

**Covenant Medical Center / Covenant Lakeside
Medical Staff Rules and Regulations**

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

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Section 1 Credentialing

1 Application Eligibility

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

2 Application Process

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

3 Reapplication Following Adverse Decision

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

4 Provisional Status

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

5 Reappointment

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6 Clinical Privileges

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

7 Change of Staff Status or Category

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply

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with Joint Commission Standard MS.01.01.01.

8 Determination of Active or Courtesy Category

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

9 Leave of Absence

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

10 Definition and Monitoring of Clinical Involvement with a Patient

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

11 Temporary Privileges

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

12 Disaster Privileges

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

13 Emergency Privileges

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

14 Telemedicine Privileges

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

15 House Staff

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

16 Covenant Fellowships

Has been moved from Rules and Regulations to Bylaws, Article X Section 1 to comply with Joint Commission Standard MS.01.01.01.

Section 2 Allied Health Professionals

1 Categories

a) 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 process.

- i) Audiologists;
- ii) Cardiovascular Pump Perfusionists;
- iii) Clinical Psychologists;
- iv) Licensed Professional Counselors;
- v) Marriage and Family Counselors;
- vi) Nurse Practitioners/Advanced Nurse Practitioners;
- vii) Orthotists;
- viii) Physician Assistants;
- ix) Prosthetists;
- x) Psychiatric Social Workers;
- xi) Surgical first assistants;

a) Affiliate Health Professionals are Physician Employees providing 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 credentialing process. The Affiliate Health Professionals shall not be entitled to the procedures set forth in the Fair Hearing Plan.

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- i) Registered Nurses;
- ii) Licensed Vocational Nurses;
- iii) Surgical Technicians
- iv) Medical Assistants

2 Supervision

- 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's assistant.

3 Qualifications

- a) Allied Health Professionals must meet the following minimum criteria for the category for which they are applying:
- b) Audiologists
 - i) Documented verification of a M.A. degree in Audiology or certification by the American Speech/Language Association, and
 - ii) Documented verification of current Texas licensure in Audiology.
- c) Cardiovascular Pump Perfusionists
 - i) Board Certified by the American Board of Cardiovascular Perfusionists, and maintain same once granted; and

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- ii) 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.
- d) Clinical Psychologists
 - i) Documented verification of graduation from an accredited doctorate program in psychology;
 - ii) Documented verification of certification by the Texas Board of Examiners of Psychologists; and
 - iii) If the clinical psychologist is to operate an independent practice, documented verification of licensure for independent practice in the state of Texas.
- e) Licensed Professional Counselors
 - i) 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.
 - ii) Documented verification of licensure as a professional counselor.
- f) Marriage and Family Counselors
 - i) 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.
 - ii) Documented verification of licensure as a marriage and family counselor.
- g) Nurse Practitioners
 - i) Documented verification of completion of a nurse practitioner program and completion of the requirements specified by the Texas State Board of Nurse

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- 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.
- ii) Licensure as a nurse practitioner by the Texas State Board of Nurse Examiners.
 - iii) Current basic cardiopulmonary resuscitation certification.
- h) Orthotists
- i) 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.
- i) Physician's Assistants
- i) Documented verification of licensure by the Texas Medical Board and certification by the National Commission on Certification of Physicians Assistants.
 - ii) Current basic cardiopulmonary resuscitation certification.
- j) Prosthetists
- i) Documentation of having met the eligibility criteria for certification by the American Board for Certification in Orthotics and Prosthetics.
- k) Psychiatric Social Workers
- i) Documented verification of licensure as a psychiatric social worker.
- l) Surgical First Assistants
- i) Graduate of accredited school of nursing or surgical technology;
 - ii) Documentation of nursing licensure if R.N. or L.V.N.;
 - iii) Documentation of current certification if a surgical technician;
 - iv) Current basic cardiopulmonary resuscitation certification; and

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v) Documentation of competency.

m) Other Qualifications for All Categories

i) Letter of recommendation from at least three references who know of the Applicant's professional experience and competence.

ii) Documented evidence of continuing education relative to the Applicant's area of specialty during the past two years.

iii) 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 file 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 laws require 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 a 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

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply with Joint Commission Standard MS.01.01.01.

2 Grounds for Corrective Action

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply with Joint Commission Standard MS.01.01.01.

3 Request for Corrective Action

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply with Joint Commission Standard MS.01.01.01.

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4 Initial Review / Informal Counseling

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply with Joint Commission Standard MS.01.01.01.

5 External Peer Review

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply with Joint Commission Standard MS.01.01.01.

6 Formal Investigation

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply with Joint Commission Standard MS.01.01.01.

7 Medical Executive Committee Review

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply with Joint Commission Standard MS.01.01.01.

8 Board Review and Final Action

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply with Joint Commission Standard MS.01.01.01.

9 Summary Suspension

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply with Joint Commission Standard MS.01.01.01.

10 Automatic Suspension

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply with Joint Commission Standard MS.01.01.01.

11 Alternative Coverage of Patients

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply

with Joint Commission Standard MS.01.01.01.

12 Automatic Termination of Membership

Has been moved from Rules and Regulations to Bylaws, Article X Section 2 to comply with Joint Commission Standard MS.01.01.01.

Section 5 Fair Hearing Plan

1 General Provisions

Has been moved from Rules and Regulations to Bylaws, Article X Section 3 to comply with Joint Commission Standard MS.01.01.01.

2 Grounds for Hearings

Has been moved from Rules and Regulations to Bylaws, Article X Section 3 to comply with Joint Commission Standard MS.01.01.01.

3 Procedural Safeguards

Has been moved from Rules and Regulations to Bylaws, Article X Section 3 to comply with Joint Commission Standard MS.01.01.01.

4 Notice of Adverse Recommendation or Action

Has been moved from Rules and Regulations to Bylaws, Article X Section 3 to comply with Joint Commission Standard MS.01.01.01.

5 Request for Hearing and Notice

Has been moved from Rules and Regulations to Bylaws, Article X Section 3 to comply with Joint Commission Standard MS.01.01.01.

6 Establishment of Hearing Committee

Has been moved from Rules and Regulations to Bylaws, Article X Section 3 to comply with Joint Commission Standard MS.01.01.01.

7 Procedures for Hearing

Has been moved from Rules and Regulations to Bylaws, Article X Section 3 to comply with Joint Commission Standard MS.01.01.01.

8 Recommendation and Action

Has been moved from Rules and Regulations to Bylaws, Article X Section 3 to comply with Joint Commission Standard MS.01.01.01.

9 Appellate Review

Has been moved from Rules and Regulations to Bylaws, Article X Section 3 to comply with Joint Commission Standard MS.01.01.01.

Section 6 Organization of Medical Staff

1. Departments

The following departments comprise the Medical Staff:

Medicine
Surgery

1.1) Sections

The following Sections comprise the Medical Staff departments:

Medicine
a) Cardiology
b) Dermatology
c) Emergency Medicine
d) Family Medicine
e) Internal Medicine
f) Nephrology
g) Pathology
h) Pediatrics
i) Physical Medicine & Rehabilitation

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- j) Psychiatry
- k) Radiology

Surgery

- a) Anesthesiology
- b) Dental
- c) Neurosurgery
- d) Obstetrics and Gynecology
- e) Ophthalmology
- f) Orthopedics
- g) Otorhinolaryngology
- h) Podiatry
- i) Surgery (general, pediatric, plastic, and transplant)
- j) Thoracic and Cardiovascular Surgery
- k) Trauma
- l) Urology

1.2) Subsections

The following subsections comprise the Medical Staff:

- a) Pain Management – Section of Anesthesiology
- b) Hand Surgery – Section of Surgery

2. Committees

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) Medical Executive Committee

The composition, duties, and meetings of the Medical Executive Committee are defined in the Medical Staff Bylaws. (Article VIII, Section 1)

b) Ethics Committee

Composition: The Ethics Committee will consist of physician Members of the Medical Staff and representatives of other related disciplines as determined appropriate by the Chief of Staff. The CHS Chief Operating Officer, or the COO's designee, the CHS Executive Ethics liaison, Senior Vice President of Mission Integration, and Senior Vice President of Quality or that SVP's designee will serve as ex-officio members without vote. Committee members will serve a two (2) year term, with one-third (1/3) of the Committee membership appointed from a list of suggested members submitted by the Ethics Committee to the Chief of Staff. The Chief of Staff will appoint the committee chair. Membership will be comprised of not less than 15 persons; not more than 20 persons.

Duties:

1. To serve on one of the Ethics subcommittees: a) the clinical ethics assistance team (CEAT); or b) the systemic ethics group (SEG). The Ethics Committee chair will serve on both subcommittees.
2. To provide educational information to the Medical Staff, Board, and CHS.
3. To perform the duties of the "medical or ethics committee" set forth in Chapter 166 of the Texas Health and Safety Code, as it may be amended from time to time. (Role of CEAT)
4. Covenant Health System's policies are indeed binding and form the basis of the Ethics Committee's (CEAT) advisory authority.

Meeting: The Ethics Committee will meet quarterly or as needed.

c) Cancer Committee

Composition: The Cancer Committee is a standing committee of the Covenant Health System.

The cancer committee includes at least one (1) physician member from the required specialties: Diagnostic radiology, general surgery, medical oncology,

pathology, and radiation oncology.

The committee shall consist of at least one (1) non-physician member from: Cancer program administration, oncology nursing, social services, certified tumor registrar, and quality improvement.

All required cancer committee members are appointed by the Chief of Staff and with input from the Cancer Committee Chair.

Additional physician or non-physician members are added to meet the needs of the oncology program. These members are also appointed by the Chief of Staff and with input from the Cancer Committee Chair.

The cancer committee chair is a physician who may also fulfill the role of one of the required physician specialties. The Cancer Liaison Physician must be a member of the cancer committee and fulfill the role of one of the required physician specialties.

Duties:

1. The Medical Executive Committee gives the Covenant Cancer Committee the responsibility and accountability for the cancer program activities.
2. Designates one coordinator for each of the four areas of cancer committee activity: cancer conference, quality control of cancer registry data, quality improvement, and community outreach on an annual basis.
3. Develops annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors on an annual basis.
4. Establishes the cancer conference frequency, format, and multidisciplinary attendance requirements for cancer conferences on an annual basis.
5. Ensures that that required number of cases are discussed at cancer conferences and that at least 75 percent of the cases discussed at cancer conferences are presented prospectively.

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6. Monitor and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis.
7. Provides a formal mechanism to educate patients about cancer-related clinical trials.
8. Reviews the percentage of cases accrued to cancer-related clinical trials each year.
9. Monitors community outreach activities.
10. Offers cancer-related educational activities each year.
11. Completes and documents the required studies that measure quality and outcomes.
12. Implements two improvements that directly affect patient care on an annual basis.
13. Establishes subcommittees or workgroups as needed to fulfill cancer program goals.
14. Completes site-specific analysis that includes comparison and outcome data and disseminates the results of the analysis to the medical staff.
15. Reviews 10 percent of the analytic caseload to ensure that AJCC staging is assigned by the managing physician and recorded on a staging form in the medical record on at least 90 percent of eligible analytic cases.
16. The Covenant Oncology Program follows the guidelines set forth in the current ACOS-Commission on Cancer Standards.

Meeting: The Cancer Committee will meet on a quarterly basis.

d) Credentials Committee

Composition: The Credentials Committee will consist of at least six (6) Members

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of the Active Medical Staff whose terms will be for two years. A member may be reappointed for successive terms. An attorney who represents the Medical Staff will be an ex-officio member without vote. Ex-officio members shall include the Vice President with administrative responsibility for credentialing, the Chief Medical Officer, and the Vice President of Quality.

Duties:

1. Review the credentials of Applicants and make recommendations for appointment, reappointment, and delineation of clinical privileges in compliance with Section 1 (Credentialing) of these Rules and Regulations;
2. Review and make recommendations on applications from Allied Health Professionals;
3. Review reports referred by the Medical Executive Committee, other committees, and by the Chief of Staff; 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.

Meeting: The Credentials Committee will meet monthly or as needed.

e) Emergency Department Call Coverage and Transfer Review Committee

Purpose: To establish a joint decision-making committee of medical staff and administration responsible for the oversight and implementation of strategies, policies, and procedures regarding emergency department non-trauma call coverage and transfer issues affecting Covenant Health System and its medical staff for the provision of medical care to the unassigned patients of our region. This is a shared committee of Covenant Medical Center and Covenant Children's Hospital.

Authority: The ED Call Coverage and Transfer Review Committee has authority to establish and implement all policies and procedures governing the medical staff and operations relating to the effectiveness of emergency department call coverage. The committee will have authority to make recommendations to administration and the

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Board of Directors regarding compensation methodology and budgets for physician call compensation as a group and within individual specialties. Committee oversight encompasses Covenant Medical Center and Covenant Children's Hospital.

Composition: The Emergency Department Call Coverage and Transfer Review Committee will be composed of:

- Department Chairs of both Covenant Medical Center and Covenant Children's Hospital
- At least five (5) members of the Active Medical Staff;
- Medical Director(s) for the Emergency Department(s);
- Medical Director for Trauma Services;
- Chiefs of Staff; and
- Representatives of the Hospital staff and Administration with responsibilities involving the emergency transfer of patients and/or acceptance of such transfers

The physician members of the committee will be appointed by the Covenant Medical Center Chief of Staff in consultation with the administration and will include members from each specialty participating in the call program. Members will serve two-year terms in staggered appointments to provide continuity. One half of the appointees will be in group A. and one half in group B. The initial term for group A. will be one year and all subsequent terms for both groups will be two years. Committee members may be reappointed and serve consecutive terms. The committee may invite any member of the medical staff to attend meetings on an ad hoc basis. Service on this committee is not compensated. In the event a committee member cannot attend a meeting, the section may provide an alternate with the approval of the Chief of Staff.

Duties/Responsibilities:

1. Conduct peer review with regard to the transfer and receipt of transfers of emergency patients. Assess all questionable unaccepted transfers with Lubbock and regional facilities for effective and appropriate physician response. Initiate inquiry and appropriate action related to questionable hospital or physician issues.
2. Review transfer reports to monitor compliance with Medical Staff and Hospital policies and procedures and applicable law. Recommend corrective action or reporting, as indicated, in accordance with these Rules and Regulations and applicable law. Determine sanctions or penalties for noncompliance with these policies or for repeated inappropriate refusal of

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transfer by a member of the call rotation.

3. Assist in obtaining call coverage for any specialty unable to provide coverage due to physician shortage or insufficient response.
4. Provide input into compensation methodology, contracts, and budgets to ensure call coverage continuity.
5. Provide physician leadership and intervention for contract resolution within specific specialties.
6. Assume responsibility for monitoring the clinical quality of positions and specialties under contract ED call coverage. Review and make recommendations as needed regarding those physicians who exhibit continuing patterns of an unacceptable quality, responsiveness, or behavior.
7. Assist with decisions regarding new physicians entering the ED call coverage rotation.
8. Assess potential EMTALA violations by regional facilities and assist with CHS response to such infractions.

Meeting: The Emergency Department Call Coverage and Transfer Review Committee will meet monthly or as needed.

f) Institutional Review Board

Composition: The Institutional Review Board will be composed of at least five (5) members in compliance with the requirements of all regulatory agencies. Physician members will be appointed by the Chief of Staff. Non-physician members will be appointed by the President. (Director of Medical Education Research will serve as Chair.)

Duties:

1. Review all investigational studies to be undertaken at the Hospital
2. Monitor investigational studies at intervals appropriate to the degree of

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risk (but in no event exceeding one year)

3. Review all ongoing studies for continuing need, relevance and feasibility.

Any adverse or negative decisions made by the Institutional Review Board will not be subject to review or modification by the Medical Executive Committee or the Board of Directors.

Meeting: The Institutional Review Board will meet at least six (6) times a year.

g) Nominating Committee

Composition: The Nominating Committee of the Medical Staff will be composed of the three Immediate Past Chiefs of Staff.

Duties:

1. Nominate Medical Staff officers.
2. 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.

Meeting: The Nominating Committee will meet every two years.

h) Physician Health and Wellness Committee

Composition: The Physician Health and Wellness Committee will consist of a maximum of six (6) Members of the Medical Staff appointed for multiple year terms.

Duties:

1. The committee shall maintain records of its proceedings, which will be confidential and kept separate from other records including hospital credentials files.

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2. Provide education about practitioner health and address prevention of physical, psychiatric, or emotional illnesses.
3. Facilitate and encourage self-referrals as well as confidential impairment referrals by other medical or hospital staff. Reporting may be directly to the Chief of Staff, to a member of this committee, or an immediate supervisor.
4. Facilitate the confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition.
5. Develop, implement, and annually review policies for the evaluation and monitoring of potentially impaired Medical Staff Members and Allied Health Professionals, to include, without limitation, testing and monitoring for use of illicit drugs, non-therapeutic mind altering substances, and alcohol;
6. Receive regular reports of status, treatment, and prognosis of physicians from the facility or practitioner responsible for evaluation and rehabilitation of the physician;
7. Investigate, provide a course of action, and provide monitoring as needed or any Member of the Medical Staff or Allied Health Professional who experiences or suffers from any impairment or other significant health issue with the potential to affect the individual's ability to provide services to the patients of this Hospital; and
8. Advise the chief of staff of instances in which a physician is unwilling to accept assistance or is non-compliant in the treatment program and recommend appropriate action; and
9. Assist the impaired Practitioner in the process of rehabilitation while protecting the welfare of patients.
10. Present a report on its activities annually to the Medical Executive Committee.
11. Authority: The Committee on Physician Health and Wellness shall have the authority to conduct, or cause to be conducted, an investigation of

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an alleged impaired physician or Allied Health Professional; to cause an evaluation of the nature and severity of the alleged impairment by appropriate consultants; to determine the appropriate course of action to be taken, including recommending appropriate restrictions of impaired physician's or Allied Health Professional's staff and/or membership status; to plan the reinstatement of a physician or Allied Health Professional when appropriate to do so.

Meeting: The Physician Health and Wellness Committee shall meet at least twice a year and at the request of the chairman as necessary.

i) Quality Review Committee

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 and the Chief Medical Officer will be voting members. Physician members shall be Members of the Active Medical Staff.

Duties:

The Quality Review Committee will be responsible for oversight of the following activities and review functions:

1. Blood Usage / Pathology Review
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

The Quality Review Committee will integrate Medical Staff/Cross-Functional Quality

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Activities as follows:

1. Oversight of all Medical Staff Quality Improvement activities;
2. Receive and assess Quality Improvement reports from combined Hospital/Medical staff committees;
3. Assess and assign Medical Staff Members to cross-functional teams;
4. Coordinate and prioritize Quality Improvement efforts between all Medical Staff Departments, Sections, and combined Hospital/Medical Staff committees to minimize duplication of efforts;
5. Participate in identifying and recommending processes, functions, and dimensions of performance that warrant cross-functional efforts for improvement;
6. Report improvement activities to the Medical Staff Executive Committee as appropriate;
7. Analyze utilization review and risk management activities
8. Communicate and recommend to Medical Staff Executive Committee optimum utilization of hospital resources and facilities commensurate with quality patient care and safety;
9. Charter cross-functional Medical Staff teams to address process issues;
10. Annually evaluate quality, utilization, and risk management programs for effectiveness, and revise as appropriate;
11. Oversight of reviews by Peer Review Organization (PRO) and third party payers when criteria is not met; and
12. Take action when improvement opportunities are identified. Assess the action taken for effectiveness and evaluate results.
13. Define purpose and objective of committee;

The Quality Review Committee will assure that both Medical Staff Departments will

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perform the following duties:

1. Develop indicators that provide quality data for tracking, trending, and improvement opportunities. These must include high volume, high risk, problem prone areas within the scope of each service and be consistent with house-wide goals;
2. Develop criteria for peer review;
3. Identify knowledge-based outcomes for comparative benchmarking;
4. Review outliers after initial screening by the Physician Quality Review Board and respond to specific questions of the reviewers;
5. Participate in cross-functional teams to study and improve processes for dimensions of performance;
6. Participate in clinical pathway development and in improving other areas within their specialties;
7. Recommend criteria for the delineation of clinical privileges within the Department, including initial appointment and reappointment;
8. Provide continuing surveillance for the professional performance of all members of the Department with clinical privileges;
9. Review results of drug utilization, blood usage, surgical case review, and medical record summaries for opportunities to improve;
10. Communicate and recommend to Quality Review Committee optimum utilization of hospital resources and facilities commensurate with quality patient care and safety; and
11. Take action and evaluate the effectiveness of the action when improvement opportunities are identified.

Meeting: The Quality Review Committee will meet monthly.

j) Physician Quality Review Board

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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. The Medical Staff Officers of Covenant Medical Center and Covenant Children's Hospital, Department Chairs, Chair of Credentials Committee, and Medical Director of Quality.

Duties:

1. Initial screening of trends and outliers based on established criteria. Request information from the Departments regarding specific questions that cannot be answered by the documentation in the medical record related to the care the patient received;
2. Screen for utilization issues that need discussion by the Medical Staff Department;
3. Identify review or education needed by the Medical Staff Departments or committees; and
4. Refer to Quality Review Committee issues which need further review or action. Issues should be summarized and signed by the Department Chair and the physician involved in the case.
5. Identify issues that affect patient care;
6. Make recommendations for quality improvement efforts to Quality Review Committee; and
7. Review as necessary the quality improvement activities as defined by the committee's purpose.

Meeting: The Physician Quality Review Board will meet bi-monthly.

k) 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.

The 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

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within two hours. Any patient admitted to the acute hospital will be seen by the physician (not an extender) within twelve hours of admission to the acute care floor. A patient admitted directly from the physician's office is an exception. The Emergency Department physician will not be considered a physician visit.

4. With the exception of pediatric trauma, patient under thirteen (13) years will not be admitted to Covenant Medical Center/Covenant Medical Center – Lakeside unless the patient requires services not available at Covenant Children's Hospital. Pediatric trauma patients will be admitted in accordance with established trauma guidelines.
5. 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.
6. 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.
7. Patients will be admitted in the following order of priorities:
 - a) Emergency admissions so designated by the attending physician;
 - 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
8. Patients will be admitted to special care units as follows:

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- a) Patients may be admitted to the Cardiac Care Unit by internists, cardiologists, and cardiovascular surgeons with admitting privileges. Other physicians may admit to these units only with immediate orders for a consultation with an internist, cardiologist, or cardiovascular surgeon.
 - b) Patients may be admitted to the Intensive Care Units by any Practitioner with admitting privileges. Appropriate consultations are recommended.
 - c) The attending physician of the Neonatal Intensive Care Unit will be a Neonatologist.
 - d) Patients will be admitted to the Mental Health Unit and Chemical Dependency Unit by psychiatrists with admitting privileges. The psychiatrist may designate another Member of the Medical Staff with admitting privileges, a Member of the Emergency Medicine Department, or a Psychiatric Resident under his supervision to provide the initial evaluation and treatment and arrange for the admission to the psychiatrist's service if he is not immediately available to see the patient prior to admission.
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) Patients with known or suspected suicidal tendencies will be admitted to the Mental Health Unit unless their medical condition requires they be 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.
 - c) Patients with known or suspected tendencies to injure others will be admitted to the 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

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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:
- b) From general care area to Intensive Care or Cardiac Care;
- c) From Emergency Department or Recovery Room to appropriate patient bed;
- d) From any special care unit to a general care area when medically indicated;
- e) From Intensive Care and Cardiac Care units to general care areas; and
- f) From temporary placement in an inappropriate area to an appropriate area.
- g) All transfers must be ordered or approved by the attending Practitioner.

12. No passes will be ordered by Practitioners or honored by Hospital personnel except for patients in the Mental Health Unit, Chemical Dependency Unit, or Rehabilitation Unit when such passes are a part of a patient's prescribed therapy.

13. 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.

14. 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, Physician Assistant, Hospice RN, or Nursing Supervisor within a reasonable time. Hospice nurses may pronounce death only for Hospice patients (specific

to agency) with no artificial means of life support. The Nursing Supervisor, Director of Nursing on-call, or the Palliative Medicine Charge Nurse (on the Palliative Medicine unit only) may pronounce death under the following conditions: attending physician must document anticipated death during this hospitalization (and discussion with family regarding such) in the progress note: an order must be present, signed, timed, and dated prior to time of death: and the patient must have no artificial means of life support. 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. NOTE: Artificial means of life support is defined as a ventilator or ECMO

15. The following criteria should assist the Medical Staff in identifying deaths in which an autopsy should be performed:
 - a) Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician;
 - b) All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds;
 - c) Cases in which autopsy may help to allay concerns of, and provide reassurance to, the family and/or the public regarding the death;
 - d) Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedure and/or therapy;
 - e) Deaths of patients who have participated in clinical trials (protocols) approved by the Institutional Review Board;
 - f) Unexpected or unexplained deaths that are apparently natural and not subject to forensic medical jurisdiction;
 - g) Natural deaths that are subject to, but waived by, a forensic medical jurisdiction, such as persons dead on arrival at hospital, deaths occurring in hospital within twenty-four (24) hours of admission, and deaths in which the patient sustained or apparently sustained an injury while hospitalized;
 - h) Deaths resulting from high-risk infections and contagious diseases;
 - i) All obstetric deaths;

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- j) All perinatal and pediatric deaths;
 - k) Deaths in which it is believed that an autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs; and
 - l) Deaths known or suspected to have resulted from environmental or occupational hazards.
16. 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.
17. 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.
18. 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.
 - i) 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.
 - ii) 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:
 - iii) The patient's name, address, date of birth, and the name of any legally authorized representatives;
 - iv) The patient's legal status for patients receiving mental health services;
 - v) Emergency care provided to the patient prior to arrival, if any;
 - vi) The record and findings of the Practitioner's assessment of the patient;
 - vii) A statement of the conclusions or impressions drawn from the medical history and physical examination;
 - viii) The diagnosis or diagnostic impression;
 - ix) The reason(s) for admission or treatment;
 - x) The goals of treatment and the treatment plan;
 - xi) Evidence of known advance directive;
 - xii) Evidence of informed consent for procedures and treatments for which informed consent is required by organizational policy, Joint Commission standards, and applicable state law;

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- xiii) Diagnostic and therapeutic orders, if any;
- xiv) All diagnostic and therapeutic procedures and tests performed and the results;
- xv) Test results relevant to the management of the patient's condition;
- xvi) All operative and other invasive procedures performed using acceptable disease and operative terminology that includes etiology, as appropriate;
- xvii) Progress notes made by the Medical Staff, physicians in training, physician assistants, and nurse practitioners;
- xviii) All reassessments, when necessary;
- xix) Clinical observations;
- xx) The patient's response to the care provided;
- xxi) Consultation reports;
- xxii) Every medication ordered or prescribed;
- xxiii) Every dose of medication administered and any adverse drug reaction;
- xxiv) Each medication dispensed to or prescribed for patient on discharge;
- xxv) All relevant diagnoses established during the course of care; and
- xxvi) Any referrals/communications made to external or internal care providers and to community agencies.
- xxvii) Conclusions at termination of hospitalization;
- xxviii) Discharge instructions to the patient and family; and
- xxix) Clinical resumes and discharge summaries, or a final progress note or transfer summary.

2. The medical record of any patient undergoing operative or other invasive procedures and/or anesthesia will include the following:
 - a) Except in life threatening emergencies, the history, physical examination, and preoperative diagnosis must be recorded in the patient's record prior to any surgical procedure. If not recorded, the operation will be postponed until all data are available.
 - b) Any indicated laboratory and x-ray examinations should be completed and recorded in the medical record or a summary of pertinent findings may be documented in the medical record.
 - c) A preoperative diagnosis prior to surgery, and the attending physician's and/or surgeon's documented plan for the operative or invasive procedure;
 - d) Documentation by the anesthesiologist of 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;
 - 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 post-procedure plan and an initial assessment of the patient's physical, mental, and neurological status and needs.
 - h) 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 conditions and complications, if any;

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- i) Postoperative documentation of the patient's vital signs and level of consciousness; medications (including intravenous fluids), blood, and blood components; any unusual events or postoperative complications, including blood transfusion reactions, and management of such events;
 - j) Postoperative documentation of the patient's discharge from the post-anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.
3. 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. Covenant Health System Tumor Registry staff may abstract data from the chart to complete the staging form, which will then be reviewed and signed by the appropriate physician. 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

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be discarded. Staging forms are not required when the patient is not registered in the hospital information system.

4. 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.
5. Physician responsibilities for moderate sedation (conscious sedation/analgesia) will be as follows:

Pre-procedure:

1. A history and physical should be in the record prior to the procedure on all patients receiving moderate or deep sedation.
2. 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 history of sedation/anesthesia complications
 - c. Physical exam of airway, heart and lung, level of consciousness
 - d. Operative and other invasive procedure plan
 - e. Sedation risk assessment (e.g., ASA score)
 - f. Plan for moderate sedation (e.g., IV sedation with monitoring)
3. Obtains and documents appropriate informed consent for procedure and sedation
4. Communicates the moderate sedation plan to involved care providers
5. Reassesses the patient prior to administration of sedation and documents that they remain a candidate for the procedure and sedation

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Post procedure:

- a) 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.
6. 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.
 7. The medical record for a patient receiving continuing ambulatory care services will include known significant diagnoses, conditions, procedures, drug allergies, and medications.
 8. All physicians treating cancer patients are required to report follow-up patient information to the cancer registry in a timely manner.
 9. Any chart will be delinquent when:
 - a) The history and physical are not present within twenty-four (24) hours after admission.
 - b) Any portion of the chart is incomplete fifteen (15) days after the date of discharge.
 10. A delinquent record that 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.
 11. Any Practitioner with a delinquent chart will be notified by letter from the Quality

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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 the suspension and the responsibilities for emergency call as assigned on the call schedule.

12. 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.
13. Each practitioner will be prompted to review and complete their patient's medical records in an electronic format Horizon Patient Folder. All Charts that require completion, correction, or a final electronic signature will be 'flagged' automatically upon 'log in'.

If the Medical Records HPF 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.

14. When Medical Records determines that the record has not been satisfactorily completed, the physician will have (7) days to complete the records. If the physician fails to complete the records within the (7) day period, the physician's name will automatically be re-posted to the suspension list.
15. 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.
16. 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.
17. 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.
18. 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.

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19. 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.
20. All orders for treatment shall be in writing. Verbal orders are discouraged and should only be given in the event of a dire patient emergency. Telephone orders by staff physicians will be accepted and transcribed when given to a 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). Verbal or telephone orders are to be dated and identify the names of the individuals who gave, received, and implemented the order. 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.

To maintain a culture of patient safety, all ordering Practitioners should request that their telephonic or emergency verbal orders be immediately read back to them.

21. Each clinical entry in the patient's medical record shall be legible, complete, accurately dated and timed, and be appropriately 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.
22. Written consent of the patient will be required for release of medical information to persons not otherwise authorized to receive this information.
23. 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.

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24. 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.
25. 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 by 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.
26. 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.
 - d) 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.
 - a) 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 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

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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:
 - d) Written order of the attending Practitioner; and
 - e) 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 the Medical Staff Bylaws and these 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 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 records 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 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

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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.
6. 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.
7. All patients transported from the Operating Room to the Post Anesthesia Care areas

(ICU/PACU) will receive supplemental oxygen.

Section 13 Trauma Program

1. The trauma program will involve multiple disciplines organized within the Trauma Section.
2. Performance improvement evaluation of trauma will be conducted within the Trauma Section and in coordination with the Quality Review Committee.
3. The trauma medical director shall have overall administrative authority for the trauma program.
 - a. Qualifications of the trauma medical director:
 - i. Board certified surgeon with special interest in trauma care
 - b. Duties of the trauma medical director include:
 - i. Recommending trauma team privileges;
 - ii. Establishing the trauma on-call lists;
 - iii. Cooperating with the nursing administration to support the nursing needs of the trauma patients;
 - iv. Developing treatment protocols;
 - v. Coordinating the performance improvement peer review process;
 - vi. Correcting deficiencies in trauma care or excluding from trauma call those trauma team members who do not meet criteria; and
 - vii. Coordinating the budgetary process for the trauma program.

Section 14 Emergency Services

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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 15 Psychiatry

1. Restraint or seclusion is to be used only if necessary to protect the safety and welfare of the patient and/or staff and/or other patients. It will never be used as punishment or for aversive conditioning. In all instances the physician must comply with the Physician Participation in Seclusion and/or Restraint Policy that is a part of the Organizational Plan for Seclusion and Restraint.
 - a) Children and adolescents below age eighteen (18) may not be hospitalized on the unit.
2. The following therapies will not be provided in the Mental Health Unit:
 - a) Aversive conditioning;
 - b) Psychosurgery;
 - c) Z-therapy;
 - d) Bioenergetics therapy;
 - e) Primal scream therapy;
 - f) Reparenting; and
 - g) Other therapies of regressive, aversive, or experimental nature.
3. Only a Member of the Medical Staff with privileges in psychiatry may admit to the Psychiatric Service.
4. Electroconvulsive therapy:
 - a) Normally, electroconvulsive therapy will be undertaken in patients age eighteen

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(18) and older in the following circumstances only:

- b) A documented major depression, bipolar disorder, or other treatment-resistant psychosis exists; and
 - c) An adequate trial of antidepressant or other drug therapy has failed, or the life or safety of the patient would be jeopardized without immediate electroconvulsive therapy.
 - d) A minimum workup will be performed prior to the electroconvulsive therapy to include: CBC; urinalysis; EKG; chest x-ray; AA chemistries or lytes plus; and if the patient is over age fifty (50) or has a history of back pain or disorder, x-rays of the spine.
 - e) An anesthesiologist must be present for all electroconvulsive therapy.
 - f) Scheduling of all ECT will be coordinated by the head nurse of the Mental Health Unit.
 - g) Standing orders must be on file for pre-ECT and post-ECT medications and procedures.
 - h) Informed consent must be obtained as per the informed consent form for ECT.
5. For Amytal or other sedative or sedative tranquilizer interviews:
- a) The psychiatrist must possess current ability perform cardiopulmonary resuscitation (CPR).
 - b) The patient or guardian must sign an informed consent form.
 - c) The interview will be scheduled by the head nurse or designee.
 - d) A crash cart will be in the room and both the psychiatrist and assisting nurse will be conversant with its use.
 - e) A nurse will be in attendance throughout all procedure.
 - f) Orders must be written governing post-interview procedures, medication, and

nursing duties.

6. Lithium carbonate:
 - a) Before administering lithium carbonate for the first time, the following tests should be performed in addition to routine history and physical and laboratory workup:
 - b) Twenty-four (24) hour urine for creatinine clearance or two (2) serial blood creatinines within normal range;
 - c) Thyroid function tests;
 - d) EKG;
 - e) CBC, urinalysis, and AA chemistries or lytes plus.
 - f) For initial administration, blood lithium level will be monitored at least weekly during hospitalization, to be performed twelve (12) hours after the last dose (in the morning before administering the a.m. dose).

Section 16 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;
 - iii) Original source verifications of information related to application and reapplication;
 - iv) Reference letters;

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- 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) Department Chair;
 - iv) Credentials Committee;
 - v) Medical Executive Committee;
 - vi) Board of Trustees or agents of the governing board; and
 - vii) Individuals with a current, signed authorization of the Practitioner or as otherwise required by law or regulation.
 - viii) A Practitioner may be granted access to his own credentials file in Medical Staff Services during regular business hours.
 - ix) Credentials files will be maintained in Medical Staff Services. Files will be kept locked when not in use.
- c) Allowing a Practitioner access to his credentials file or peer review file shall not

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constitute a waiver of any privilege applicable to the documents in such files under federal law or Texas law.

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.
 - vii) The information regarding quality assessment activities shall not be used for commercial purposes.

b) 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;
 - 3) Department Chair;
 - 4) Credentials Committee;
 - 5) Medical Executive Committee;

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- 6) Board of Trustees 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.
- 8) A Practitioner may be granted access to his own peer review file in Medical Staff Services during regular business hours.

c) 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;
 - 4) or 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.
- 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.

d) 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.

3. 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.

4. Disposition of Information Following Reappointment

- a) Documentation of formal corrective action, as specified in these Rules and Regulations, will be retained.
- b) With the exception of documentation relating to formal corrective action, all information

will be retained for six (6) years.

Section 17 Codes of Ethics

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