

**BYLAWS**  
**RULES AND REGULATIONS**  
**OF**  
**THE PATTIE A. CLAY**  
**REGIONAL MEDICAL CENTER**

*IN ORDER TO PREVENT THESE BYLAWS FROM BECOMING ANTIQUATED AND  
DISREGARDED, THEY SHOULD BE REVIEWED AND REVISED, IF NECESSARY,  
PERIODICALLY BY A COMMITTEE OF THE MEDICAL STAFF AND  
ADMINISTRATOR OF THE HOSPITAL, APPROVED BY THE GOVERNING BODY,  
AND AN ATTESTED COPY IN THE MINUTE BOOK OF THE MEDICAL STAFF  
PROCEEDINGS FOR READY REFERENCE.*

May 2002  
June 2002  
October 2002  
November 2002  
December 2002  
March 2003  
September 2003  
November 2003  
April 2004  
May 2004  
October 2004  
May 2005  
April 2006  
August 2006  
October 2006  
January 2007  
February 2007  
August 2007  
September 2007  
October 2007  
November 2007  
February 2008  
January 2009  
February 2009  
March 2009  
October 2009

**BYLAWS OF THE MEDICAL STAFF  
PATTIE A. CLAY REGIONAL MEDICAL CENTER**

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**STATEMENT OF PURPOSE**

The purpose of Pattie A. Clay Regional Medical Center is to provide culturally competent quality healthcare to a diverse population in Madison County and neighboring communities.

**STATEMENT OF MISSION**

The Mission of PACRMC is to provide quality healthcare in a modern facility by a Team of highly-skilled physicians and staff through nurturing, personalized services.

**STATEMENT OF VISION**

A center of excellence: To honor our obligation as a center of excellence by our commitment to constant and never-ending improvement in the quality of care of our patients.

**PREAMBLE**

WHEREAS, the Pattie A. Clay Regional Medical Center, is a non-profit corporation organized under the law of the Commonwealth of Kentucky; and

WHEREAS, its purposes are to serve as a general hospital providing patient care and to further medical education; and

WHEREAS, the Medical Staff recognizes and accepts responsibility for the quality of care in the hospital in a cooperative effort with the governing body;

THEREFORE, the physicians and dentists practicing in the hospital hereby organize themselves into a departmentalized medical staff in conformity with the Bylaws, Rules and Regulations in order to provide the best possible patient care.

**ARTICLE I - NAME**

**ARTICLE II - PURPOSE**

**ARTICLE III - DEFINITIONS**

## **ARTICLE I**

### **NAME**

The name of the organization shall be the “Medical Staff of the Pattie A. Clay Regional Medical Center.”

## **ARTICLE II**

### **PURPOSE**

1. To ensure that all patients admitted to the hospital or those treated as outpatients receive the best possible medical care:
2. To provide a means whereby problems of a medico/administrative nature be discussed by the medical staff with the hospital governing body and administration.
3. To establish Bylaws, Rules and Regulations in order to:
  - A. Initiate and maintain self government unencumbered by bureaucratic intimidation.
  - B. Delineate the members’ qualifications, status and clinical duties and responsibilities.
4. To provide appropriate educational setting and to maintain scientific standards that will continue advancement in professional knowledge and skills.
5. To assure high level of performance of all practitioners authorized to practice in the hospital through delineation of clinical privileges and through a mechanism to regularly review, evaluate and monitor staff practices and functions.

## **ARTICLE III**

### **DEFINITIONS**

1. The term "medical staff" means all physicians and dentists who are privileged to participate in patient care (inpatient and outpatient) in the hospital.
2. The "governing body" means the board of directors of the hospital.
3. The "executive committee" means the committee of the medical staff composed of the president, vice president and secretary/treasurer, and two members of the staff (members at large) elected at the annual meeting.
4. The "chief of staff" or "president" is the practitioner elected as chief medical officer by the medical staff at the annual meeting.
5. The term "service" means "Medicine Service", "OB/Pediatric Services or "Surgery Services" to which each practitioner with appropriate privileges will be assigned. (see Article VI, Section I).
6. The "chief of service" means the individual staff member elected by members of a service to head that department. (Article VI, Section III ).
7. The term "medical staff member" or "licensed practitioner" are used interchangeably meaning physician or dentist with a current State of Kentucky license and working and residing in a legal status in the United States by virtue of citizenship or current valid INS documentation. [3/03]
8. "Allied Health Professionals" are other currently licensed individuals permitted by law and by the hospital to provide patient care services independently, supervised or dependent in the hospital who are working and residing in a legal status in the United States by virtue of citizenship or current valid INS documentation.
9. "Accredited Medical School" is a medical school that is approved by the American Association of Medical Colleges or the American Association of Osteopathic Colleges or recognized as acceptable to the Kentucky Board of Medical Licensure.

## **ARTICLE IV**

### **MEDICAL STAFF MEMBERSHIP**

## **ARTICLE IV**

### **MEDICAL STAFF MEMBERSHIP**

#### **SECTION I: NATURE OF MEDICAL STAFF MEMBERSHIP**

- A. Membership on the medical staff of Pattie A. Clay Regional Medical Center:
- B. is a privilege which shall be extended only to professionally competent and currently licensed physicians and dentists who continuously meet the qualifications, standards and requirements set forth in these bylaws.
- C. Only physicians and dentists currently licensed to practice in Kentucky and are residing and working in the United States by virtue of citizenship or current valid INS documentation and can document their background, experience, training and demonstrate their adherence to the ethics of their profession, and their good reputation shall be entitled to membership on the medical staff. No physician or dentist shall be entitled to membership on the medical staff or to exercise particular clinical privileges in the hospital merely by virtue of the fact that he/she is duly licensed to practice medicine or dentistry in this for any other state, or that he/she is a member of some professional organization or that he/she had in the past, or presently has such privileges at another hospital.
- D. Emergency Department Physicians are referenced under Article V, Section III of these bylaws. [8/07]
- E. No applicant shall be denied medical staff membership on the basis of sex, race, color, creed, religious, national origin or disability.
- F. The Medical Staff is provided with a copy of the mission statement upon initial appointment and reappointment to the staff. The medical staff as a whole, and on an individual basis, will abide by and provide clinical care consistent with the mission and vision of Pattie A. Clay Regional Medical Center.

#### **SECTION II: QUALIFICATIONS**

An applicant for membership to the medical staff shall:

- A. Be a graduate of an accredited medical or dental school.
- B. Be currently licensed to practice medicine or dentistry in Kentucky.
- C. Be qualified for membership in the Madison County Medical Society or Dental Society.
- D. Practice and live within distance of the hospital as delineated under Article V, Section I of these bylaws.
- E. Currently and legally residing and working in the United States by virtue of United States citizenship or current valid INS documentation.

## **SECTION II : QUALIFICATIONS ( continued)**

- E. Have a stable personality, good character and be worthy in all matters of personal ethics.
- F. Show evidence of competence in his/her area of practice by:
  - 1. Satisfactory completion of an accredited residency training program and/or board certified or board eligible.
  - 2. **In case of a shortage only**, a physician who has successfully entered his/her last year of an accredited residency program in emergency medicine may be granted privileges at Pattie A. Clay Regional Medical Center. Each need will be evaluated on a case by case basis and the physician will be monitored under remote supervision by the sponsoring staff physician.
  - 3. Recommendation from appropriate sources, current Kentucky license, current DEA Certification, current malpractice insurance.
  - 4. Complying with credentialing as under Article V, Section III of the Bylaws Rules and, Regulations.
- G. Be in satisfactory mental and physical health to practice medicine.
- H. Applications to the staff will not be accepted if the necessary competency information is not submitted.

## **SECTION III: APPLICANTS**

- A. Applications for membership of the medical staff shall be presented in writing on the Kentucky Standardized Application form (7/07) which shall state the qualifications and references of the applicant also signify his/her agreement to abide by the Bylaws, Rules and Regulations of the Medical Staff. Each applicant shall be provided a copy of the current prevailing bylaws rules and regulations of the medical staff at the time of application. Applications shall also contain the following information;
  - 1. The type of practice for which privileges are requested.
  - 2. Whether proposed practice is individual, partnership or associated with a group.
  - 3. Or if applicant is associated with Health Maintenance Organization, Preferred Provider Organization, Independent Physicians Organization or a similar organization
- B. By applying for appointment to the Medical Staff each individual applicant thereby:
  - 1. Signifies his/her willingness to appear for an interview in regard to his/her application.
  - 2. 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 his/her competence.

### **SECTION III: APPLICANTS (continued)**

3. Consent to the hospital's inspection of all hospital and training documents that may be material to an evaluation of his/her credentials, and any organization which provides information to the hospital in good faith without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges.
  4. National Practitioner's Data Bank will be queried for each application to the medical staff at the time of initial appointment and reappointment and when requesting additional privileges.
- C. The applicant shall have the burden of establishing his/her qualifications and current competence in performing the clinical privileges he/she requests. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every staff member's obligation to provide continuous care and supervision of his/her hospital patients, and to abide by the bylaws, rules and regulations of the medical staff.
- C. For initial appointment, the applicant's education, training, licensure, experience, character/judgment, and current competence shall be verified. The Medical Staff Executive Committee has the authority to require documentation as to the applicant's current health status.
- E. Applicant must disclose any previously successful or currently pending malpractice claims, suits, settlements, final judgments or arbitration proceeding involving their professional practice and show that he/she has adequate liability insurance to cover such litigation. Previously successful or currently pending challenges to any licensure or registration (state or district, DEA) or voluntary or involuntary termination of such license or registration. Voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, denial or loss of clinical privileges at another hospital must be disclosed at the time of application.
- F. Completed application will be when all questions are answered, all information received and all primary sources are verified.(when possible). Photo ID on a government issued ID is required (drivers license, passport).
- G. All new applicants must provide written evidence of U.S. citizenship (birth Certificate/visa) or current and valid evidence of legal residence and working status in the United States at the time of application.

#### **SECTION IV: TERM OF APPOINTMENT AND REAPPOINTMENT**

- A. Initial appointment to the medical staff shall be made by the governing body to the hospital and shall be for a period of one year. (Refer to Article V, Section VI). At the end of the term the hospital governing body may reappoint a member of the medical staff for a period of two years, providing the recommendation has not been made that a specific appointment not be renewed. Allied Health Professionals request for privileges are initially for a one year period and at the end of the term, the hospital governing body may renew the privileges for a two year period providing the recommendation has not been made that privileges not be renewed. Expedited process may be used by the governing board (Section H below) for the appointment and reappointment reviews.
- B. Medical staff reappointment and delineation of privileges must be carried out in manner as to ensure the continuing function of the staff. Reappointment forms shall include privileges requested with any basis for change and information pertaining to continuing education since the last appointment. Applications for reappointment shall be submitted to the Office of the Medical Staff. Completed applications and delineation of privileges will be reviewed by the chief of service and forwarded to the credentials committee with his/her recommendations. The Medical Staff Executive Committee of the Medical Staff serves as Credentials Committee along with the appropriate Chief of Service.
- C. The applicant for reappointment or renewal of clinical privileges is required to submit any reasonable evidence of current ability to perform privileges that may be requested by the credentialing committee.
- D. The review process shall include appraisal of the applicant's health status, professional performance, judgment and skills, license and participation in continuing education. Applicant must disclose (on a separate sheet) any previously successful or currently pending challenges to any licensure or registration (State or District, Drug Enforcement) voluntary or involuntary relinquishment of such license or registration or voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, denial or loss of clinical privileges at another hospital since the date of his/her last (re) appointment. Information on any malpractice claims, suits, settlements, final judgments or arbitration proceedings involving the physicians professional practice will be reported - at minimum, final judgments or settlements involving the applicant are reported. Current malpractice insurance.
- E. Applicants for reappointment who are not United States citizens must present proof of legal residence and work status in the United States. If legal status is due to expire during a two year reappointment period, the applicant must provide evidence for his/her credential file during that two year period of a legal residence and work status.

#### **SECTION IV: E.**

- F. The Medical Staff Executive Committee shall have the authority to require documentation as to the applicant's current health status. Peer review will be considered by the Medical Staff Executive Committee in making recommendations for appointment and reappointment to the Medical Staff and/or granting of clinical privileges.
- G. Should the hospital governing body wish to take the initiative in refusing to make appointment or reappointment of any members, it shall so advise the medical staff, stating reasons and asking for recommendations from the medical staff.
- H. To expedite initial appointments to the Pattie A. Clay Medical Staff and granting of privileges, reappointment to membership or renewal or modification of privileges, the governing board may delegate the authority to render those decisions to a committee of at least three voting members of the governing board. Any of the following situations will make an applicant for privileges ineligible for the expedited process.
  - 1. Applicant submits an incomplete application
  - 2. The MSEC makes a final decision that is adverse or has limitations

The following situations will be evaluated on a case by case basis and usually result in ineligibility for the expedited process.

- 1. There is a current challenge or previously successful challenge to license or registration
- 2. The applicant has received an involuntary termination of medical staff membership at another organization.
- 3. The applicant has received involuntary limitation, reduction, denial or loss of clinical privileges or
- 4. The hospital determines that there has been either an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant.

Criteria for the expedited process is also used when recommending privileges  
1/07]

#### **SECTION V: ETHICS AND ETHICAL RELATIONS**

The Code of Ethics adopted by the American Medical Association, American Osteopathic Association or the American Dental Association shall govern the professional conduct of members of the medical staff. Physicians who have privileges at Pattie A. Clay Regional Medical Center agree to honor advanced directives as outlined in the hospital policies and procedures and as stated in the Kentucky statutes. Periodic updates or policies and procedures will be done. The Pattie A. Clay Regional Medical Center Code of Ethics will be widely distributed and will be adhered to by the Ethics Committee. Code of Conduct for Practitioners will be signed at the time of appointment and reappointment [2/09].

## **ARTICLE IV**

### **SECTION IV: C      APPOINTMENT PROCEDURE**

- A. Application for membership on the staff and delineation of clinical privileges being requested shall be presented to the President/CEO of the hospital who shall forward it to the medical staff coordinator.
- B. The applicant's credentials shall be verified from the primary source (if possible) and filed with this application. Delineation of privileges are reviewed, proof of training/competency is obtained. Completed application and delineation of privileges being requested are forwarded to the appropriate Chief of Service for review/evaluation/recommendation.  
Completed application for medical staff membership and clinical privileges will include all information the applicant has been asked to provide and validation of that information. Chief of Service forwards his/her recommendations to the Medical Staff Executive Committee serving as the Credentials Committee. MSEC shall review all reports, application, delineation of privileges at the next regularly scheduled meeting and submit their recommendations to the next regular meeting of the Board of Directors or as soon thereafter as possible, recommending that the application be accepted, deferred or rejected. In no case shall this report be delayed for more than three months after date of completion of the application..
- C. The hospital governing body shall either accept the recommendation of the staff or refer it back for further consideration. In this case the hospital governing body shall instruct its secretary to state to the medical staff the reasons for such action. The governing body is not bound by the medical staff executive committee recommendation but has the ultimate authority to render a decision, adverse or not, as long as the decision is neither arbitrary, capricious, discriminatory, nor contrary to the bylaws.
- D. When final action has been taken by the hospital governing body, they shall be authorized to transmit this decision to the Medical Staff Executive Committee. The applicant will be notified within one week of the final decision of the Board of Directors.
- E. The applicant or any member of the staff shall have the right to appeal at any step of the above. (See Article IX).
- F. A personal interview will be conducted by the Medical Staff Executive Committee (credentials committee) with all applications for active staff privileges. This interview will be conducted before a report is made to the Board of Directors.
- G. Temporary Privileges may be granted by the Chief of Service and/or Chief of Staff and the CEO of the hospital if a situation exists that a physician needs privileges before his/her completed application/credentials can be reviewed/approved by the Board of Directors. The privileges will be time limited and the application will be processed according to the bylaws, rules and regulations. (See Article V, Section XI)

### **SECTION VII:    DUES:**

The annual dues shall be one hundred (\$100 for active staff and \$125 for consulting and ER staff) for improvement of the library or any other significant projects, to help defray expenses for the staff dinners. Active Staff and Consulting and ER Staff are required to pay dues.

**ARTICLE V**

**DIVISION OF THE MEDICAL STAFF**

## **ARTICLE V**

### **SECTION I**

#### **DIVISION OF THE MEDICAL STAFF**

Each applicant to the medical staff shall qualify for and be appointed to one, of the following categories - with the exception of provisional staff:

- |                            |                    |                                |
|----------------------------|--------------------|--------------------------------|
| A. Active                  | E. Courtesy        | H. Dental                      |
| B. Consulting              | F. Provisional     | I. Temporary/Locum Tenens      |
| C. Emergency               | G. Medical Student | J. Allied Health Practitioners |
| D. Refer and Follow [1/09] |                    |                                |

#### **SECTION I: ACTIVE MEDICAL STAFF**

- A. Shall be composed of the physicians who attend and admit patients to Pattie A. Clay Regional Medical Center.
- B. Shall be eligible to vote and hold office.
- C. Reappointment of the active medical staff shall be made every two years by the hospital governing body on the recommendation of the MSEC.
- D. Should attend the medical staff meetings and staff members are to serve on the committee(s) to which they are appointed (as provided in Article X, Section IV of the Bylaws).
- E. In order to be readily available to meet the care needs of patients at Pattie A. Clay Regional Medical Center, active staff physicians shall maintain a professional office in Madison County. Physicians who are granted active staff privileges shall take ER call within the area of their practice and on-call physicians must respond to a call (cell phone, telephone, beeper) within 20 minutes and be able to be physically available in the hospital within 30 minutes, if the patient situation necessitates.  
Active Staff physicians shall comply with Federal Regulations regarding evaluation, stabilization, transfer or admission of a patient. Disregard of any of these bylaw provisions will be grounds for immediate suspension and any further action will be in accordance with the provisions of the Medical Staff Bylaws, Rules and Regulations (Article VIII and Article IX).  
An active staff physician may make arrangements with another active staff physician at Pattie A. Clay Regional Medical Center, with similar training to assume their on-call duties.
- F. Shall take emergency room call in their area of practice. Each service of the medical staff shall determine its rotation for emergency room call schedule except as outlined in Section M of the Rules and Regulations.
- G. Active Staff show enough activity per year (at least twenty five (25) patient care or procedures per year) to maintain their active staff privileges at Pattie A. Clay Regional Medical Center. [8/07]

## ARTICLE V

### SECTION II: CONSULTING MEDICAL STAFF

- A. Shall consist of recognized specialists for which the active medical staff feels there is a need.
- B. Shall be appointed by the hospital governing body on recommendation of the medical staff.
- C. Shall comply with the same credentialing process as for the active staff as outline under Article VI, Section IV, of the bylaws.
- D. May provide their professional services at the request of any active member, especially in those cases where consultation is required by the staff rules and regulations.
- E. Shall have no admitting privileges.
- F. My use the facilities of Pattie A. Clay Regional Medical Center as an outpatient facility.
- G. Consulting physicians or his/her designated medical representative from their group should attend medical staff meetings and service meetings as required for active staff privileges (Article X, Section IV).
- H. Consulting staff shall agree to serve on medical staff committee assignments. Reappointment of the consulting medical staff shall be made every two years by the hospital governing body on the recommendation of the MSEC.
- I. Consulting Staff show enough activity per year (at least twenty five (25) consults or procedures per year to maintain their privileges at Pattie A. Clay Regional Medical Center. Consulting staff will be required to submit a list of procedures from their primary facility at the time of reappointment if they have not had 25 procedures at Pattie A. Clay Regional Medical Center. [8/07]

## **ARTICLE V**

### **SECTION III: A                   EMERGENCY ROOM STAFF**

This division of the medical staff is further divided into:

- A. Full-time emergency room staff, which should consist of physicians who are accepted to the full-time emergency room service. They shall have voting privileges (unless on provisional status), be required to attend the medical staff meetings, may hold committee positions and may hold office. Full-time emergency room staff is defined as an emergency room physician who works an average of at least thirty-six (36) hours per week as the emergency room physician at the Pattie A. Clay ER
- B. Part-time emergency room staff are those physicians who are accepted to the emergency room service who work less than an average of thirty-six (36) hours per week in the Pattie A. Clay Emergency Department.
- C. An applicant for membership to the Medical Staff for Emergency Dept. privileges:
  - 1. Be a graduate of an accredited medical school.
  - 2. Have a current license to practice in Kentucky
  - 3. Have a stable personality, good character, and be worthy in all matters of personal ethics.
  - 4. Show evidence of competency in his/her area of practice.
    - a. Satisfactory completion of a suitable, accredited residency training program and board eligible/ board certified in emergency medicine or board eligible/ board certified in family practice or internal medicine and worked the past three years in emergency medicine (ER comparable to Pattie A. Clay Emergency Department). [8/07]
  - 5. Recommendations from appropriate sources, current Kentucky license, current DEA certification, current malpractice insurance.
  - 6. All full and part-time physicians with emergency department privileges are required to be verified in the following: Ten (10) CAT I continuing education credits in emergency Radiology interpretation every three years and ten (10) CAT continuing education credits in emergency pediatrics every three year. New physicians on staff will have a one year period to obtain the required CEU's.

### **SECTION IV:   REFER AND FOLLOW**

Refer and Follow staff shall consist of the medical staff members who are privileged to use hospital services (lab, x-ray), attend medical staff meetings, CME programs, social events. A Refer and Follow physician may consult with attending physician on their patient, review patient's hospital medical record, perform outpatient and pre-admission H&P, visit with patient. Physician may not manage inpatient care or make notations in hospitalized patient's medical record. [1/09]

### **SECTION V:   PROVISIONAL MEDICAL STAFF**

All new staff members, except for temporary ER and locum tenens, shall be appointed provisional staff members for one year in order that their ability and competence maybe demonstrated. The privileges and staff qualifications of the provisional members shall be the same as for the appropriate permanent division of staff. At the end of the one year of provisional staff membership, the physician must apply for transfer from provisional staff to the appropriate staff category by a written request submitted to the medical staff executive committee. After review of application, the MSEC shall recommend to the governing body that the application be accepted, deferred or rejected.

## **ARTICLE V**

### **SECTION V: PROVISIONAL MEDICAL STAFF (continued)**

The governing body shall either accept the recommendation of the MSEC or refer it back for further consideration. In this case the hospital governing body shall instruct the secretary to state to the medical staff executive committee the reasons for such actions. When final action has been taken by the hospital governing body, they shall be authorized to transmit their decision to the provisional staff member. Provisional staff shall be for a period of one year only. The provisional staff member or any staff member shall have the right of appeal at any step of the above. (see Article I X).

Provisional staff members shall not be eligible to vote on:

- a. change in bylaws rules and regulations
- b. election of officers and chief of the service to which they are assigned.
- c. change of category of provisional staff member to full staff.

Provisional staff members shall serve on committees but shall not be hold office.

### **SECTION VI: COURTESY STAFF**

Courtesy Staff shall consist of medical staff members who are privileged to use hospital services (lab and x-ray only). Physician may not attend or admit patients.

### **SECTION VII: MEDICAL STUDENT**

Medical Student who is actively enrolled in an accredited medical school will be at all times under the supervision of an active member of the Pattie A. Clay Medical Center.

### **SECTION VIII: DENTAL/CONSULTING STAFF**

The dental staff shall consist of those members of the dental profession who are eligible for membership and who meet all requirements for membership to the medical staff.

Dental staff members may attend patients in the hospital only in consultation to an active medical staff member. The dentists who have hospital privileges:

- A. Are under the overall supervision of the Chief of Surgery.
- B. Shall have their patients admitted by a member of the medical staff, who will be responsible for the admission history and physical to be recorded by medical records.
- C. Are to record the dental history and physical findings and the dental diagnosis.
- D. Are to have any medical problems at the time of admission or arising during hospitalization made the responsibility of a member of the active medical staff .

### **SECTION IX: TEMPORARY PRIVILEGES**

Temporary privileges are to be granted for the purpose of patient care and not the convenience of the practitioner.

The Hospital President (CEO), Chief of Staff and/or the Chief of Service may grant temporary privileges to a practitioner when information reasonably supports a favorable granting of privileges (application, current license, DEA, privilege delineation, insurance, data bank, training, experience and competence) (documented telephone call is acceptable). They may have to meet qualifications stated in Article IV, Section II (Qualifications for Medical Staff). A vice president in administration will act in the absence of the CEO, if necessary. The practitioner exercising temporary privileges shall be subject to all Bylaws, Rules and Regulations of the Medical Staff and Pattie A. Clay Regional Medical Center. Temporary privileges are time limited.

**ARTICLE V****SECTION: X      TEMPORARY PRIVILEGES** (continued)

Conditions for Temporary Privileges:

1. Pending Application (application is complete, approved by the MSEC/Credentials Committee but has not been approved by the Board of Directors) Privileges may be

granted prior to completion of the application process of the medical staff. This is

not to exceed 30 days.

2. Locum Tenens

The chief of staff or service and hospital CEO may permit a physician to serve as a locum tenens for another physician of the medical staff for a period designated by the Medical Staff Executive Committee and the Chief of Staff.

3. Temporary Emergency Room Privileges

Temporary emergency room privileges may be granted with approval of the emergency room director, chief of staff and the Hospital President (CEO).

Temporary ER privileges may be granted for no more than a period of 90 days.

Temporary ER privileges may be terminated at any time by the ER Director.

4. Disaster Emergency Temporary Privileges - **Emergency Management Plan**

Temporary Emergency Privileges may be granted to volunteer licensed physicians and allied health personnel who are not members of the Pattie A. Clay Regional Medical Staff but volunteer their services when the Emergency Management Plan has been activated. The President/CEO or the Chief of the Medical Staff (or their designees) may grant emergency temporary privileges when the emergency management plan is activated and the hospital is unable to handle the immediate patient needs. The President/CEO or the Chief of Medical Staff is not required to grant privileges to any individual and emergency privileges for volunteers will be granted on a case by case basis after receipt of identification document(s).

Key identification document(s) can be one of or more of the following:

- a. Current hospital photo identification (ID) card.
- b. Current medical license and valid photo ID issued by the state, federal or regulatory agency.
- c. Identification indicating that the licensed independent practitioner is a member of a state or federal disaster medical assistant team.
- d. Identification indicating that a federal, state or municipal entity grants a licensed independent practitioner the authority to care for patient's in an emergency.
- e. Presentation of a current hospital or medical staff member with personal knowledge of the practitioner's identity.

When immediate situation is under control, all volunteer's credentials will be verified and temporary privileges will be signed by the CEO or chief of staff (or their designee(s)). Process for granting privileges will be according to hospital policy on credentialing volunteer practitioners for temporary privileges when the disaster plan is implemented and hospital is unable to handle immediate patient care needs ( Policy: MSS-001-032). All volunteers will be issued an identification badge by the hospital when approved to work as volunteers. [11/02] All emergency privileges shall immediately terminate once the emergency is over and may be terminated at any time without any reason or cause. Hearing and appeals process does not apply in emergency situations.

## **ARTICLE V**

### **SECTION XI: ALLIED HEALTH PERSONNEL**

The clinical category of allied health professionals includes such individuals as certified registered nurse anesthetists, certified surgical assistants, clinical psychologists, clinical social workers, (not employed by the hospital), certified physician assistants, certified nurse practitioners, podiatrists and certified nurse midwives who provide examinations or care for patients who are at the Pattie A. Clay Regional Medical Center and practice under medical staff approved protocols. Allied Health Professionals are independently licensed health care providers who provide patient services under the supervision, collaborative agreement or directives of members of the medical staff. Supervising physicians shall be responsible for ensuring that their AHP is practicing within the scope of the practice guidelines delineated and approved by the Kentucky Board of Medical Licensure and Kentucky Board of Nursing when applicable.

Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Certified Nurse Practitioners, Certified Physician Assistants, Podiatrists and Clinical Psychologists/Social Workers shall go through the same credentialing process as members of the medical staff (Article IV, Section IV). The privileges granted shall be exercised under the supervision of the sponsoring or attending physician (if applicable).

Physicians supervising AHP's shall file a copy of the approval with the hospital of their supervision by the Kentucky Board of Medical Licensure (when applicable).

Allied Health Professionals credentialed by the medical staff and considered as special allied health professionals are Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Podiatrists and Clinical Psychologists/Social Workers. These special allied health professionals will have the same hearing and appeals process as the medical staff (as outlined in Article IX -Hearing and Appellate Review Procedure. All other Allied Health Professionals will have the hearing and appeals process as outlined in Section VIII: Hearing and Appellate Review Process for AHP's. [PAC Policy-MSS-001-003]

### **SECTION XII: TELE-MEDICINE**

Practitioners who diagnose or treat patients without clinical supervision or direction via telemedicine link are subject to credentialing and privilege process at Pattie A. Clay Regional Medical Center. Medical Staff will recommend the clinical services to be provided by telemedicine.

### **SECTION XIII NON-EMERGENCY OUTPATIENT DEPT. PHYSICIANS**

Care for patients in the Pattie A. Clay Medical Center non-emergency outpatient departments. Refer patients for admission, ER evaluations, lab and x-rays. Refer patients back to their primary care doctor. May assist patient in locating a primary care physician. May review any hospital medical record that is needed for outpatient care. Participates in hospital committees pertinent to their area of credentialing. Supervise and collaborate with AHP's in their outpatient department. Maintain a medical reporting relationship with the Chief of Staff. May be assigned to a medical service at the discretion of the chief of staff. Attend medical staff meetings, CME and medical social functions. This category has no voting rights and no

admitting privileges and may not act as an attending physician in the hospital.

## ARTICLE VI

### CLINICAL SERVICES AND PRIVILEGES

#### SECTION I: SERVICES AND SECTIONS

##### A. Composition -

The active medical staff shall be divided into the following services. Medicine and Surgery and Pediatrics

These services are made up of clinical sections as follows:

**1. Medicine Services Section**

Dermatology  
Family Practice  
Internal Medicine  
Cardiology  
Pulmonary  
Nephrology  
Gastroenterology  
Neurology

**3. Pediatrics Section**

Pediatrics  
Obstetrics  
(Midwives)

**2. Surgery Services Section:**

Anesthesiology  
General Surgery  
Radiology  
Gynecology  
Orthopedics  
Otolaryngology  
Ophthalmology  
Urology  
Pathology  
Plastic Surgery  
Oral Surgery  
Obstetrics  
Pain Management  
Radiology

**4. Emergency Department Section:**

ER Physicians

## **ARTICLE VI**

### **SECTION II: ASSIGNMENT OF SERVICES**

1. Assignment of the different services shall be made by the medical staff executive committee at the first meeting after it's membership has been appointed by the hospital governing body. The medical staff executive committee may elect to approve or disapprove of any appointment. The assignment to the services or section are for a one year period.
2. Each member of the staff shall be assigned to a single service but may hold privileges in another service.

### **SECTION III: ORGANIZATION FOR SERVICES AND FUNCTIONS**

1. Immediately after assignment has been made, the members of each service shall organize in a manner as to ensure proper patient care and elect a chief of each service to serve for one year.
2. Each section shall be organized as necessary to provide adequate functioning of that section. A chairperson shall be designated to serve for a one year period.

### **SECTION IV: DUTIES OF THE CHIEF OF SERVICE**

The chief of each service is certified by an appropriate specialty board or affirmatively establishes comparable competence through the credentialing process. Some of the duties of the chief of service are as follows:

1. Responsible for all clinically related activities of the department and all administratively related activities, unless otherwise performed by the hospital.
2. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges. Responsible for establishing criteria for clinical privileges relevant to the care provided in the department. Recommending clinical privileges for each member of the department.
3. Assessing and recommending off site sources for needed patient care services not provided by the department or hospital. Integration of the department into the primary functions of the hospital.
4. Coordination and integration of inter departmental and intra departmental services. Development and implementation of policies and procedures as needed.

## **ARTICLE VI**

### **SECTION: IV DUTIES OF CHIEF OF SERVICE (continued)**

5. Recommendation for sufficient number of qualified and competent staff to provide care, treatment or service; input into the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide care, treatment or service.
6. Continuous assessment and improvement of the quality of care, treatment and services provided.
7. Maintenance of quality control programs, as appropriate. Orientation and continuing education of all persons in the department or service.
8. Recommendation for space and other resources needed by the department or service.
9. Chief of Medicine and Chief of Surgery will service as members of the MSEC.

### **SECTION V: CLINICAL PRIVILEGES/CREDENTIALS**

In order to maintain an optimal level of professional performance, the medical staff shall have an appointment/reappointment procedure with delineation of clinical privileges and periodic reappraisal of staff members. Privilege delineation shall be reasonably comprehensive, but not necessarily a detailed list of procedures or medical diseases. All individuals who are permitted by law and by the hospital to provide patient care services independently in the hospital have delineated clinical privileges whether or not they are medical staff members. All medical staff members and all others with delineation of privileges are subject to medical staff bylaws, rules and regulations all departmental policies and procedures and are subject to review as part of the organizational performance improvement.

Delineation of privileges shall be based on verified information available in an applicant or staff member's credentials file. The file on each individual shall contain information on training, experience, and current competence before privileges are granted.

#### **A. Request for Privileges**

1. Staff physicians requesting new privileges will be individually evaluated based

on evidence of training in the requested privileges.

Request for new privileges must be submitted in writing to the appropriate Chief of Service. Notification and appeal procedure are the same as for credentialing a new physician. Board of Directors has the final approval of new privileges being added to privilege list.

## ARTICLE VI

### SECTION: IV

#### CLINICAL PRIVILEGES - CREDENTIALING (continued)

1. New physicians requesting privileges will be individually evaluated and will be granted privileges commensurate with their training, recommendations of their colleagues and demonstrated ability in their field. If a physician is granted privileges for a procedure which involves sedation by non-anesthesia personnel, then the physician will automatically be privileged for the sedation required for the procedure. Final approval by the Board of Directors.
- B. Evidence of Training When Requesting Additional Privileges:  
Definition of "evidence of training" shall mean any of the following:
1. Residency training with specialty supervision in the privilege.
  2. Post-graduate course work with specialty trained supervision.
  3. Personal training and supervision by another physician recognized as competent.
  4. Post-graduate continuing education meetings and courses which contain material covering the request of the privilege.
  5. Focused Professional Practice Evaluation Policy (MSS-001-036) is a process designed for Pattie A. Clay to evaluate the privilege specific competency of a practitioner who does not have documented evidence of competency performing the requested privileges at Pattie A. Clay Medical Center. (see policy)
- C. Review of The Request  
Application and delineation of privileges will be reviewed by the chief of the prospective service to which the privileges pertain. The chief of the service will notify the physician of his/her recommendations on privileges. The privileges will then be forwarded along with the complete application to the Medical Staff Executive Committee (serving as the Credentials Committee). The Medical Staff Executive Committee will forward their recommendation to the Board for review and approval.
- D. Appeal of Decision
1. A physician disagreeing with the privilege determination may appeal. Within ten (10) days of receiving notification, the physician may appeal by proceeding with the procedures of Hearing and Appellate Review, Article IX of the Bylaws
- E. The Board of Directors appoints, reappoint to the Medical Staff and grants initial, renewed or revised clinical privileges based on medical staff recommendations and in accordance with these bylaws, rules and regulations.

## **ARTICLE VI:**

### **SECTION V: CREDENTIALING** (continued)

2. At any point in the appeal procedure, the physician and/or the Medical Staff Executive Committee and/or the Governing Board may have legal counsel of their choice present. Minutes will be recorded at all appellate meetings. Recording devices and court stenographers will be permitted at all reviewing committees, the cost of which will be borne by the requesting party. After exhaustion of all appeal procedures as provided herein, the decision of the final authority shall be final and not subject to review at the hospital level.
3. In all cases, both existing staff members and new staff members must have their request for privileges approved before they may exercise those privileges in the Pattie A. Clay Regional Medical Center. A physician may not exercise a privilege while it is in the appeal procedure.

### **SECTION VI: TERMINATION OF CONTRACT**

Any physician who is employed by the hospital and who is required to have membership

on the medical staff shall have the same medical responsibilities and privileges as other staff members of the same status. His/her privileges may not be terminated without the same process of other members of the medical staff unless otherwise stated by the contract.

### **SECTION VII: EMERGENCY SITUATIONS**

In case of a dire, life-threatening emergency, any medical staff member who has clinical privileges is permitted to provide any type of patient care necessary as a life-threatening measure or to prevent serious harm - regardless of his or her medical status or clinical privileges - provided that the care provided is within the scope of the individual's license.

### **SECTION VIII: LEAVE OF ABSENCE**

The Board of Directors, for a good cause, may grant a leave of absence (LOA) to a member of the Medical staff for a stated period of time not to exceed two years. Absence for longer than two years constitutes voluntary relinquishment of medical staff membership and privileges. Requests for a LOA may be made in writing to the Chief of Staff and to the CEO/President and shall state the beginning date and estimated date of return for the LOA. The CEO shall forward the request to the MSEC which shall make a recommendation to the Board of Directors. Medical staff members called to active duty will be afforded expedited action by the CEO upon receipt of the written request. At the conclusion of the LOA, the individual may be reinstated upon filing a written statement with the CEO which will be forwarded to the MSEC summarizing his/her professional activities during the LOA. The individual shall also provide other information that may be requested by the hospital. If the leave of absence is taken for medical reasons, the individual must submit a report from his/her attending physician indicating that the medical staff member is physically/mentally capable of resuming a hospital practice and performing the privileges requested. After review of the information, the MSEC shall make a recommendation to the Board of Directors

for a final action on the request. In acting upon the reinstatement, the Board may approve the reinstatement to the same category or a different category, and may recommend limitation or modification of privileges.

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## **ARTICLE VII:**

### **ORGANIZATION OF STAFF**

#### **SECTION I: OFFICERS**

- A. The officers of the medical staff shall be president, vice president and secretary/treasurer and two members at large. Chief of Surgery and Chief of Medicine will also be officers on the Medical Staff Executive Committee.
- B. All officers shall be members of the active staff or consulting staff and in good standing with ability and experience to fill the position and a willingness to devote the time and effort to fulfill the responsibilities of the office.
- C. The Chief of Staff, Vice Chief of Staff, Secretary/Treasurer and two members at large shall be elected by a majority of the vote at the Medical Staff Meeting held in each year in July.
- D. Term of Office: All officers shall serve a one-year term from their election or until a successor is elected. Officers shall take office on the first day of the medical staff year (August 1). The president shall serve no more than two consecutive years.
- E. Removal From Office: All officers are subject to removal from office at the discretion of the medical staff. Removal of an officer from office requires a 2/3 majority vote, secret ballot of the medical staff. If a member's privileges are suspended, they are automatically removed from office. Officers may be removed from office if he/she fails to carry out any of his/her defined responsibilities/duties under the bylaws.
- F. Membership: All active and consulting staff members of the medical staff are eligible for membership on the Medical Staff Executive Committee regardless of his/her specialty. The MSEC may also include licensed independent practitioners.

#### **SECTION II: DUTIES OF OFFICERS**

- A. The president, who shall be known as the chief of the medical staff shall call, preside at all meetings, shall be an ex-officio member of all committees, and have a generalized supervision of all professional work of the hospital. The president shall be the medical staff representative to the Board of Directors.

**ARTICLE VII:**

**SECTION II: DUTIES OF OFFICERS** (continued)

- B. The vice-president, in absence of the president, shall assume all of the duties and have all the authority. He/she also will be expected to perform such duties of supervision as may be assigned him/her by the president. He/she shall also be a member of the executive committee.
  
- C. The secretary/treasurer shall keep adequate records and include minutes of all meetings, attend to all correspondence and perform all duties as ordinarily pertain to his/her office. If there are funds to be accounted for, he/she will be the treasurer.
  
- D. All officers shall be a member of the active or consulting medical staff and demonstrate competency in their specialty. They shall be willing and able to discharge the duties of the office they hold.

**SECTION III: COMMITTEES**

- A. Organization of Committees:  
The primary duties of the major committees will be to provide, promote and oversee an integrated approach to medical staff performance improvement. This will be done by the medical staff as a whole participating in organizational performance improvement activities.  
The structure of the committees is as follows:
  - 1. The Executive Committee is the major coordinating committee.
  - 2. The standing committees which report to the executive committee are:
    - a. Pharmacy and Therapeutics
    - b. Credentials Committee (performed by the Executive Committee)
    - c. Emergency Department
    - d. Infection Control
    - e. Continuing Education/Library Committee

**ARTICLE VII:****SECTION III: COMMITTEES** (continued)

- f. ICU/Cardiology Committee
  - g. Safety Committee (Disaster Plan) coordinated with hospital committee.
  - h. Nominating Committee
  - i. Bylaws Committee
  - j. Performance Improvement
  - k. Hospital Utilization
  - l. Ethics Committee
  - m. Major Service Committees (Medicine, OB/Pediatrics, Surgery)
  - n. Tumor Board
  - o. M and M Committee
2. The major service committees (Medicine, OB/Pediatrics and Surgery) and sections composition, function and meetings are designated in Article VII, Section III. Their primary duties are to review and evaluate patient care and treatment.
  4. The Bylaws shall designate the following for all committee members.
    - a. Composition
    - b. Terms
    - c. Duties
    - d. Meetings
  5. All committees shall keep a record of their meetings with recommendations, conclusions and any actions instituted. Physicians in attendance will be considered a quorum {11/09}
  6. The following committees/services should meet at least 10 months per year.
    - a. Medical Staff Executive Committee
    - b. Emergency Room Committee
    - c. Safety Committee
    - d. Performance Improvement
    - e. Infection Control
    - f. Tumor Board
    - g. Mortality and Morbidity Committee [7/09] .

## **ARTICLE VII**

### **SECTION III: COMMITTEES** (continued)

7. The following committees shall meet bi-monthly:
  - a. Pharmacy and Therapeutics
8. The following committees shall meet quarterly or as necessary:
  - a. ICU/CCU
  - b. Physical Medicine
  - c. Respiratory Therapy
  - d. Utilization Review
  - e. Ethics Committee (when needed)
  - f. Bylaws Committee (at least annually)
  - g. Nominating Committee (annually)
  - h. Continuing Education (when needed)
  - i. OB/Pediatrics
  - j. Surgery Services
  - k. Medicine Services
  - l. Ionizing Radiation

### **B. EXECUTIVE COMMITTEE**

1. The executive committee shall consist of the president, vice president, secretary/treasurer, two members at large, chief of medicine and the chief of surgery. [Revised 8/07] All officers are to be members of the active or consulting and are actively participating in the hospital. No medical staff member actively participating in the hospital is ineligible for membership on the executive committee solely because of his/her professional discipline or specialty. The executive committee may also include licensed independent practitioners [Revised 10/06]. Officers will be elected at the time of the annual July meeting each year but will not take office until August 1st. The CEO (hospital president) and the vice president for patient care services shall serve as ex-officio members of the executive committee. The Chairman of the Board of Directors (or his/her designee) may attend all regular committee meetings unless it is a special meeting to discuss medical staff matters.
2. The duties of the executive committee shall be to coordinate the activities and general policies of the various services, departments, to act for the staff as a whole under limitations as may be imposed by the staff and carry out such other responsibilities as the medical staff may delegate. The committee shall act for the staff in the interval between staff meetings. The committee is responsible for making medical staff recommendations directly to the governing body for its approval. Such recommendations may pertain to medical staff structure, mechanism for reviewing credentials and delineation of privileges, recommendation for individuals for medical staff membership, recommendation for delineation of privileges for eligible individuals, participation of the medical staff in organization performance improvement activities, mechanism by which medical staff membership may be terminated, mechanism for fair hearing procedures.
3. The executive committee shall meet at least 11 times a year and maintain a

permanent record of the proceedings and actions. Quorum will be at least 50% of the Medical Staff Executive Committee members. [11/09]

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## ARTICLE VII

### SECTION III: COMMITTEES (continued)

4. The members of the executive committee, or a staff appointee shall act as liaison between the medical staff and the governing body of the hospital and shall meet jointly with the president/CEO and the governing body as deemed necessary by either the Board or Medical Staff. Chief of Staff is the medical representative on the Board of Directors and shall report to the Board on Medical Staff activities at monthly board meeting.
5. The executive committee shall initiate and pursue corrective action when warranted in accordance as medical staff bylaws provide.
6. The executive committee serves as the credentials committee.  
The credentials committee will investigate the credentials and delineation of privileges of all applicants for membership and make recommendations in conformity with Article IV. Investigate breach of medical ethics that may be reported: Review any records that may be referred to the MSEC or other committees in reference to medical ethics  
  
The credentials committee shall screen all applicants for reappointment as directed in Article IV, Section IV of the Bylaws and make recommendations to the Board of Directors.
7. The Executive Committee serves as the blood review committee. Blood utilization reports are reviewed quarterly.
8. The Executive Committee is to review and act on reports from medical staff committees and sub-committees and other activities of the hospital when necessary. Performance improvement reports are reviewed quarterly by the MSEC.
9. The committee shall supervise and appraise medical records and ensure their maintenance at the required standards. The committee shall report to the active staff the names of members who are delinquent in completion of their records.
10. Medical Staff Executive Committee will make the determination of whether a professional review action must be reported to the National Practitioners Data Bank.

## **ARTICLE VII**

### **SECTION III: COMMITTEES (continued)**

#### **C. Service Committees**

1. The composition of the major committees shall be all active staff who are members of the service.
2. The major service committees shall meet 4 times per year.
3. The primary duties of the major committees would be to review and evaluate the care and treatment rendered to patients by that service. Chart reviews shall be done to determine the appropriateness or quality of patient care.
4. A record shall be made of recommendations, conclusions and actions instituted if any.
5. The clinical sections shall organize in an appropriate manner in order to carry out the business of that section. The sections shall meet quarterly or as necessary to review and evaluate patient care in that department, and to report the findings to the appropriate major service or the executive committee

#### **D. Infection Control**

1. The committee shall consist of a pathologist, an infectious disease specialist and a member of the departments of medicine, pediatrics and surgery.  
It is recommended that a member of nursing, housekeeping, maintenance, pharmacy, central supply, employee health nurse and an operating room nurse attend.
2. The committee shall meet at least once a month and report to the medical executive committee its findings and recommendations in reference to operating rooms, delivery room, nursing units, and special units or other recommendations that they fit.
6. The committee shall be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of prevention and corrective programs designed to minimize infection hazards, and the supervision of infection control in all phases of hospital activities.
4. Recommendation of isolation procedures, prevention of nosocomial infection by anesthesia apparatus or respiratory therapy equipment and performance of other services as requested by the executive committee are duties of this committee.

## **ARTICLE VII**

### **SECTION III: COMMITTEES (Continued)**

#### **E. Library Committee**

The duties of the library committee shall be to:

1. Approve the selection and acquisition of journals, texts of reference material for the library.
2. Establish rules on use of books.
3. Publicize information as to materials available.
4. Monitor the amount of time it takes to receive journal copies from various Sources ( UKMC Library, AHEC).
5. Monitor the use of Internet located in the Medical Library
6. Committee shall meet at least once a year. Members will be appointed by the Chief of Staff. MSEC can also serve as the Library Committee.

#### **F. CME Committee**

1. The chairperson of the CME committee shall be appointed by the Chief of Staff on a yearly basis.
2. The chairperson of this committee will coordinate the scientific program for the medical staff meetings. CME programs will be selected for their pertinence to the type of physician practices at Pattie A. Clay Regional Medical Center. Physicians will be polled once a year for input on the topics for CME programs during the year.
3. The chairperson shall encourage CME accreditation and that the credit is documented. Credits will be reviewed at time of appointment and reappointment.

#### **G Pharmacy and Therapeutics**

1. The committee shall be made up of one or more members of the staff to be appointed by the chief of staff.
2. The committee shall work with the hospital pharmacist, administration and nursing to operate the pharmacy as efficiently and economically as possible.
3. The medical staff shall have the right and privilege to participate in establishing the drug formulary. The medical staff requests that all drugs purchased by the hospital be from ethical, named drug companies.
7. The committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the hospital in order to assure optimum clinical results and minimal potential for hazard. The committee shall assist in formulation of broad professional policies regarding evaluation of appraisable selection, procurement, storage, distribution, use, safety procedures, adverse drug reactions and other matters related to drugs in the hospital.

**SECTION III: COMMITTEES (continued)**

4. The committee shall develop and periodically review the formulated drug list for use in the hospital and make recommendations concerning drugs to be stocked on nursing unit floors and other services.
  5. The committee shall act as the Drug Utilization Committee. Specific functions will be to monitor antibiotic utilization, policies and practices in the hospital and to make recommendations for the most effective use hospital and to make recommendations for the most of antibiotics
- I. ICU/CCU Committee/Cardiology Committee
1. Composition - Internist, surgeon, family practice, ICU nurse and ICU/CCU Medical Director appointed by the chief of staff.
  2. Duties -
    - a. formulation, evaluation for improvement of coronary care, intensive care and telemetry procedures.
    - b. Inservice education and training for personnel.
  3. Meetings - quarterly meetings, keep records, refer to the Medicine Services Committee.
  4. The medical director shall be responsible for and have medical direction over the activities of the ICU/CCU unit.
- J.. Emergency Room Committee
1. Composition - At least two physicians and a physician chairman of the committee appointed by the chief of staff as the physician director of the Emergency Department. ER nurse coordinator, hospital nursing director and physician director of the Instant Care Center will serve as ex-officio members [Revised 8/09]  
Duties -
    - a. Review all mortalities and codes in the ER.
    - b. Review at least 1% of cases to determine appropriateness and quality of care delivered in the ER.
    - c. Review standards, policies, procedures and equipment for operating ER and recommend changes as necessary.
    - d. Meeting - Monthly, report to the Executive Committee.

K. Performance Improvement Committee

1. Composition - Three physicians appointed by the chief of staff, Chief Executive Officer; Vice President, Patient Care Services, Administrative Assistant, Support Services; Member of the Board, director of quality management and other management personnel. Individual departments will report quarterly to this committee.
2. Duties:
  - a. Review all departmental reports for quality of care issues.
  - b. Make recommendations as needed when departments fail to take actions.
  - c. Refer any pertinent matters to PAC Hospital Board of Directors.
3. Meeting - Monthly Meeting. Reports to MSEC and Hospital Board.

L. Bylaws Committee

Composition - the chairperson and two other members of the medical staff appointed by the chief of staff following the annual meeting

Duties - To review bylaws for any revisions, additions, deletions needed. proposed changes will be sent to the Medical Staff for approval. Any proposed changes

will

have two readings by the Medical Staff. Medical Staff will forward any proposed changes to the Board of Directors for final approval.

Meeting - the committee shall meet as needed (at a minimum of one time per year) to carry out its functions of providing guidelines and rules for an orderly program and quality care of patients.

Any significant changes in the bylaws will be distributed to all professionals with privileges at Pattie A. Clay Regional Medical Center at the time of the change.

M Nominating Committee

Composition - the committee shall be composed of the last two presidents and one member elected by the medical staff at the annual meeting (April).

Duties - to provide a nomination of officers at the annual meeting or as necessary if need arises. Meetings held as needed.

- N. Physical Therapy Physician Director  
 Composition - one physician appointed by the chief of staff and the physical therapy director.  
 Duties -
- a. overall direction of the physical therapy department
  - b. policies and procedures
  - c. periodic review of policies and procedures and revisions if necessary.
  - d. Oversee the quality of patient care services
- O. Cardio Respiratory Therapy Physician Director  
 Composition - one physician appointed by the chief of staff the director of respiratory therapy.  
 Duties -
- a. overall direction of respiratory therapy
  - b. policies and procedures
  - c. periodic review of policies and procedures and revisions if necessary.
  - d. Oversee the quality of patient care services
- P. Safety Committee  
 Composition - Head of each hospital department, safety officer and one physician representative.  
 Duties -
- a. Review incident reports, give summary to medical staff executive committee.
  - b. Be responsible for review and approval of plans for the protection and care of hospital patients and others at the time of internal or external disaster.
  - c. See the medical staff is informed of the Hospital Disaster Plan so the medical staff members are knowledgeable about reception and evaluation of casualties in the event of a disaster (Disaster Committee is a sub-committee of the Safety Committee).
- Meeting - Committee is required to meet on a monthly basis.
- Q Special Committees  
 Special committees shall be appointed from time to time by the chief of staff as may be required to carry out properly the duties of the medical staff.

R. Obstetrics/Pediatrics Committee

Composition of the OB/Pediatrics Committee will be all pediatricians, obstetricians, family practice physicians who practice obstetrics and/or pediatrics, Director of Obstetrical Services, Obstetrical Clinical Manager, Director of Med/Surg, Pediatrics and 4 East, Vice President of Patient Care Services, Pediatric Clinical Manager and Nurse Midwives.

The Committee will meet quarterly and/or at any time a committee members feels an additional meeting is needed.

Duties of the committee - Review and/or discuss findings/reports from monthly peer review chart reviews and cumulative service statistics from the previous quarter. Review and evaluate the care and treatment rendered to patients by the services. Discuss any pertinent issues (equipment, purchases, changes in professional standards, policies, procedures, etc.).

Monthly peer review will be conducted to determine the appropriateness or quality of patient care. Peer review of charts will be done on all mortalities, c-sections for non-reassuring fetal heart rate patterns, transfers from the newborn nursery, and any specific patient or patient populations that reflect a current interest of the committee. A record of the chart review will be maintained with recommendations, conclusions drawn and actions instituted. A report on peer review will be presented at OB/Pediatrics Quarterly Meeting. OB/Pediatrics Committee Reports will be sent to the Medical Staff Executive Committee. Monthly statistics from the service will be distributed to all medical staff members of the OB/Pediatrics Committee

S. Mortality Review Committee

Mortality Review Committee will evaluate all mortalities in the hospital on a Monthly basis to make sure the physician was aware of the critical nature of the Case as noted in physician's orders, lab procedures, timeliness of consultations. The committee shall review and analyze the supervision of mortalities beginning with early recognition of complications, re-evaluation based on clinical and Laboratory studies and modification of the therapeutic regime in accordance with the changing condition of the patient to determine if the diagnosis can be supported.

Data collected will be included in the Performance Improvement Program.

Mortality Review Committee may report interesting cases for educational purposes.

[7/09]

**ARTICLE VII**

**SECTION III: S COMMITTEES (continued)**

## S. ETHICS COMMITTEE

The Pattie A. Clay Regional Medical Center Ethics Committee is to be a multi-disciplinary committee which deals with complex ethical issues that arise during the care of patients. The committee is to consist of, but not limited to, ministers, attorneys, administration, nursing, social services, physicians, governing board. Members, patient/public relations, consulting ethical personnel and other members as deemed necessary at any particular time.

The purpose of this committee is to be advisory to the physicians and hospital president along with the patients and their families related to ethical issues and treatment. However, this committee will not be limited just to this, but is to document and review policies and procedures concerning:

1. Patient Rights and Responsibilities
2. Informed Consent
3. Advanced Directives
4. Resolution of conflict in care or treatment decisions
5. Withholding resuscitation and ongoing or withdrawing life sustaining treatment.
6. Pain Management
7. Interviews with clinical staff. Interviews with patients and family and review of patient medical records as deemed necessary.

In each of these instances, the Ethics Committee is to meet annually and will serve on an "on call" basis for any problems that should arise pertaining to the above. The Ethics Committee will abide by the American Medical Association, American Dental Association and the American Osteopathic Code of Ethics. Periodic updates or policies and procedures will be done. The Pattie A. Clay Regional Medical Center Code of Conduct will be widely distributed and will be adhered to by the Ethics Committee. Medical Staff will abide by the PAC Ethics policies and procedures.

## **ARTICLE VIII**

### **CORRECTIVE ACTION**

**ARTICLE IX**

**HEARING AND APPELLATE REVIEW PROCEDURE**

## **ARTICLE VIII**

### **CORRECTIVE ACTION**

#### **SECTION I: PROCEDURE**

- A. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the medical staff or to be disruptive to the operations of the hospital, corrective action against such practitioner may be requested by any member of the medical staff, by the chief executive officer (hospital administrator), or by the governing body. All requests for corrective action shall be made in writing, shall be made to the executive committee, and shall be supported by reference to the specific activities or conduct which constituted the grounds for the request. The practitioner against whom the complaint is made shall be notified by the chief of staff within forty-eight (48) hours.
- B. Whenever any corrective action is requested the executive committee shall meet and investigate the matter.
- C. Within seven (7) days after the executive committee receives a request for corrective action, the executive committee shall meet with the practitioner against whom the corrective action has been requested. At such meeting the practitioner shall be informed in writing of all charges of a specific nature against him/her and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, and shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing shall apply there to. A record of such interview and its findings shall be made by the executive committee and included with its report.

## **CORRECTIVE ACTION**

### **SECTION I: D      Procedure (continued)**

- D. The executive committee's report will be presented to the medical staff unless the accused physician is satisfied with the decision and requests that it not be presented to the medical staff.
  
- E. The action of the executive committee on a request for corrective action may be to:
  - 1. Reject or modify the request for corrective action.
  - 2. Issue a warning.
  - 3. Issue a letter of admonition
  - 4. Issue a letter of reprimand
  - 5. Impose terms of probation
  - 6. Impose a requirement for consultation
  - 7. Recommend reduction, suspension or revocation of clinical privileges.
  - 8. Recommend termination, modification or continuation of an already imposed summary suspension of clinical privileges.
  - 9. Recommend suspension or revocation of practitioner's staff membership.
  
- F. Any action by the executive committee shall entitle the affected practitioner to the procedural rights provided in Article IX of these Bylaws.
  
- G. The chairman of the executive committee shall promptly notify the chief executive officer in writing of all requests for corrective action received by the executive committee and shall continue to keep the chief executive officer fully informed of all action taken in connection therewith. After the committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Article IX of the Bylaws, Rules and Regulations.

## **SECTION II: SUMMARY SUSPENSION**

- A. Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of a patient(s) or whenever the member's conduct presents a danger or immediate or serious harm to the life, health or safety of any patient, prospective patient, or other person the governing board or its designee, the medical staff executive committee, or the chairman of the department (or his/her designee) in which the member holds privileges may summarily restrict, or suspend their medical membership or clinical privileges of such member. Unless otherwise stated such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible for imposing the suspension shall promptly give written notice to the member, governing executive committee, and the chief executive officer of the hospital. The summary restriction or suspension shall be a specific period, which shall be no longer than is necessary to resolve the matter as set forth unless otherwise indicated by the terms of the summary, restriction or suspension, the member's patients shall be promptly assigned to another member of the medical staff by the chief of the department or by the chief of staff, considering where feasible the wishes of the patient in the choice of a substitute member.
- B. As soon as practicable after such restriction or suspension has been imposed, a meeting of the Medical Staff Executive Committee shall be convened to review the issue under investigation and consider the action. The member may attend and make a statement concerning, on such terms and conditions as the MSEC may impose. MSEC may be convened in accordance with Article IX of the Bylaw, Rules and Regulations.

## **SECTION III: AUTOMATIC RELINQUISHMENT OR LIMITATION**

In the following instances, the member's privileges or membership may be suspended for up to 14 days or limited as described below, which action shall be final without right of hearing or further review pursuant to Article IX or otherwise.

A. Licensure

1. Revocation and Suspension: Whenever a members' license or other legal credentials authorizing practice in the Commonwealth of Kentucky is revoked or suspended, medical staff membership and clinical privileges shall be automatically relinquished as of the date of such action by the licensing or certifying authority becomes effective.
2. Restriction: Whenever a member's license or other legal credentials authorizing to practice in the Commonwealth of Kentucky is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date the action by the licensing or certifying authority becomes effective term.
3. Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his/her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action by the licensing or certifying authority becomes effective and throughout its term.

B. Controlled Substances

1. Whenever a member's DEA Certificate or prescribing authority is revoked, limited, suspended, the member shall automatically and correspondingly be divested of the right to prescribe medication covered by the certificate, as of the date such action became effective throughout its term.
2. Probation: Whenever a member's DEA Certificate or prescribing authority is subject to probation, the member's right to prescribe such medications in the hospital shall automatically become subject to the same probationary period

C. Malpractice Insurance [Revised 10/06]

1. Suspension of privileges are invoked for lapsed professional liability coverage suspension, revocations, or limitations placed on the insurance coverage.

D. Medical Records

1. Members of the Medical Staff are asked to complete medical records within the time set forth in the Rules and Regulations. A limited relinquishment in the form of withdrawal of admitting and other related privileges until medical records are completed can be imposed by the chief of the medical staff, or his/her designee, after notice of delinquency and a reasonable opportunity to complete records, for failure to complete medical records. for the purpose of this section "related privileges" means voluntary on-call service for the emergency department, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within the hospital for future patients. Members whose privileges have been relinquished for delinquent records may admit patients only in life threatening situations. The relinquishment shall continue until lifted by the president of the medical staff or his/her designee.
2. Vacation or bona fide illness may constitute an excuse subject to approval by the president of the medical staff.

**ARTICLE VIII**

**SECTION III: D**

E. Fraud, Abuse or Conviction of a Crime

Conviction of a crime constituting a felony, or conviction of a crime related to health care or health care fraud or abuse, or being listed by the federal government as debarred, or otherwise ineligible to participate as a provider under any federally funded health care program, including but not limited to, Medicare or Medicaid, shall automatically, without further act or action, suspend the members privileges and/or membership until the matter is reviewed and acted upon by the Medical Staff Executive committee and the Governing Board.

- G. As soon as practicable after action is taken or warranted as described in this section, the Medical Staff Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate.

#### **SECTION IV: IMPAIRED PROFESSIONAL POLICY**

Pattie A. Clay Regional Medical Center's Impaired Professional Policy has been instituted for the purpose of educating hospital leaders and the medical staff about licensed independent practitioner health, address prevention of physical, psychiatric or emotional illness and to facilitate confidential diagnosis, treatment and rehabilitation of licensed independent practitioners who suffer from a potentially impairing condition. The goal of this policy is to assist and help rehabilitate, rather than discipline, and to aid licensed independent practitioners in retaining or regaining optimal professional functioning, consistent with protection of patients.

##### **EDUCATION:**

1. Education regarding illness and impairment issues will be provided to the staff on an annual basis, either as a sponsored program or with written materials discussed at staff meetings. Education will include at risk criteria, signs and symptoms of impaired provider and management of the affected healthcare provider.
2. All physicians and allied health professionals will be given written information regarding illness and impairment issues at the time of initial appointment to the medical staff. Policy will also be provided to all individuals when being reappointed to the staff or when renewing their privileges.

##### **CONFIDENTIALITY:**

Confidentiality of the individual referred will be strictly maintained with the exception of:

1. State and Federal limitations ( if applicable)
2. Ethical obligations
3. When maintaining confidentiality threatens the safety of a patient or patients.
4. In all instances, every effort to protect the confidentiality of the individual referred for assistance will be made.

##### **IMPAIRED PROFESSIONAL COMMITTEE:**

The Medical Staff Executive Committee will serve as the "Impaired Professional Committee." The Chief of Staff will serve as the chairman of the committee. Referrals for physicians will be made to the Kentucky Physician Foundation affiliated with the Kentucky Board of Licensure

#### **ARTICLE VIII**

#### **SECTION IV: IMPAIRED PHYSICIAN (continued)**

Licensed independent practitioners will be allowed to self-refer to the program. All other licensed independent practitioners will be referred to the appropriate professional internal or external resources for evaluation, diagnosis and treatment of the condition or concern. All referrals will be made on a confidential basis.

#### MONITORING:

The Impaired Professional Committee (MSEC) will appoint two active staff physicians and the hospital CEO to serve as a monitoring committee for impaired professionals. The committee will keep information on internal and external resource individuals and organizations to be used for referral when needed. Physicians may self refer to the Kentucky Physician Foundation or will be referred to the Kentucky Physician Foundation.

Committee will be appointed per case. Records shall be kept on individual practitioners who are being followed by the committee. Records will be strictly confidential and will be separate from the practitioner's credential file.

#### REPORTING:

Reports should be made to the Chief of Staff and/or Chief of Service and/or Emergency room physician when appropriate. A report will be written or oral, but if oral, it shall be followed immediately by a written report. Report of instances in which a LIP is providing unsafe treatment will be forwarded to the Medical Staff Executive Committee.

1. Reasonable suspicion that an LIP is providing unsafe care would be observation of a pattern of abnormal conduct and in the judgment of the observer, patient care is at risk.
2. Any individual within the organization has the responsibility to report concerns regarding unsafe treatment by an LIP. Reports should be made directly to the chief of service that the LIP is a member of.
3. Reports may also be made to the chief of staff and/or hospital CEO.
4. Reports of this nature are to be kept confidential and will follow the routine medical staff evaluation process.
5. All allegations, concerns, and complaints regarding the potential impairment of a licensed independent practitioner will be brought before the committee to be thoroughly investigated and evaluated by the committee as a whole for their validity. A licensed independent practitioner under investigation may provide information to the committee that he/she feels may clarify any allegations, concerns or issues brought before the committee.
6. If a practitioner believes a report has been made against him/her in bad faith with no reasonable basis to support the report, the practitioner may report that concern to the committee. Any such report will be investigated and resolved through normal corrective action or discipline processes by administration or the medical staff, as appropriate depending on the identity of the individual alleged to have made the bad faith report. That informant has the right to request and receive confidentiality regarding referrals.

### ARTICLE VIII

#### SECTION IV: IMPAIRED PHYSICIAN (continued)

#### REFERRALS

1. All licensed independent practitioners will be allowed to self refer to a program.
2. The Kentucky Physicians Health Foundation - affiliated with the Kentucky Board of licensure will be contacted for an evaluation for referral for rehabilitation/ treatment for physicians.
3. All other licensed independent practitioners will be referred to the appropriate organization and/or individual.

#### DISTRIBUTION

A copy of this policy will be provided at the time a physician/AHP is granted privileges and at the time of reappointment. Policy on Impaired Professionals will also be reviewed at the time of employee orientation.

#### GOALS OF POLICY

While the goal of the Impaired Professional Policy is to provide assistance rather than disciplinary action, in some instances the committee members may request discipline of the LIP as a necessary action to improved or resolve quality of care issues. All licensed independent practitioners are eligible to participate in the Impaired Professional Program

#### PROCEDURE FOR IMMEDIATE EVALUATION:

The chief of staff or a designee will come to the hospital in the capacity as the evaluating physician to meet with the practitioner in question. If the evaluating physician or the practitioner in question request the presence of a third party, the chief of service or hospital CEO will be notified.

If the evaluating physician concurs that there is a reasonable suspicion of impairment, the chief of staff can request appropriate screening. If the individual refuses, their privileges will be suspended immediately and a medical staff executive committee meeting will be called within seventy two (72) hours. The chief of service, in consultation with the suspended LIP will be responsible for obtaining immediate coverage of patients by an associate or another physician in an appropriate specialty.

The Medical Staff Executive Committee may, if it is deemed helpful, solicit the input of the KPHF, via one of its members or by the committee as a whole, to decide appropriate referral.

### **ARTICLE VIII**

#### **SECTION V: DISRUPTIVE PHYSICIAN POLICY [8/07]**

##### **A. POLICY STATEMENT**

It is the policy of the Pattie A. Clay Medical Staff that all individuals within the hospital be treated courteously, respectfully and with dignity. Therefore,

all members of the medical staff and allied health professionals will conduct themselves in a professional and cooperative manner while in the hospital.

**B. DEFINITION OF DISRUPTIVE BEHAVIOR**

- ...conduct that interferes with the provision of quality patient care
- ...conduct that constitutes sexual harassment
- ...making or threatening reprisals for reporting disruptive behavior
- ...shouting or using vulgar or profane or abusive language
- ...physical assault or intimidating behavior
- ...refusal to cooperate with other staff members
- ...making statements that are malicious, arbitrary or inappropriate comments in the hospital or medical staff meetings
- ...writing of malicious, arbitrary or inappropriate comments/notes in medical records
- ...discrimination on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability or sexual orientation.

- T. If the conduct of a medical staff member or allied health professional is disruptive, the matter will be addressed according to this policy. Any physician, employee, patient or visitor may report potentially disruptive behavior. Report will be submitted to the CEO of the hospital and/or chief of staff (Vice Chief if Chief is not available).

Documentation of disruptive behavior is necessary since it is ordinarily not one incident that justifies disciplinary action, but a pattern of conduct. The documentation shall include:

- ...date and time of the incident
- ...if the behavior affected or involved a patient in any way, the name of the patient
- ...circumstances that precipitated the situation
- ...description of the questionable behavior limited to actual, objective language as much as possible.
- ...consequences, if any, of the disruptive behavior as it relates to pt. care or hospital operations.
- ...record of any action taken to remedy the situation including, time, date, place, action and name(s) of those intervening.

The Chief of Staff and CEO shall review the allegations contained in the report to determine if, in their opinion the matter has merit and violates this policy.

If it is determined that the complainant does have merit and that such conduct complained of does or may violate this policy it will be determined:

**ARTICLE VIII**

**DISRUPTIVE PHYSICIAN**

- a. if the matter is of such serious nature, or represents such a continuing course of abusive conduct that the matter should be referred to the Medical Staff Executive Committee (MSEC) to be reviewed by the MSEC pursuant

to the provisions of Article VII regarding Corrective Action or

- b. because the matter is not of such a serious nature or does not represent a course of abusive conduct, it can, in their opinion, be addressed informally with the offending individual in which case they shall jointly meet with and discuss the matter with the offending individual and emphasize that such conduct is inappropriate and that a repetition of such conduct shall result in a referral of the matter to the MSEC for formal action. The informal meeting between the offending individual, the CEO and the Chief of Staff shall be documented and placed in the offending individual's peer review file.

A follow-up note to the practitioner shall state that the practitioner is required to behave professionally and cooperatively.

- c. If disruptive behavior continues, the Chief of Staff shall meet with and advise the practitioner that such conduct is intolerable and must stop. This meeting is not a discussion but constitutes the practitioner's final warning. It shall be followed with a letter reiterating the warning. This letter becomes part of the practitioner's permanent peer review record.
- d. If based upon subsequent complaints of disruptive behavior, it is determined that there exists a pattern of disruptive behavior, or if the practitioner persists in disruptive behavior despite having either agreed to cease such conduct, or after having been warned informally to cease such conduct, then and in such event further complaints of disruptive behavior shall be referred by the Chief of Staff to the MSEC for consideration of corrective action pursuant to the provisions of Article VIII of the Bylaws, Rules and Regulations of the Medical Staff. Such corrective action shall include any of those remedies authorized under the Articles of the Bylaws.
- e. Documentation of all complaints, reports, letters or other written material regarding reported abusive conduct shall be maintained in the practitioner's confidential peer review file in the Medical Staff Office.
- f. Any unprofessional/disruptive behavior by a member of the Pattie A. Clay Medical Staff will be investigated by the MSEC. If it is determined that there is a valid issue, the incident will be dealt with according to the policy and procedures (disruptive physician or impaired physician policy).
- g. Reporting of disciplinary action will be made to the appropriate licensing board.
- g. All practitioners with privileges at Pattie A. Clay Regional Medical Center will sign a Practitioner's Code of Conduct at the time of appointment and reappointment. [2/09]

## **ARTICLE IX**

### **SECTION I. A HEARING AND APPELLATE REVIEW PROCEDURE**

- A. When a practitioner receives notice of a recommendation of the executive committee that, if accepted by the governing body, will adversely affect his appointment to or status as a member of the medical staff or his exercise of clinical privileges, he/she shall be entitled to hearings and to appellate review as follows :
  - 1.. To a hearing before the ad hoc committee of the medical staff. If still adverse to the practitioner.
  - 2. To appellate review by the governing body or by a committee appointed by it.
  - 3. To appellate review by the governing body or by a committee appointed by it.
  
- B. When a practitioner receives notification of an action by the governing body that will affect his appointment to or status as a member of the medical staff or his/her exercise of clinical privileges, and such decision is not based on prior adverse recommendation by the executive committee of the medical staff, he shall be entitled to a hearing and to appellate review as follows:
  - 1. To a hearing before the executive committee of the medical staff. If still adverse to the practitioner
  - 2. To a hearing before the ad hoc committee of the medical staff. If still adverse to the practitioner, then
  - 3. To appellate review by the governing body or by a committee appointed by it.
  
- C. All hearing and appellate review shall be in accordance with the procedural Safeguard set forth in this Article IX to assure that the affected practitioner is accorded all rights to which he/she is entitled.
  
- D. All notices to be given herein by either the affected practitioner or by the medical staff or any of its committees or by the governing body or any of its committees shall be given in writing, sent certified mail, return receipt requested, to the last known address of the party to whom notice is intended.
  
- E. Notice shall be deemed given upon the date of mailing. Notice shall be deemed received on the third day following the mailing thereof. In calculating the time for notices herein, weekends and holidays shall not be counted.

## **ARTICLE IX**

### **SECTION I: HEARING APPELLATE (continued)**

- F. An adverse recommendation of the executive committee of the medical staff

and/or its ad hoc hearing committee shall become and remain effective against the practitioner pending the governing body's decision on the matter. Any final decision by the governing body shall become and remain final and effective against the practitioner.

## **SECTION II: REQUEST FOR HEARING**

- A. The chief of the medical staff shall give written notice of any adverse recommendation or decision rendered by its executive committee or the ad hoc hearing committee, affecting any practitioner who is entitled to a hearing or to appellate review. Such written notice shall be given within two (2) days of the adverse decision.
- B. The chief executive officer or the hospital shall give written notice of any adverse decision of the governing body affecting any practitioner who is entitled to a hearing or to appellate review. Such written notice shall be given within two (2) days of the adverse decision.
- C. The failure of an adversely affected practitioner to request a hearing or appellate review to which he is otherwise entitled within the ten (10) days from the date of his receipt of notice of such adverse recommendation or decision, and in the manner herein provided, shall be deemed a waiver of his rights to such hearing and to appellate review and to all subsequent review and the matter shall then be submitted directly to the governing body for final action.

## **SECTION III: NOTICE OF HEARING**

- A. Within ten (10) days after receipt of a request for hearing from a practitioner entitled to a hearing, the executive committee or governing body, whichever made the decision adverse to the practitioner, shall schedule same and, through its designee, notify the practitioner of the time, place and date so scheduled. The hearing date shall be not less than (10) days nor more than fifteen (15) days from the date of receipt of the request for hearing provided, however, that a hearing for a practitioner who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than five (5) days after the date of receipt of such practitioner's request for hearing.

## **ARTICLE IX**

### **SECTION III: HEARING AND APPELLATE (Continued)**

- B. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative

charts being questioned and/or the other reasons or subject matter which was considered in making the adverse recommendation or decision. If the hearing is prompted by the actions of another body or a prior hearing or determination, the decision or recommendation of such other body may suffice and serve this purpose.

#### **SECTION IV: COMPOSITION OF HEARING COMMITTEE**

- A. When a hearing relates to an adverse recommendation of the executive committee, such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the medical staff appointed by the chief of the medical staff in consultation with the executive committee and one of the members so appointed shall be the chairman. No staff member who actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee unless it is otherwise impossible to select a representative group due to the size of the medical staff.
  
- B. Individuals involved in peer review activities shall be impartial peers and shall not have an economic interest in and/or a conflict of interest with the subject of the peer review activity. Impartial peer would also exclude individuals with blood relationships, employer/employee relationships, or other potential conflicts that might prevent the individual from giving an impartial assessment, or give the appearance for the potential of bias for or against the subject of the peer review.[Revised 10/06]
  
- C. When a hearing related to an adverse decision of the governing body that is contrary to the recommendation of the executive committee, the governing body shall appoint an ac hoc hearing committee pursuant to Section 7, paragraph 8 hereof to conduct such hearing and shall designate one of the members of this committee to be chairman.

#### **SECTION V: CONDUCT OF HEARING**

- A. All members of the hearing committee shall be present when the hearing takes place. The absence of any member of the committee shall be grounds for the continuance of such hearings.
  
- B. An accurate record of the hearing must be kept. The mechanism shall be established by the ad hoc hearing committee, and may be accomplished by use of a court recorder, electronic recording unit, detailed transcription or by the taking of adequate minutes.

### **ARTICLE IX**

#### **SECTION V: CONDUCT OF HEARING (continued)**

- C. The personal presence of the practitioner for whom the hearing has been

scheduled shall be required. A practitioner who fails without good cause, to appear and proceed at such hearing shall be deemed to have waived his/her rights to proceed by hearing and shall be deemed to have accepted the adverse recommendation or decision involved, and the same shall thereupon be submitted to the governing body for final consideration, without further review.

- D. Postponement of a hearing beyond the time set forth in these Bylaws, shall be made only with the approval of the ad hoc committee. Granting of such postponement shall only be for good cause and be mutually agreeable to the hearing committee and the affected practitioner.
- E. The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the medical staff in good standing or by a member of his local professional organization, or by an attorney. The executive committee of the medical staff or the governing body, as the case may be, may be represented at any phase of the hearing procedure by an attorney.
- F. The chairman of the hearing committee shall preside over the hearing to determine the order of procedure during the hearing; to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.
- H. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible in civil or criminal actions. The practitioner for whom the hearing is being held shall, prior to or during the hearing be entitled to submit memoranda concerning any issue or procedure or of fact and such memoranda shall become a part of the hearing record.
- I. The 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 the facts in support of its adverse recommendation, and to examine witnesses. The governing body, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses.

## **ARTICLE IX**

### **SECTION V: H**

#### **CONDUCT OF HEARING (continued)**

It shall be the obligation of such representative to present appropriate evidence

in support of its adverse decision, but the affected practitioner shall thereafter have the burden of supporting his challenge to the adverse recommendation or decision by an appropriate showing that the charges or ground involved lack any factual basis or that such basis or any action based thereupon is either arbitrary, unreasonable or capricious.

- I. The affected practitioner shall have the right to call and examine witnesses, to introduce written evidence, to cross - examine any witness or any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the practitioner does not testify in his own behalf, he may be called and examined as if under cross-examination.
- J. The hearing committee may, with the approval of the affected practitioner, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation or oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.
- K. Within five (5) days after the final adjournment of the hearing, the hearing committee shall make a written report and recommendation to the body which appoints it and shall forward the same together with the hearing record and all other documentation to such body. The report may recommend acceptance, modification, or rejection of the adverse decision or recommendation of the committee or the governing body which prompted the hearing.
- L. The executive committee or governing body, as appropriate, shall, within five (5) days of its receipt of the hearing committee's recommendation, forward said report and recommendation to the governing body for action. The affected practitioner shall be given notice of the recommendation of the hearing committee within two (2) days of the committee's receipt of the hearing committee's recommendation.

## **ARTICLE IX**

### **SECTION VI: APPEAL TO THE GOVERNING BODY**

- A. Within ten (10) days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, she/he may, by written notice to the governing body,

delivered through the chief executive officer of the hospital, request an appellate review by the governing body. Such notice may request that the appellate review be held on the record of which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

- B. Within ten (10) days after receipt of such notice of request for appellate review, the governing body shall schedule a date for such review, including the time and place for oral argument if such has been requested, and notify the affected practitioner in writing of the same. The date of the appellate review shall not be less than ten (10) days, more than fifteen (15) days, from the date of the receipt of the notice of request for appellate review except that when the practitioner requesting that review is under a suspension which is then in effect, such review shall be scheduled as soon as arrangements can be made, but not more than five (5) days after the date of receipt of such notice.
- C. The appellate review shall be conducted by the governing body or by a duly appointed appellate review committee of the governing body of not less than three (3) members.
- D. The affected practitioner shall have access to the report and record (and transcript, if any) of the ad hoc committee and all other materials favorable or unfavorable, which were considered in making the decision or recommendation, he shall have five (5) days to submit a written statement in his own behalf, in which those factual and procedural matters with which he disagrees, and his reasons for such disagreement shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the governing body through the chief executive officer by certified mail, return receipt requested, at least four (4) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the executive committee of the medical staff or by the chairman of the hearing committee appointed by the governing body, and if submitted, the chief executive officer shall provide a copy thereof to the practitioner at least two (2) days prior to the date of such appellate review by certified mail, return receipt requested. In effect, such review shall be scheduled as soon as arrangements can be made, but not more than five (5) days from the date of receipt of such notice.

## ARTICLE IX

### SECTION VI: E APPEAL TO THE GOVERNING BOARD (continued)

- E. The governing body or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider

the written statement submitted pursuant to subparagraph D of this Section VI, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested by either party as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him by any member of the appellate review body.

- F. New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record shall only be introduced at the appellate review under unusual circumstances and only with permission of the governing body or the committee thereof appointed to conduct the appellate review.
- G. If the appellate review is conducted by the governing body, it may affirm, modify or reverse the prior decision or, in its discretion, refer the matter back to the executive committee of the medical staff for further review to and recommendation within five (5) days. Such referral may include a request that the executive committee of the medical staff arrange for a further hearing to resolve specified disputed issues.
- H. If the appellate review is conducted by a committee of the governing body, such committee shall, within ten (10) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the governing body affirm, modify or reverse the prior decision or refer the matter back to the executive committee for further review and recommendation within ten (10) days. Such referral may include a request that the MSEC arrange for a further hearing to resolve disputed issues. Within five (5) days after receipt of such recommendation after referral, the committee shall make its recommendation to the governing body as above provided.

## **ARTICLE IX**

### **SECTION VII: FINAL DECISION BY GOVERNING BODY**

- A. All decisions concerning a practitioner's exercise of clinical privileges at the hospital or his/her status as a member of or appointment to the hospital's medical staff rest ultimately with the governing body. No recommendation or decision becomes final without acceptance by the governing body.
- B. Within five (5) days after the conclusion of the appellate review, the governing body shall make its final decision in the matter and shall send notice thereof to the executive committee, and, through the chief executive officer, to the affected practitioner. If this decision is in accordance with the executive committee's last such recommendation in this matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is not in accordance with the executive committee's last such recommendation, the governing body shall refer the matter to an ad hoc committee composed of five (5) members of the governing body and an equal number of the medical staff for further review and recommendation within ten (10) days and shall include in such notice of its decision a statement that a final decision will not be made until the ad hoc committee's recommendation has been received. Within ten (10) days after receipt of the ad hoc committee's recommendation, the governing body shall make its final decision and shall give written notice thereof to the affected practitioner.
- C. Notwithstanding any other provision of these bylaws, no practitioner shall be entitled, as a matter of right, to more than one hearing and one appellate review on any matter which shall be the subject of action by the MSEC, or by the governing body, or by a duly authorized committee of the governing body, or by both.

**SECTION VIII: HEARING AND REVIEW PROCESS - ALLIED HEALTH PROFESSIONALS ( AHP )**

General Provisions

No matter which body (MSEC or Board of Directors) recommends or takes adverse action, the affected AHP shall receive notice of the action in a timely manner and shall receive an evidentiary hearing if requested in a timely manner. The hearing will be conducted by a hearing panel appointed by the chief of staff. The Medical Staff Executive Committee shall review the report and recommendations from the hearing committee and shall make a recommendation to the Board of Directors.

**ARTICLE IX**

**SECTION VIII: HEARING AND REVIEW PROCESS - ALLIED HEALTH PROFESSIONALS**

1. The AHP shall have fifteen (10) days following receipt of the notice to

request a hearing. The request shall be in writing addressed to the body whose recommendation is at issue and filed with the Medical Staff Coordinator and CEO of the hospital. In the event the AHP does not request a hearing within the time and in the manner described the AHP shall be deemed to have waived any right to a hearing or appeal and to have accepted the recommendation involved. When a request for a hearing is received, the chief of staff shall schedule a hearing and give notice to the AHP of the time, date of the hearing within 15 days of receipt of the request.

All decisions concerning the exercise of AHP privileges at PAC Medical Center or of one's appointment to or status at the hospital rests ultimately with the discretion of the Board of Directors. No recommendation or decision becomes final without the approval of the Board of Directors.

2. Hearing Committee

The hearing committee shall consist of five members. Chief of Staff, two members of the medical staff who are members of the MSEC, chief of service, and CEO. The chief of staff shall act as the chairman of the hearing committee.

3. Conduct of Hearing

The hearing committee shall endeavor to assure that all participants in the Hearing have a reasonable opportunity to be heard and to present relevant Oral and documentary evidence in an efficient and expedient manner. The Chair is entitled to set the agenda and time limits for the hearing.

4. Rights of the AHP to be represented at any phase of the hearing or preliminary procedures by an attorney at law or by any person of the party's choice. To have a record made of the proceedings. To present evidence determined relevant and requested by the hearing committee. To submit a written statement at the end of the hearing.

5. Recommendations:

The recommendations of the hearing committee shall be based on the evidence introduced at the hearing. A majority of the hearing committee must be present throughout the meeting. Any recommendation from the hearing committee shall be approved by the majority of its members.

6. Recommendation and Report

Within thirty (30) days after the final adjournment of the hearing, the hearing committee shall render a recommendation which shall be accompanied by a report in writing stating the findings of facts, conclusions, recommendations and the reason for the recommendations. A copy of the report will be delivered to the MSEC and the AHP.

## **ARTICLE IX**

### **SECTION VIII: HEARING AND REVIEW PROCESS - ALLIED HEALTH PROFESSIONALS**

7. MSEC Recommendation and Appellate Review

The MSEC shall within ten (10 to fifteen (15) days of receiving the hearing committee's recommendation(s) consider the report and recommendation of the hearing committee and act thereon. It shall make its written recommendation to the Board of Directors and give notice thereof to the AHP. The MSEC shall submit its recommendations together with the hearing report and all documentation to the Board of Directors and act thereon. It shall make its written recommendation to the

If the Board recommendation is adverse to the AHP, the AHP shall have ten (10) days to file a written request for an appellate review. The request shall be delivered to the CEO of the hospital in person or by certified/registered mail. If the AHP wishes to be represented by an attorney at any appellate review, the request for appellate review must so state, giving the name, address and telephone number of the attorney.

A member who fails to request an appellate review within the time and in the manner specified shall be deemed to have waived any right to an appellate review.

The CEO of the Hospital shall deliver the request for appellate review to the Chairman of the Board of Directors. The Board shall schedule and arrange for an appellate review which shall take no more than 30 days after the CEO receives the request. The AHP shall be notified of the time, place and date of the review. The chairman of the board shall appoint an appellate review committee.

Appellate Review Committee shall submit its findings, recommendations together with a written report to the Board of Directors. The Board of Directors decision shall be final for all purposes when rendered. When the decision of the Board is final, it shall not be subject to further hearing or appellate review. The Board will immediately give written notice to the AHP via certified or registered mail, return receipt requested. The notice shall concisely state the reasons for the action.

**ARTICLE X - MEETINGS**

**ARTICLE XI - RULES AND REGULATIONS**

**ARTICLE XII - AMENDMENTS**

**ARTICLE XIII - ADOPTION**

# **ARTICLE X**

## **MEETINGS**

### **SECTION I: QUARTERLY MEETING**

The quarterly meeting of the medical staff shall be held on the second Monday of the month every January, April, July and October of each year. Retiring officers and committees shall make such reports as may be desired at the July meeting and officers for the ensuing year shall be elected. The July Medical Staff Meeting will be considered a mandatory meeting.

### **SECTION II: GRAND ROUNDS BREAKFAST/TUMOR BOARD/JOURNAL CLUB**

Continuing education will be provided for the medical staff at a grand rounds breakfast or dinner which will be held monthly, the third Wednesday of the month. Notice will be sent out in advance. Programs will be presented by a member of the medical staff if possible. Tumor Board is held monthly the third Thursday of the month. Case presentations/discussions are held on current and interesting cases. CME's are issued from AHEC. Journal Club Meeting is held monthly, the first Wednesday of the month. Interesting articles/cases will be reviewed/discussed by the medical staff.

### **SECTION III: SPECIAL MEETINGS**

Special meetings may be called at any time by the president or may be called at the request of a majority of the active staff. A forty-eight hour's notice is required before the said meeting.

### **SECTION IV: ATTENDANCE**

Members of the active medical staff should attend the Medical Staff Meetings and the service/committee meetings he/she may be appointed to.

Any member of the active staff may attend and participate in any publicized committee meeting and have voting privileges.

### **SECTION V: MINUTES**

Minutes of each regular and special meeting of the staff or a committee shall be signed by the presiding officer and be filed as a permanent record.

## **ARTICLE XI**

### **RULES AND REGULATIONS**

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the governing body. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be a part of these Bylaws except that they may be amended or repealed at any meeting at which a quorum is present. Such changes shall become effective when approved by the governing body.

## **ARTICLE XII**

### **AMENDMENTS**

The Bylaws may be amended as follows: Submission of the proposed amendment at any regular or special meeting of the medical staff. The proposed amendment shall be referred to a special committee which will report on it at the next regular meeting of the medical staff, or a special meeting called for such purpose. To be adopted the amendment shall require a two-thirds vote of the active member of the medical staff present at the meeting. Amendments so made shall be effective only when approved by the governing body. If significant changes are made in the Bylaws, Rules and Regulations all medical staff and others with delineated clinical privileges will be provided with a copy of the revisions. Bylaws will be reviewed/revised as often as necessary but at a minimum every two years.

Neither the organized medical staff nor the governing body may unilaterally amend the Medical Staff Bylaws, Rules and Regulations.

Medical Staff Bylaws, Rules and Regulations are available on the Pattie A. Clay Web Site

## ARTICLE XIII

### ADOPTION

These Bylaws, together with the Rules and Regulations shall be adopted at any regular meeting of the active Medical Staff and shall replace any previous Bylaws and shall become effective when approved by the governing body of the hospital.

\_\_\_\_\_  
William Allen, M.D.  
Chief of Staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
Rajan Joshi, M.D.  
Secretary/Treasurer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Thomas Bonny  
Chairman, Board of Directors

\_\_\_\_\_  
Date

\_\_\_\_\_  
Laura Steidle  
Secretary, Board of Directors

\_\_\_\_\_  
Date

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## **A. ADMISSION AND DISMISSAL OF PATIENTS**

1. Patients may be admitted by members of the active medical staff or by a certified nurse midwife credentialed as an allied health professional and with admitting privileges.
2. Dentists/Oral surgeons who have hospital privileges shall have their patients admitted by a member of the medical staff who will be responsible for the admission history and physical. Dentists/Oral surgeons will be responsible for recording the dental history and physical findings and the dental diagnosis.
3. The attending physician or designated allied health professional with delineated privileges shall provide a provisional diagnosis at the time of admission and record a history and physical exam within 24 hours.
4. Same Day Surgery pre-op evaluation, including lab, EKG, and x-ray results should be available for review the day prior to the scheduled surgery.

## **B. CARE OF THE PATIENT**

1. Visiting or consulting medical staff members shall have an active member of the medical staff attend their patients. Management of a patient's care is the responsibility of a qualified licensed independent practitioner with appropriate clinical privileges. Management of a patient's general medical condition is the responsibility of a qualified physician member of the medical staff.
2. Physicians shall be responsible for providing care of their patients during their absence. The coverage is to be known to the nursing staff so the proper physician can be called if needed.
3. Every patient shall be seen by a LIP (Licensed Independent Practitioner) at least once every (24) twenty-four hours.
4. Role of the Medical Staff in patient and family education includes but not limited to explaining procedures, benefits, risks, alternatives, discharge instructions, request for special education needs, explaining diabetes education, equipment use, medication use, instructions regarding importance of compliance and repercussions of non-compliance.

## **C. MEDICAL RECORDS (Revised 3/09)**

The history and physical examination shall include:

- a. A description of the patient's chief complaint, the major reason for hospitalization;
- b. A history of the patient's:
  - Present illness
  - Past illnesses
  - Surgeries
  - Medications
  - Allergies
  - Social history
  - Immunizations
- c. A review of the patient's anatomical systems and level of function at the time of the exam;
- d. A patient's vital signs;
- e. A general observation of the patient's:
  - Alertness
  - Debilities
  - Emotional behavior

The physical exam should be a record of a current assessment reporting both positive and negative findings. It is acceptable to use a content outline for the medical history and physical examination to assure completeness of the comprehensive evaluation with exceptions that the user will add other pertinent information as necessary.

## **INPATIENT ADMISSIONS**

A medical history and physical exam must be completed no more than 30 days before or 24 hours after hospital admission, but prior to surgery/outpatient procedure. The history and physical is documented and placed in the medical record within 24 hours of admission and in all cases prior to surgery/outpatient

procedure. When the history and physical exam is performed within 30 days of admission, a repeated medical history and physical is required within 24 hours of admission to determine whether there are any changes in the patient's condition since the initial examination. The physician or other allied health professional qualified to perform the H&P is required to write an updated medical record entry documenting the repeated physical examination. This update is added to the original history and physical and entered into the medical record within 24 hours after admission and prior to any surgical procedure, and addresses the patient's current status and/or any changes in the patient's status, regardless of whether there were any changes in the patient's status. A durable, legible copy of this report may be used in the patient's record.

When using an H&P performed 30 days prior to admission an updated note on or attached to the H&P must be made within 24 hours of admission unless-

the patient is having surgery or another procedure that places the patient at risk and/or involves the use of sedation or anesthesia. These situations require an update of the patient's condition prior to the surgical procedure or initiation of sedation or anesthesia. The pre-anesthesia assessment could be accomplished in a combined activity.

- The admission H&P is good for the entire length of stay.

### OUTPATIENT ADMISSIONS

- It is recognized that the prenatal patient is a special situation in that, in and of itself, the pre-natal course of care is a planned, systematic updating of the history and physical performed at the first visit and throughout the pregnancy. As such, the entire prenatal record can be utilized as the history and physical, provided it is updated to reflect the patient's condition upon admission.
- The entire H&P must be performed and documented and in the record at the time of the outpatient services. When the H&P was performed within 30 days prior to the outpatient surgery an update to the patient's condition is required prior to the start of a procedure. The update note must be on or attached to the H&P and reviewed and signed by the physician prior to surgery.
- The update may be performed by an AHP with privileges to perform H&P's. When the update is performed by an AHP, the physician must review and sign prior to the procedure.
- The content of the update to the patient's condition and the location of the update may vary per hospital policy.
- The H&P, including all updates and assessments, must be included in the patient's medical record except in emergency situations, prior to surgery or procedures.

A pre-anesthesia evaluation must be performed within 48 hours prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. At a minimum, the pre-operative anesthetic evaluation of the patient should include:

- i. Notation of anesthesia risk
- ii. Anesthesia, drug and allergy history;
- iii. Any potential anesthesia problems identified;
- iv. Patient's condition prior to induction of anesthesia.

### OPERATIVE REPORT: (6/07)

The operative report must be written or dictated immediately after an operative procedure and/or anesthesia use. "Immediately" after surgery is defined as "upon completion of surgery and before the patient is transferred to the next level of care." If the surgeon accompanies the patient from the operating room to the next unit or care area, the operative note or progress note can be written in the unit or care area. (Hospital

The operative report describes the procedure(s) performed and description or findings of each procedure, estimated blood loss, the specimen(s) removed and disposition of each specimen, the post-operative diagnosis, the name of the primary surgeon and any assistants, and the clinical condition of the patient. A printed content outline and/or a pre-printed guide may be used in writing or dictating conditions of the individual patient. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, an operative progress note is entered in the medical record immediately after surgery to provide pertinent information for any individual required to attend to the patient.

A post-anesthetic assessment, with findings shall be recorded by the anesthesiologist, medical staff anesthetist, or nurse anesthetist on all patients receiving sedation/anesthesia. The post-anesthetic assessment shall be recorded upon discharge from post-anesthesia recovery unit or within forty-eight (48) hours after the procedure requiring anesthesia. The note shall include:

- i. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
- ii. Nausea and vomiting
- iii. Mental status
- iv. Postoperative hydration
- v. Cardiovascular function, including pulse rate and blood pressure
- vi. Pain
- vii. Temperature
- viii. Any follow up care and patient instructions

### DELINQUENT CHARTS

A chart becomes delinquent (15) fifteen days after preparation of the chart by Medical Records but shall not exceed a period of 30 days from patient discharge. It shall be the duty of the medical records department or a person designated by the hospital administration to personally contact any physician with delinquent charts to help in any way possible to expedite chart completion. The report of delinquent charts shall be furnished to the medical staff executive committee on the first Tuesday of the month by the medical records technician. Physicians who are expected to be on vacation, attending meetings, (medical) or absent due to illness, shall be allowed the equivalent time to complete the records. The physician shall inform the medical records technician of the time expected to be absent due to attendance of medical meetings, or vacation but in cases of the chief of service should inform the proper department.

Medical Records which are delinquent shall be reported to the medical staff executive committee at the regular meeting, designating the physician involved and also the reporting of the number of deficient charts. Recommendation for follow-up will be made at that time. If the committee recommends that the practitioner be suspended, the suspension will take lace effective the second Tuesday of the month. Temporary suspension shall include all clinical privileges except:

- a. Patient(s) already admitted shall be cared for by the regular physician.
- b. Emergency call missed due to suspension must be made up within (60) days of reinstatement to the medical staff.
- c. Suspension may be waived by the chief of staff in case of a catastrophic situation.
- d. Temporary suspension for delinquent charts shall continue until all deficiencies are corrected.
- e. Deficiencies are corrected.

The names of physicians suspended, or the reinstated physicians shall be reported by the chief of staff to the hospital administrator, who will then notify the suspended physician and the following individuals.

- a. Record Technician
- d. Chief of Service

- b. Operating Room supervisor
- c. Admitting Clerk
- e. Nursing Supervisor

After the physician has completed the delinquent charts, he/she shall notify the hospital president/CEO. The CEO will notify the individuals listed above (#12). Any medical staff member who knowingly allows a suspended physician to admit patients in his/her name shall also have his/her privileges similarly suspended. Physicians disagreeing with suspension may appeal by the procedure outlined in Article VII; Section I. the suspension will remain in force during the appeal process. Permanent medical records shall not be removed from the hospital except in accordance with a subpoena or court order.

**D. ORDERS** (revised 3/09)

1. All written orders shall be signed, dated and timed by the responsible physician. Orders, at a minimum, should contain drug name, dosage strength (unless a single source item), route of administration, and frequency of administration. Also, if needed, any additional instructions necessary for safe administration of drug should be included. When a medication is ordered based on weight, the weight should be included in the order and it should be an actual weight not a stated weight. Also, all orders for pediatric patients <40kg must be weight based.

2. All previous orders are canceled and must be re-written after the patient goes to the operating room with the exception of some minor procedures not requiring extensive anesthesia (hospital policy regarding Moderate Sedation, MSS-001-017). Orders must be re-written if the patient is transferred to a specific service such as ICU/CCU. This is also required if the reverse patient transfer is made such as from ICU/CCU to any nursing unit. New orders must be written when the patient is transferred to Swing Bed status.

3. Telephone or verbal orders must be signed, dated and timed at the time of authentication, by the practitioner giving the order or another practitioner who is responsible for the care of the patient, as soon as possible, but no later than 48 hours after the order was given. The nurse or appropriate staff taking the verbal /telephone order, when allowed, must immediately write the order in the medical record and read back the order in its entirety to the ordering prescriber, who will verify or correct the order. Telephone or verbal orders for medications shall be given only to a licensed practical or registered nurse or pharmacist. Other types of orders may also be given to respiratory therapist, registered dietitians, licensed physical/occupational/speech therapists in accordance with the therapist's scope of practice and hospital policy and procedure (PCS-002-002).

4. Orders for controlled substances and corticosteroids have a five (5) day soft stop and anti-infective agents have a soft stop of seven (7) days. Meperidine has a two (2) day soft stop and ketorolac four (4) days unless reordered by the physician. Pharmacy will place a notification sticker in the order section of the medical record. The ordering physician must check to discontinue or continue the medication.

5. Medication orders which are to be used as needed or PRN shall be qualified with a time interval or specific dosage administration interval. All PRN orders must list an indication for use in order to be valid unless there is only one intended use for the product. Orders such as "resume home medications", "may take medications as at home", or "resume preoperative medications" are incomplete. When such an order is written, nursing personnel will contact the prescriber and obtain medication orders that meet the criteria for a complete medication order.

6. Investigational drug studies and herbal products are not initiated and supplied in this facility.

7. When an error is made on a medication order, one line should be drawn through the error and the word "error" and the initials of the person written. Rewrite the correct work out from the error. Medication orders are not to be obliterated.

8. When using pre-printed order sets:

- i. The last page of the orders must be signed, dated, and timed, and identify the total number of pages in the order set.
- ii. The practitioner must sign or initial the top or bottom of each page of the order set if that page has been changed. The practitioner must also initial each place on the page that reflects a change-  
“*additions, deletions, or strike-outs of components that do not apply.*”
- iii. Preprinted checked boxes that are part of the order set do not need to be signed or initialed as long as there are no changes made to the option(s) selected.

## **E. CONSULTATIONS**

1. Consultations shall be requested except in emergencies on:
  - A. Poor operative risk patients
  - B. Patients with obscure diagnosis after a complete study
  - C. A difficult therapeutic choice
  - D. Unusually complicated cases
  - E. When severe psychiatric symptoms occur
  - F. When requested by the patient or a responsible member of the family.
2. The consultation sheet shall show the pertinent findings of the consulting physician with his/her opinions and recommended treatment. This shall be included as part of the patient’s record.
3. Every patient admitted to the ICU/CCU will have an attending physician. This "attending physician" will be the physician who admits that patient to the unit. He or she is totally responsible for all care of that patient and all calls will be directed to him or her. Then, he or she may decide which other physician, i.e., consultants, the call should go to. The attending physician may advise the nursing staff, by written order, to direct the calls to the appropriate consultant. If there is no written order redirecting the calls, then all calls will come to the attending physician.
4. The physicians' responsibility for the medical record is the same as elsewhere in the hospital. A death summary is to be completed in all appropriate cases. A brief written note will be done at the time of admission by the attending physician. This will contain historical items pertinent to the present illness, significant items of the history, such as coexisting diseases, and significant physical findings. All physicians will adhere to the Medical Staff Rules and Regulations regarding orders as outlined in Article XI, Section 4. They will visit patients at least daily and a progress note will be completed following each visit. In case of consultation, they should record adequate information in the progress notes so that the consultants can appraise the clinical situation as quickly and accurately as possible. Without such notes, personal communication between the attending physician and consultant will be necessary for the patient to receive the best possible care. The primary ICU/CCU nurse will be available for discussion about the patient with the physicians.
5. We will not require consultation by a qualified specialist on all cases admitted to the ICU/ CCU. However, the physicians' responsibility to keep abreast of advancing scientific standards in this area is considered very important. The ICU/CCU Committee is responsible for maintaining a high quality of service to the patient and in the following instances will require the attending physician, if not qualified to provide needed care, to obtain consultation.
  - a. Complicated cases in which specific special skills of physicians (as outlined by delineation of privileges) would be needed, i.e.,
    - i. High grade AV block.
    - ii. Pacemaker/Swan Ganz Insertions
    - iii. Cardio version
    - iv. Thrombolytic Agent Therapy
      - v. Massive GI Bleed.
      - vi. Acute Abdomen.
      - vii. Massive Hemoptysis
      - viii. Obscure diagnosis after exhaustive testing

- ix. Condition of patient not improving or deteriorating despite medical intervention
  - x. Persistent sinus tachycardia.
  - xi. Persistent supraventricular tachycardia.
  - xii. Severe brady arrhythmia.
  - xiii. Persistent unrelieved chest pain
  - xiv. Complex Ventricular arrhythmias
  - xv. Cardiogenic shock or persistent hypotension.
  - xvi. Persistent or Complicated Respiratory Failure.
  - xvii. When the patient is not a good risk for a surgical procedure or some modality of medical treatment.
  - xviii. Acute and Progressive Renal Failure
  - xix. In the attending physicians' clinical judgment for any critically ill patient
- b. When requested by patient or patients' family after notification of attending physician. The attending physician is responsible for requesting consultations when indicated, and for contacting the consultant. The attending physician will remain primarily responsible for the patients' care, unless care has been transferred to and accepted by another physician.
6. ICU/CCU personnel will be responsible for photocopying one copy of the patients' face sheet and placing it in the physicians' hospital mailbox... When they obtain a request for consultation, they should obtain information regarding the priority of consultation from the attending physician, i.e., immediate, today, in A.M. They should notify the office of the consultant as soon as possible. During non office hours they will notify the consultants as soon as possible. When the consultant is not available, ICU/CCU personnel should notify the primary physician for direction.

**F. SURGERY (Revised 3/09)**

1. Physicians not having adequate training, as determined by the Chief of Surgery, shall not be permitted to do any surgical procedures until a review by the credentials committee of directors. A list of approved surgical privileges for each practitioner is available in the surgery department and will be updated as needed. Surgical privileges granted will automatically include sedation privileges by non-anesthesia personnel for that procedure/privilege.
  2. Consultation with the chief of surgery or his appointed representative is required for any case involving an unusual risk.
  3. The patient or his legal representative shall sign consent to surgical procedures unless the procedure is a life-saving emergency and the patient's condition does not permit it. Licensed independent practitioner is responsible to provide the risks and benefits, and alternatives procedures and treatments to the patient.
  4. All patients undergoing anesthesia, including conscious sedation, must have a pre-anesthesia and post anesthesia assessment by a licensed independent practitioner. **(See Section B-Care of the Patient)**
  5. Sterilization operations consent must be signed by the patient in accordance to Kentucky State law. Elective sterilization consent for both male and female Medicaid patients must be signed 30 days prior to the procedure in accordance with Kentucky State Law. Medicaid consent expires 180 days after signature.
  6. Surgeons are expected to operate at the time scheduled. Persistent tardiness shall be dealt with by the chief of surgery in an appropriate manner.
- 7
7. Physicians wishing to schedule procedures prior to 8:00 a.m. shall obtain permission of the physician having the first regularly scheduled case. The physician having the first case on the regular schedule has the option to start early.
  8. Should a second elective surgery be required during a patient's stay in the hospital a second consent form shall be obtained as soon as possible.
  9. Non-medical personnel may be permitted in the OR suite by invitation and at the discretion of the specific surgeon. The OR coordinator will be notified when non-medical personnel will be in the OR

suite. Non-medical individuals are to be admitted to one specific area and do not have permission to be present in any other area. These people are at all times under the direct supervision of the attending MD. Non-medical personnel will be allowed in the OR suite for observation only. (hospital Policy: SSS-001-012)

#### **G. DEPARTMENTS (6/07)**

1. Respiratory Therapy Department shall have a physician of the active staff appointed by the chief of staff to be the chief of the department. They shall be governed by the anesthesia departmental procedures manual of the respiratory therapy department.
2. Anesthesia shall have a physician act as the medical director for the department.
3. ICU/CCU Department.
  - a. In the ICU/CCU, the Medical Director is appointed by the Chief of Staff.
  - b. In the event that the Medical Director is unable to be contacted, the Chief of Medicine then assumes this responsibility.
  - c. In the absence of both Medical Director and the Chief of Medicine, the Chief of the Medical Staff will assume the responsibilities.
  - d. The Medical Director shall be responsible for and have medical direction over the activities of the unit which include but are not limited to:
    - Be available to the nursing staff for consultation and a reference source.
    - Participate in the in-service program provided for ICU/CCU nursing staff.
    - Coordinate a systematic program of on-going monitoring and evaluation of specific indicators to support continuous improvement of patient care or services in the ICU/CCU.
    - Serve as Chairperson of the ICU/CCU multidisciplinary Committee, which directs and guides the activities of the ICU/CCU.
    - Serve as mediator.
    - A patient will generally remain in the unit until complications are under control as deemed advisable by the attending physician. In the event that all beds are occupied and an emergency admission or transfer fulfilling the aforesaid criteria would arise, the priority for the bed shall be resolved by the physician attending the emergency and the physician attending the occupant whose clinical condition seems most stable. The priority decision will be with the attending physician of the patient already in the unit. If the disposition remains unresolved, the Medical Director of the ICU/CCU is responsible for determining patient priority.

#### **H. TRANSFER OF PATIENTS (Revised 03/09)**

1. No patient shall be transferred from one physician's service to another without the approval of the responsible physician.
2. Communication shall be directly between physician desiring to transfer care and physician to which care is being transferred.
3. Transfer of care shall be noted in the physician orders
4. Priorities for transfer shall be established by the chief of staff and the chief of service.

#### **I. ACUTE PSYCHOTIC DISORDERS/CHEMICAL SUBSTANCE ABUSE AND/OR ALCOHOL ABUSE PATIENTS (Revised 6/07)**

Pattie A. Clay Regional Medical Center staff will abide by all current policy and procedures of the Pattie A. clay Regional Medical Center. (Hospital Policy: EMS-001-040 and ICU-002-001)

#### **J. PATIENT RESTRAINTS (3/09)**

Pattie A. Clay Regional Medical Center staff will abide by all current policy and procedures of the Pattie A.

### **K. SPECIAL SERVICES**

Admission to the intensive care or coronary care unit and discharge from the same unit may only be required from the attending physician except in unusual circumstances, the chief of service or chief of staff will have final control.

All physician orders are canceled on being transferred from ICU or CCU to another part of the hospital and must be rewritten by the attending physician. (NUR-002-004, ICU-002-003)

### **L. CLINICAL PATHOLOGY, LABORATORY AND X-RAY**

1. All patients admitted to Pattie A. Clay Regional Medical shall have appropriate laboratory work done on the written order of the physician. Patients admitted to the hospital by physicians with written, standing orders in which VDRL's are specifically requested will continue to have the VDRL done.
2. Pre-operative lab test results should be available by 1900 hours on the day prior to surgery.
3. Pre-Op chest x-rays are done only as ordered by the physician.
4. All specimens removed at operation shall be sent to the pathologist for examination except for those listed by the pathologist. This list shall be maintained in the OR policy/procedure manual.
5. X-ray requests should be completed as requested in the physician orders by the x-ray department.
6. The radiologist and pathologist shall arrange the hours of the attendance so that all patients shall have prompt service and that all consultations requested from the staff are completed within a reasonable length of time.

### **M. PHYSICIAN CALL SYSTEM**

Active medical staff membership includes an obligation to actively participate in an on "Call" for duty rotation in order to assure that medical coverage is readily available to patients presenting themselves to the hospital emergency department. The on call rotation should be such that the hospital emergency room personnel have the name of an individual physician in each area of service available for call in the event of an emergency. A physician is available for "call" when, for a specific period, usually a 24 hour period he/she can be readily contacted by the hospital emergency room and is able to respond to the needs of the emergency room and patient within a reasonable period of time.

In order to implement this regulation, the chief of each of the three services shall supply the emergency room, prior to the end of each month, with a call schedule for the upcoming month. The schedule shall be such that the hospital's emergency room personnel have available the name of a physician in the specialties within that service available at any given time, to attend an emergency room patient. In the event, in any given month, that the emergency room does not receive a call schedule from any service by the last day of the month, then the MSEC shall adopt and deliver to the emergency department a call schedule for that month and for that service.

Each instance of a physician's failure or refusal to appropriately respond to an on call request shall be submitted by the emergency department physician to the Medical Staff Executive Committee for corrective or disciplinary action. Such action may include a recommendation as follows:

1. Physician's voting privileges at meetings of the Medical Staff be suspended or revoked.
2. Admitting privileges and/or medical staff membership be suspended or revoked.

In the event of a recommendation by the Executive Committee adverse to the physician, the physician shall have the right to a hearing and appellate review as set forth in (Article IX) of the Medical Staff Bylaws, Rules and Regulations.

Physicians on the active staff may request of the Medical Staff Executive Committee an exemption from on call scheduling after reaching the age of 60 or after having taken call for at least 20 years as an active staff member of Pattie A. Clay Regional Medical Center.

Physicians on staff 20 years or more will not be required to pay annual dues.

Physicians on staff 20 years or more are not required to attend meetings or serve on committees unless they chose to do so or are requested to attend for peer review.

#### **N. DEATH/AUTOPSY**

In the event of a hospital death the deceased shall be pronounced dead by the attending practitioner or his/her designee as soon as possible after death. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. In the event a death is a "coroner's case" the Madison County coroner or his/her deputy should be notified.

Coroner's Case means a case in which the coroner has reasonable cause for believing that death of a human being within his/her county was caused by any of the conditions set forth in KRS 72.025 (ADM-010-034).

Autopsies: it shall be the duty of all members of the medical staff to secure meaningful autopsy whenever possible. An autopsy may be performed only with a written consent signed in accordance with Kentucky State Law. All autopsies shall be performed by the hospital pathologist or by a physician to whom he may delegate the duty. Provisional Anatomic Diagnosis shall be recorded on the medical record within seventy two (72) hours and the completed protocols shall be made part of the record within six (6) weeks. Attempts to obtain an autopsy shall be made in cases including but not limited to:

Unanticipated death; intra operative or intra procedure death; death occurring within forty eight (48) hours after surgery or an invasive procedure; death incident to pregnancy; death of infants or children; death where the cause is obscure enough to delay completion of the death certificate; and death occurring while a patient is being treated under any experimental regimen. Results will be discussed in quality improvement activities.

The primary care physician will be notified by the house supervisor of the time and date of the performance of the autopsy and this will be documented in the patient's chart. Autopsies required by the coroner's office will be handled according to coroner's office protocol KRS 72.020 (ADM-010-034).

Autopsies initiated by attending physician:

1. The autopsy procedure is carried out only when initiated by the attending physician, not at the request of the family member.
2. An autopsy will not be performed unless the proper forms have been completed.

#### **O. COMMITTEE AND RULES OF ORDER**

All standing committees shall be appointed by the Chief of Staff within one week after the annual meeting and change in committees will be July 1. Medical Staff will be notified of appointments to committees by the medical staff office.

#### **P. QA/PI (Revised 03/09)**

Medical Staff actively participates in the review of clinical work. QA/PI functions include the appropriateness of the selected service/activity and the management of same in the following processes:

- i. Medication therapy- including antibiotics and non-antibiotics for all service types(in, out, ambulatory and emergency) patients

- ii. Infection Control- including community acquired and healthcare acquired infections in patients and health-care workers
- iii. Surgical/invasive and manipulative procedures- including tissues and non-tissue producing cases, with or without anesthesia and/or moderate sedation
- iv. Blood-(including component) product usage (including for all service types of patients.
- v. Data management-(accuracy, currency, transferability)- with emphasis on medical record pertinence and timeliness;
- vi. Discharge planning
- vii. Utilization management
- viii. Complaints regarding medical staff related issues
- ix. Restraint/seclusion usage
- x. Mortality review

Refer to PAC policy QUR-001-003

## **Q. POLICIES AND PROCEDURES**

Medical Staff will abide by all current policies and procedures and hospital approved protocols of the Pattie A. Clay Regional Medical Center and Medical Staff policies and procedures

**ADOPTED BY THE ACTIVE MEDICAL STAFF  
PATTIE A. CLAY REGIONAL MEDICAL CENTER**

\_\_\_\_\_  
William Allen, M.D.  
Chief of Staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
Rajan Joshi, M.D.  
Secretary/Treasurer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Thomas Bonny  
Chairman, Board of Directors

\_\_\_\_\_  
Date

\_\_\_\_\_  
Laura Steidle  
Secretary, Board of Directors

\_\_\_\_\_  
Date