, as applicable, may interrogate the witnesses or call additional witnesses if they deem such action appropriate. At their discretion, the hearing committee, arbitrator or hearing officer, as applicable, may request for permit both sides to file written position statements.

f) Duties of the Parties

- i) The Medical Executive Committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff Member to represent it at the hearing, to present facts in support of the recommendation for Adverse Action, and to assist in the examination of witnesses. The Board, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present facts in support of its decision for Adverse Action, and to assist in the examination of witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision for Adverse Action.
- ii) The Affected Practitioner shall be responsible for supporting his challenge to the Adverse Action recommendation or decision by providing appropriate evidence.
- iii) The Medical Executive Committee, Board and the Affected Practitioner each have the right to be represented by legal counsel in a hearing.

g) Standard of Proof

- i) Whenever a hearing relates solely to a proposed denial of (1) appointment

to the Medical Staff, (2) requested clinical privileges, or (3) requested advancement in Medical Staff Category, the Affected Practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, (a) that he or she meets the standards for appointment or reappointment to the Medical Staff or for the granting of the clinical privileges or Medical Staff category requested and (b) that the denial of appointment or reappointment, requested clinical privileges or requested advancement in Medical Staff category will be arbitrary and capricious. In all other cases, the Medical Executive Committee, or Board, whichever proposed the adverse recommendation or action, shall present supporting evidence, but the Affected Practitioner shall have the burden of proving by a preponderance of the evidence, that the Adverse Action or basis therefore is either arbitrary, unreasonable, or capricious.

h) Rights of the Parties

i) The Affected Practitioner and his representative or attorney, and the Medical Executive Committee or Board and its representative or attorney, shall have the right to:

- (1) Call and examine the witnesses;
- (2) Present and introduce written and/or oral evidence;
- (3) Cross-examine any witness on any matter relevant to the issue of the hearing;
- (4) Challenge any witness;
- (5) Rebut any evidence; and
- (6) Submit a written statement to the hearing committee at the close of the hearing.

8 Recommendation and Action

a) Recommendation of Hearing Committee

i) The hearing committee shall prepare and deliver a written report of the

hearing records to the Medical Executive Committee or the Board, as applicable, within thirty (30) days after final adjournment of Unexpedited Hearing, or within three (3) Business Days after final adjournment of an Expedited Hearing. The report shall include any recommendations of the hearing committee and a concise statement of the reasons in support of the recommendations. The report shall contain any dissenting views in writing, supported by reasons and references. A copy of the written report of the hearing committee shall also be forwarded to the Affected Practitioner, the President, and the Medical Executive Committee or Board, as applicable.

b) Action on the Recommendation of the Hearing Committee

- i) Either the Medical Executive Committee or the Board, as applicable, shall review the report and recommendation of the hearing committee and shall make a decision concerning its reconsideration of the recommendation or action for Adverse Action as follows:
- ii) If an Unexpedited Hearing, the matter shall be reconsidered at the next regularly scheduled meeting. Written notice of the decision shall be promptly delivered to the Affected Practitioner, President and the Medical Executive Committee or Board, as applicable.
- iii) If an Expedited Hearing, the matter shall be reconsidered within five (5) days of receipt of the hearing committee's report. Written notice shall be promptly delivered to the Affected Practitioner, President, and the Medical Executive Committee or Board, as applicable.

c) Action by Board

- i) The Board shall review the report of the hearing committee and the recommendation of the Medical Executive Committee, if applicable, and shall render a decision. The decision of the Board may affirm, modify, or reverse the recommendation of the Medical Executive Committee and shall be made as follows:
- ii) If an Unexpedited Hearing, the matter shall be considered at the next regularly scheduled Board meeting.
- iii) If an Expedited Hearing, the matter shall be considered within three (3)

Business Days of receipt of the Medical Executive Committee's recommendation.

- iv) Written notice of the decision shall be promptly delivered to the Affected Practitioner, President and the Medical Executive Committee. The decision of the Board shall be final.

Section 6 Organization of Medical Staff

1 Committees

a) Medical Executive Committee

- i) The composition, duties, and meetings of the Medical Executive Committee are defined in the Medical Staff Bylaws.

- 2 The following standing committees will be established to carry out the functions of the Medical Staff and will report and be responsible to the Medical Executive Committee. Special committees may be appointed by the Chief of Staff and/or the Medical Executive Committee as they deem necessary. Any standing committee may designate specific duties to a subcommittee of any number of its members.

Unless otherwise stated, committee members and chairs will be appointed by the Chief of Staff. All committee members will be voting members.

a) Credentials Committee

- i) The Credentials Committee will consist of six (6) Members of the Active Medical Staff whose terms will be for three years. Appointments will be staggered to replace two (2) members each year. An attorney who represents the Medical Staff will be an ex-officio member without vote.
- ii) The duties of the Credentials Committee will be to:
 - (1) review the credentials of Applicants and make recommendations for appointment, reappointment, and delineation of clinical privileges in compliance with Section 1 of these Rules and Regulations;

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- (2) review and make recommendations on applications from Allied Health Professionals;
- (3) review reports referred by the Medical Executive Committee or other committees, and by the Chief of Staff, and make recommendations based on such reports where applicable; and
- (4) review and make recommendations, with input from the applicable Department Chair, for the establishment of specific eligibility criteria for appointment, reappointment, and the granting of clinical privileges.

b) Nominating Committee

- i) The Nominating Committee of the Medical Staff will be composed of the three Immediate Past Chiefs of Staff.
 - ii) The Nominating Committee will be responsible for nominating Medical Staff officers.
- (1) The Nominating Committee will publish the names of candidates for each officer at least thirty (30) days prior to the annual meeting. The Nominating Committee may substitute nominees at the annual meeting if any Members nominated either refuse or are otherwise unable to accept nomination.

c) Quality Review Committee

- i) Composition: The Quality Review Committee will be composed of a minimum of twelve (12) Members of the Medical Staff appointed by the Chief of Staff in consideration of the Plan for Improving Organization Performance. The Chair will be the Immediate Past Chief of Staff. The Administrative Medical Director of Quality Management will be a voting member. Physician members shall be Members of the Active Medical Staff. The Quality Review Committee will be responsible for oversight of the following activities and review functions:

- (1) Blood Usage / Pathology Review

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- (2) Infection Control
 - (3) Intensive Care Units
 - (4) Laser Safety
 - (5) Medical Records
 - (6) Pharmacy & Therapeutics
 - (7) Physician Quality Review Board
 - (8) Radioisotope and Radiation Safety
 - (9) Transplant
 - (10) Risk Management
 - (11) Utilization Review
 - (12) Sentinel Event Review
- ii) Integration of Medical Staff/Cross-Functional Quality Activities will be as follows:
- (1) Quality Review Committee's Responsibilities:
 - (a) Oversight of all Medical Staff Quality Improvement activities;
 - (b) Receive and assess Quality Improvement reports from combined Hospital/Medical staff committees;
 - (c) Assess and assign Medical Staff Members to cross-functional teams;
 - (d) Coordinate and prioritize Quality Improvement efforts between all combined Hospital/Medical Staff committees to minimize duplication of efforts;
 - (e) Participate in identifying and recommending processes, functions, and dimensions of performance that warrant cross-functional efforts for improvement;
 - (f) Report improvement activities to the Medical Staff Executive Committee as appropriate;
 - (g) Analyze utilization review and risk management activities
 - (h) Communicate and recommend to Medical Staff Executive Committee optimum utilization of hospital resources and facilities commensurate

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with quality patient care and safety;

- (i) Charter cross-functional Medical Staff teams to address process issues;
- (j) Annually evaluate quality, utilization, and risk management programs for effectiveness, and revise as appropriate;
- (k) Oversight of reviews by Peer Review Organization (PRO) and third party payers when criteria is not met; and
- (l) Take action when improvement opportunities are identified. Assess the action taken for effectiveness and evaluate results.

d) Physician Quality Review Board

(1) Composition: At least three (3) Active Medical Staff Members appointed by the Board. Terms will be staggered for a period of one (1), two (2), or three (3) years. Responsibilities are as follows:

- (a) Initial screening of trends and outliers based on established criteria. Request information from the Quality Review Committee regarding specific questions that cannot be answered by the documentation in the medical record related to the care the patient received;
- (m) Screen for utilization issues that need discussion by the Quality Review Committee;
- (n) Identify review or education needed by the Medical Staff or committees; and
- (o) Refer to Quality Review Committee issues which need further review or action.

(2) Combined/Medical Staff Committee's Quality Responsibilities:

- (a) Define purpose and objective of committee;
- (b) Identify issues that affect patient care;

- (c) Make recommendations for quality improvement efforts to Quality Review Committee; and
- (d) Review as necessary the quality improvement activities as defined by the committee's purpose.

e) Professional Graduate Medical Education Committee

The Professional Graduate Education Committee and the medical staff, through its Medical Education Committee, must regularly communicate, and must meet at least annually about the safety and quality of patient care provided by interns, residents, and fellows and their related educational and supervisory needs. The Professional Graduate Education Committee and the Quality and Patient Safety Committee of the Board of Directors must periodically communicate about the educational needs and performance of interns, residents, and fellows. At least annually, the Professional Graduate Education Committee must submit a comprehensive report on the educational needs and performance of interns, residents, and fellows for consideration by the Quality and Patient Safety Committee of the Board of Directors.

Professional Graduate Education Committee will consist of the following members:

- 1) Medical Director for Education and Research
- 2) TTUHSC Residency Directors from specialties with current affiliation agreements
- 3) Chief of Staff, Covenant Medical Center/Lakeside
- 4) Chief of Staff, Covenant Children's Hospital
- 5) Chief Medical Officer, Covenant Children's Hospital
- 6) Chief Medical Officer, CHS Physician Services

Section 7 Admission and Discharge of Patients

- 1 A patient may be admitted to the Hospital only by a Member of the Medical Staff with admitting privileges. All Members will be governed by the official admitting policy of the Hospital.

- 2 A Member of the Medical Staff will be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring Practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff Member, a note covering the transfer of responsibility will be entered on the order sheet of the medical record. The admitting physician will be considered the attending physician unless such a written transfer is accomplished.
- 3 A patient admitted to an intensive level of care will be seen by an appropriate physician within two hours of notification of patient arrival. If the admitting physician delegates the patient to another physician, the admitting physician must discuss the delegation with the physician and obtain consent to delegate the responsibility. If a resident or fellow admits a patient to an intensive level of care, the attending physician must see the patient within two hours.
- 4 Except in an emergency, no patient will be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement will be recorded as soon as possible. An initial set of orders will be available at the time of admission unless precluded by an emergency situation in which case, they will be recorded as soon as possible.
- 5 A patient to be admitted on an emergency basis who does not have a private physician may request any physician Member in the applicable Department to attend to him. Where no such request is made, a physician will be assigned from the applicable Department, on a rotational basis, from a schedule furnished by each Department Chair.
 - a) The on-call physician will assume responsibility for evaluating and treating any patient accepted while on-call, including patients who arrive at Covenant after the physician's call time has expired, as well as patients to be seen in the physician's office on the following day, or as appropriate.
- 6 Patients will be admitted in the following order of priorities:
 - a) Emergency admissions so designated by the attending physician;

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- b) Urgent admissions so designated by the attending physician;
 - c) Preoperative admissions to include patients already scheduled for surgery or other special procedures;
 - d) Routine elective admissions
- 7 Transfer of Non-Assigned Patients
- 1) During periods of impending full census, the transfer center will contact the nursing supervisor to determine pediatric and pediatric intensive care unit (PICU) bed and staffing availability prior to calling the pediatrician on-call, pediatric emergency room physician and/or pediatric intensivist.
 - 2) Incoming transfer center requests for the Hospital will be triaged as follows:
 - a) If it is deemed that PICU care is probable, the pediatric intensivist will be called.
 - b) If it is an office, clinic, or ER transfer request regarding an unassigned pediatric patient, the pediatric ER physician will be called.
 - c) If it is a request for hospital-to-hospital transfer of a child not requiring PICU care, the pediatrician on-call will be contacted.
- 8 Admission to the critical care unit requires consultation with a pediatric intensivist.
- 9 The admitting Practitioner of any patient will be responsible for furnishing information necessary to protect the patient from self-harm and others from harm by the patient.
- a) A patient with known or suspected suicidal tendencies will be admitted to the Covenant Lakeside Mental Health Unit unless the patient's medical condition requires treatment on a medical or surgical floor.
 - b) For such length of time as a patient with known or suspected suicidal tendencies is required to be on a medical or surgical floor, twenty-four (24) hour nursing companionship will be provided at the patient's expense.

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- c) Patients with known or suspected tendencies to injure others will be admitted to the Covenant Lakeside Mental Health Unit unless their medical condition requires they be on a medical or surgical floor.
 - d) For such length of time as a patient with known or suspected tendencies to injure others is required to be on a medical or surgical floor, twenty-four (24) hour nursing companionship will be provided at the patient's expense. If necessary, police authorities will be summoned to ensure protection of all concerned.
 - e) All patients described in (a) and (c) above will be offered immediate psychiatric care and the record must contain clear evidence that such referral was offered, whether or not the patient or his family rejects such care.
- 10 Admission to any bed or unit, and continued stay in any bed or unit, will be subject to established criteria, and applicable policies and procedures.
- 11 Patient Transfers
- a. Patients will be transferred in the Hospital according to the following priorities:
 - i. From general care area to Intensive Care;
 - ii. From Emergency Department or Recovery Room to appropriate patient bed;
 - iii. From any special care unit to a general care area when medically indicated;
 - iv. From Intensive Care unit to general care areas; and
 - v. From temporary placement in an inappropriate area to an appropriate area.
 - b. All transfers must be ordered or approved by the attending Practitioner.
- 12 Patients will be discharged only upon orders of the attending Practitioner. Should a patient leave the Hospital without proper discharge orders, a notation of the

event will be made in the patient's medical record.

- 13 In the event of a death in the Hospital and within current applicable state laws, the deceased will be pronounced dead by the attending Physician, his physician designee, the Nurse Practitioner, and/or the Physician Assistant, within a reasonable time. The body will not be released until an entry has been made and signed in the deceased patient's medical record by the attending Practitioner or his physician designee.
- 14 Autopsies should be requested in all perinatal and pediatric deaths.
- 15 A hospital autopsy should not be requested in deaths which are reportable to the Medical Examiner/Coroner which include:
 - a. Patients who are dead on arrival (DOA);
 - b. Deaths within twenty-four (24) hours following admission;
 - c. Deaths known or suspected to result from other than natural causes (accident, suicide, homicide);
 - d. Anesthetic deaths including those under initial induction and those who do not recover from anesthesia;
 - e. Deaths in which the disease process responsible is work-related;
 - f. Stillbirths and neonatal deaths when maternal injury has occurred or is suspected, either prior to admission or during delivery (the placenta and umbilical cord should be saved in such cases); and
 - g. Maternal deaths during or following delivery, including any death in which abortion is suspected.
- 16 An autopsy may be performed only with a written consent, signed in accordance with State law. Provisional anatomical diagnoses will be recorded in the medical record within forty-eight (48) hours, and the complete protocol will be made a part of the record within one month.
- 17 Any Medical Staff Member admitting Medicare patients to the Hospital will honor

the condition of the Hospital's contract with the Department of Health and Human Services.

Section 8 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;

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- 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

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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)

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- 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.

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- 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.

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- 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. Any orders given by the Ordering Practitioner while detained in the operating room or otherwise indisposed should only be received by qualified personnel (as described above) and should adhere to verbal or telephone order guidelines. Orders, critical values, or results of a critical test received by phone should immediately be written and then read back to the staff physician for verification purposes.
- 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.

- e) 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.

Section 9 General Conduct of Care

- 1 A general consent form for diagnosis or treatment, signed by the patient or legally authorized individual, on behalf of every patient admitted to the Hospital must be obtained at the time of admission. The admitting officer should notify the attending Practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the Practitioner's obligation to obtain proper consent before the patient is admitted to the Hospital.

In addition to obtaining the patient's general consent for diagnosis or treatment, a separate consent that informs the patient of the nature of any special treatment or surgical procedure will be obtained prior to special treatment or surgery.

- 2 The Practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.
- 3 All previous orders are canceled when a patient goes to surgery.
- 4 All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopeia, National Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluations, and hospital formulary. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Food and Drug Administration.
 - a) A notation is to be placed in the chart twenty-four (24) hours prior to indicate that drugs or biologicals will require renewal to be continued. The physician who

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prescribed the drug or biological shall write 'renew order' or so indicate which of the drugs or biologicals listed he or she wishes to continue, otherwise, there will be an automatic cancellation of these drugs.

- b) Medications brought to the Hospital by patients will be given to the nurse in charge and identified by the attending Practitioner or Hospital pharmacist. Identified medications will be administered from the Hospital pharmacy on the Practitioner's orders as to dosage, method and frequency of administration. Unidentified or foreign medications will not be administered by Hospital personnel unless the attending Practitioner certifies in writing that the medication is necessary for the medical well being of the patient and writes orders as to dosage, method, and frequency of administration. Patients taking unidentified or foreign medications on order of the attending Practitioner shall execute a release of the Hospital from any liability in administering such medications.
 - c) A patient admitted to the Hospital who is taking an experimental or investigational drug or medication under a protocol from another Joint Commission accredited institution may be administered such medication in the Hospital upon the following:
 - i) Written order of the attending Practitioner; and
 - ii) Compliance with the policies and procedures of the Institutional Review Board
- 5 Drugs and medications may be administered by qualified Members of the Medical Staff and Allied Health Staff with clinical privileges to do so. Drugs and medications may also be administered by registered nurses, licensed vocational nurses, and licensed respiratory care practitioners within the scope of their respective licenses.
- 6 An employee of a Medical Staff Member, whose qualifications are not otherwise specified in these Bylaws, Rules, and Regulations, shall meet the qualifications for similar personnel employed by the Hospital and will be allowed to perform only duties that similarly trained Hospital personnel are permitted to do. Ordering Practitioner-employed nurses (R.N. or L.V.N.), or any other lesser qualified Ordering Practitioner-employed individual may not initiate orders of any kind - - written, verbal, telephone, pre-printed or standing. These employees may gather information and relay that information to their Ordering Practitioner. The Ordering Practitioner

must then call the Covenant Medical Center/Lakeside and Covenant Children's Hospital employee to initiate any orders needed. These employees may not write in the medical record on behalf of their Ordering Practitioner employer. Any such employee of a Medical Staff Member must be approved by the President or his designee prior to working in the Hospital and shall comply with all applicable Hospital rules and regulations.

- 7 The attending Practitioner is primarily responsible for requesting consultations when indicated and for calling in a qualified consultant. He will provide a written authorization to permit a consultant to attend or examine his patient, except in an emergency.
- 8 The Medical Executive Committee, when necessary and appropriate, will develop and set forth criteria that determine which clinical procedures or treatments or medical, surgical, or psychiatric conditions require consultation with, or management by, a physician or other licensed independent practitioner.
- 9 All members of the Hospital Medical Staff shall abide by the terms of the Notice of Privacy Practices prepared and distributed to hospital patients as required by the federal patient privacy regulations.

Section 10 Dental Regulations

- 1 A patient admitted by a dentist, with the exception of an oral surgeon who has been granted privileges to perform the admitting history and physical, must be examined by physician Member of the Medical Staff who will record a medical history and physical examination and provide medical supervision of the patient. This medical supervision will continue until the dismissal of the patient.
- 2 Complete records, both dental and medical, will be required for each patient and will be part of the Hospital record.

Section 11 Podiatric Regulations

- 1 A physician Member of the Medical Staff will serve as co-admitter with a podiatrist Member, and the physician Member will be responsible for completing the patient's history and a physical examination and assessment of the vascular status of the limb.

This medical supervision will continue until the dismissal of the patient.

- 2 A detailed podiatric history and examination of the foot with admitting diagnosis will be the responsibility of the co-admitting podiatrist.
- 3 The patient will be discharged only upon the joint order of the physician Member and podiatrist Member. The discharge orders and discharge summary will be written by the podiatrist and countersigned by the Member physician.

Section 12 Surgery

- 1 Except in emergencies, the history, physical examination, and preoperative diagnosis must be in the patient's medical record prior to any surgical procedure. If not recorded, the operation will be canceled. In any emergency the Practitioner shall make at least a definitive note regarding the patient's condition prior to the induction of anesthesia and start of surgery.
- 2 Proper surgical consent shall be obtained prior to the operative procedure except in emergent situations.
- 3 Except in emergencies, all procedures involving laterality will require the surgeon's confirmation of the correct site prior to transporting the patient to the Operating/Procedure Room. The surgeon will confirm the correct site by signing his initials with an indelible marking pen verifying laterality on the patient within the surgical field. For cases involving identification of levels/sides of the spine, an instrument will be placed at the proposed surgical site and an x-ray taken. The x-ray will be read and reported immediately by a staff radiologist for confirmation.
- 4 In all operative and invasive cases, the procedure will not be started until the surgeon, anesthesiologist if in attendance, and circulator have verbally confirmed and recorded the following:
 - a. Correct patient
 - b. Correct procedure
 - c. Correct side/approach, if applicable per Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery – Administrative Policy PC #23.

- 5 In those patients who are found to be difficult to intubate, and/or in those patients who might be difficult to re-intubate in the event of a medical emergency following extubation, the anesthesiologist or pulmonologist will indicate this fact by placing a colored flag directly on the endotracheal tube at the time of the initial intubation. This flag should be placed in such a manner as to be clearly visible to all those practitioners subsequently involved in the care of the patient.
 - a) If an outpatient surgery patient has respiratory distress and/or reintubation following surgery, the anesthesiologist will see the patient and document their status prior to discharge. A doctor's order will be required to ensure that nursing staff are aware of the need to contact the anesthesiologist prior to discharge.
 - b) All patients transported from the Operating Room to the Post Anesthesia Care areas (ICU/PACU) will receive supplemental oxygen.

Section 13 Emergency Services

- 1 The Medical Staff will adopt a method of providing medical coverage in the emergency service area. This will be in accord with the Hospital's basic plan for the delivery of such services.
- 2 The duties and responsibilities of all non-physician personnel serving patients within the emergency service area will be defined in a procedural manual relating specifically to the emergency service area.
- 3 All patients admitted to the emergency department will be evaluated by a physician.
- 4 An appropriate medical record will be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record, if such exists. The record will include, when possible:
 - a) Adequate patient identification;
 - b) Information concerning the time of the patient's arrival, means of arrival and by whom transported;
 - c) Pertinent history of the injury or illness including details relative to first aid or

emergency care given the patient prior to his arrival at the Hospital, whenever possible;

- d) Description of significant clinical, laboratory and roentgenologic findings;
 - e) Diagnosis;
 - f) Treatment given;
 - g) Condition of the patient on discharge or transfer; and
 - h) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.
 - i) As authorized by the patient or his/her legally authorized representative, a copy of the record of emergency services provided is available to the Practitioner responsible for follow-up care.
- 5 Each patient's emergency medical record shall be signed by the Practitioner in attendance who is responsible for its clinical accuracy.
- 6 There will be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. Such plan will be updated annually.

Section 14 Confidentiality of Credentials Files, Peer Review Files, and the Peer Review Process

- 1 Credentials Files
- a) Credentials files will be maintained for all Practitioners and Allied Health Professionals with staff privileges. Credentials files will include the following:
 - i) Original application for membership and/or privileges;
 - ii) Reapplications for membership and/or privileges;

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- iii) Original source verifications of information related to application and reapplication;
 - iv) Reference letters;
 - v) Documented verification of licenses, registrations, and certifications;
 - vi) Documentation of professional liability insurance and claims history;
 - vii) Any other information related to application for appointment or reappointment;
 - viii) Correspondence to and from the Practitioner;
 - ix) Documentation concerning the membership, privileges and/or status of the Practitioner, including any restrictions, denials or revocations of membership or privileges;
 - x) National Practitioner Data Bank queries and responses;
- b) Access to the credentials files will be for the purpose of credentialing or recredentialing activities, and confidentiality will be maintained. Access will be limited to:
- i) Medical Staff Services personnel;
 - ii) Chief of Staff;
 - iii) Credentials Committee;
 - iv) Medical Executive Committee;
 - v) Board or agents of the governing board; and
 - vi) Individuals with a current, signed authorization of the Practitioner or as otherwise required by law or regulation.
- c) Allowing a Practitioner access to his credentials file or peer review file shall not constitute a waiver of any privilege applicable to the documents in such files

under federal law or Texas law.

- d) A Practitioner may be granted access to his own credentials file in Medical Staff Services during regular business hours.
- e) Credentials files will be maintained in Medical Staff Services. Files will be kept locked when not in use.

2 Peer Review Files

- a) A peer review file shall be maintained, as needed, for Practitioners and Allied Health Professionals with staff privileges. Contents will include:
 - i) Practitioner Reappointment Profiles;
 - ii) Case review forms;
 - iii) Correspondence to and from peer review committees;
 - iv) Results of special or intensified reviews;
 - v) Relevant incident reports or other documentation of situations requiring trending or investigation; and
 - vi) Memoranda of informal counseling.
- b) The information regarding quality assessment activities shall not be used for commercial purposes.
- c) Access to Peer Review Files
 - i) Access to peer review files shall be for the purpose of discharging Medical Staff responsibilities, and subject to the requirement that confidentiality be maintained. Access shall be limited to:
 - (1) Medical Staff Services personnel;
 - (2) Chief of Staff;

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- (3) Department Chair;
 - (4) Credentials Committee;
 - (5) Medical Executive Committee;
 - (6) Board or agents of the governing board; and
 - (7) Individuals with a current, signed authorization of the Practitioner or as otherwise required by law or regulation.
- ii) A Practitioner may be granted access to his own peer review file in Medical Staff Services during regular business hours.
- d) Insertion of Information
- i) Any person may provide information to the Medical Staff about the conduct, performance, or competence of its Members. Such information shall be submitted in good faith and confined to documented acts, demeanor, or conduct reasonably likely to be:
 - (1) detrimental to patient safety or to the delivery of quality patient care within the hospital;
 - (2) unethical;
 - (3) contrary to these Medical Staff Bylaws or Rules and Regulations; or
 - (4) below applicable professional standards.
 - ii) All adverse information deemed important for credentialing purposes shall be reviewed by the Chief of Staff and a decision made to:
 - (1) Not insert the information in the peer review file; or
 - (2) Provide a written summary of the adverse information to the Member and offer him the opportunity to rebut this information before it is entered into the peer review file.

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- iii) Information obtained in the course of an investigation shall remain in a separate file during the course of the investigation and until the outcome of the investigation is resolved.
- e) Member's Opportunity to Request Correction, Deletion, or Addition to Any Information in the Peer Review File
 - i) When a Member has reviewed his file as provided in these Rules and Regulations, he may address a written request to the Chief of Staff for correction or deletion of information in his file. Such requests shall include a statement of the basis for the action requested.
 - ii) The Chief of Staff and Department Chair, if requested by the Practitioner, shall review such a request within thirty (30) days and shall recommend to the Medical Executive Committee whether to make the requested correction or deletion. The Medical Executive Committee shall make a final decision by majority vote.
 - iii) The Member shall be notified in writing within two (2) weeks of the decision of the Medical Executive Committee.
 - iv) A Member, with notification to the Medical Executive Committee, will have the right to add to his own peer review file a brief statement responding to any information contained in the file.
- f) Confidentiality in the Peer Review Process

Member agrees to keep confidential and not take, retain, use or disclose to others at any time records, documents or information of any kind that may be provided to Member pertaining to medical staff peer review and/or credentialing of System medical staff and allied health staff applicants or members. Member understands that any breach of peer review confidentiality may result in termination of medical staff membership and/or privileges. Any Member who breaches confidentiality will be ineligible for any position of medical staff officer or leadership, including appointment to all committees. If Member is currently a medical staff officer or in a position of leadership, the Member will be dismissed from this position, and in addition will be removed from any committee membership he holds at the time.

g) Disposition of Information Following Reappointment

Documentation of formal corrective action, as specified in these Rules and Regulations, will be retained.

- a) With the exception of documentation relating to formal corrective action, all information will be discarded after reappointment action has been taken by the Board unless the Credentials Committee, Medical Executive Committee, or Board requests such information be retained for further scrutiny, review, or tracking.
- b) Information retained at the request of the Department Chair, Credentials Committee, Medical Executive Committee, or Board will be reviewed following the next two-year reappointment cycle, and if acted upon favorably at that time, will be handled in the same manner as Section 16.2.f.ii.

Section 15 Codes of Ethics

Each Member and Allied Health Professional shall adhere to the code of ethics of his respective profession.