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REVISIONS:

- 10/97 Bylaws, Rules and Regulations and Policies and Procedures
- 04/98 Rules and Regulations and Policies and Procedures
- 01/99 Rules & Regulations and Policies and Procedures
- 07/99 Bylaws, Rules and Regulations and Policies and Procedures
- 12/99 Bylaws, Rules and Regulations
- 01/01 Bylaws, Rules and Regulations and Policies and Procedures
- 06/01 Policies and Procedures (Moderate Sedation)
- 05/02 Policies and Procedures (Article VIII, Section 4, Automatic Suspension, Paragraph C)
- 05/03 Policies and Procedures (Article VII, Section 6, Emergency Privileges, added Emergency Disaster Privileges)
Policies and Procedures Added Disruptive Physician Conduct Policy and Impaired Physician Policy)
- 08/03 Policies and Procedures, Article VII, Section 5, Temporary Privileges Amended
- 11/03 Policies and Procedures, Article VII, Section 7, Moderate Sedation Amended
- 06/04 Policies and Procedures (Eliminated Articles I through VI, incorporated into Bylaws. Renumbered remaining policies and moved Fair Hearing Plan to Article I. Eliminated Article XIV, Removal of Medical Staff Officers; this policy incorporated into Bylaws)
- 08/06 Policies and Procedures, Article III Moderate Sedation, Section 7 Paragraph A, added vital signs, mental status, and exam of heart and lungs by auscultation. Paragraph C, edited to read "time out", rather than Pause in the action in the room.
Article IV, Section 3C, Ethics Committee, meetings changed to ad hoc.
Article IV, Section 3F, Physician Affairs Committee deleted. This committee is addressed in Medical Staff Bylaws. Succeeding paragraphs in the section changed, i.e., former paragraph G, moved to F, etc.
- 03/07 Peer Review Policy replaced by Ongoing Professional Practice Evaluation Policy
- 07/07 Moderate Sedation Policy edited to add Cath Lab as a dept where Sedation can be performed.\
- 04/08 Eliminated Special Care Committee
- 10/08 Added Focused Professional Practice Evaluation Policy as Article III. Numbering on subsequent Articles changed.
- 11/08 Ongoing Professional Practice Evaluation Policy; Article V, Paragraph V, A. Added language to define who would be responsible for correspondence to the individual under review.
Eliminated all references to Attachments; those are contained in Hospital P&Ps and are referenced.
- 07/09 Ongoing Professional Practice Evaluation Policy; Article II (Changes include peer review by a practitioner with privileges to perform the same service or procedure(s) as that under review; prior to submitting a case for external review, a determination shall be made by the Section Chief or Chief of Staff as to whether a member of the individual's Section is qualified to conduct an internal review; change of responsible individual; and editing to read Sections rather than Committees as appropriate).

ARTICLE I. FAIR HEARING PLAN AND APPELLATE REVIEW PROCEDURE

SECTION 1 DEFINITIONS

The following definition, in addition to those stated elsewhere in the Bylaws, shall apply to the provision of this Plan:

- A. JUDICIAL REVIEW COMMITTEE** means the committee appointed pursuant to this Plan to hear a request for an evidentiary hearing properly filed and pursued by a practitioner.
- B. NOTICE** means a written communication delivered by certified mail, return receipt requested.
- C. PARTIES** means the practitioner and the body who initiated the adverse action or requested the hearing or appellate review.

SECTION 2 INITIATION OF HEARING

- A. GROUNDS FOR HEARING.** One of more of the following actions shall, if deemed adverse pursuant to Section 2B of this Plan, entitle the practitioner affected thereby to a hearing:

1. Denial of initial staff appointment;
2. Denial of staff reappointment;
3. Suspension of staff membership or clinical privileges until completion of specific conditions or requirement;
4. Revocation of staff membership;
5. Denial of requested advancement in staff category;
6. Reduction in staff category;
7. Limitation or suspension of admitting privileges;
8. Denial of requested clinical privileges;
9. Reduction in clinical privileges;
10. Summary suspension of staff membership and/or clinical privileges during the pending of corrective action and hearing and appeal proceeding;
11. Revocation of clinical privileges;
12. Terms of probation; and/or
13. Individual requirement of consultation.

- B. WHEN DEEMED ADVERSE.** An action enumerated in Section 2A of this Plan shall be deemed adverse only when it has been:

1. Taken or recommended by the Executive Committee;
2. Taken by the Board contrary to a favorable recommendation by the Executive Committee;
or
3. Taken by the Board on its own initiative without benefit of a prior recommendation by the Executive Committee.

Adverse actions at Section 1A1, 2A5, 2A8, and 2A13 shall be effective when taken

and shall remain in effect unless and until modified, overturned or revoked. All other adverse actions at Section 2A, unless otherwise provided in the Bylaws or specified by the Executive Committee or Board at the date of adverse action, shall become final and effective in accordance with the provisions of this Plan, except that an automatic suspension or summary suspension of Medical Staff Membership, admitting privileges, or clinical privileges shall be effective immediately.

- C. NOTICE OF ADVERSE ACTION** A practitioner against whom an adverse action has been taken shall promptly be given notice of such action. Such notice shall advise the practitioner of his right to a hearing under this Plan and shall include statements
1. That an adverse action has been proposed against the practitioner;
 2. Of the reasons for the proposed action;
 3. That the practitioner has the right to request a hearing on the proposed action;
 4. Of the time limit within which to request a hearing; and
 5. A general summary of the practitioner=s rights in the hearing.
- D. REQUEST FOR HEARING** A practitioner shall have thirty (30) days following receipt of notice pursuant to Section 2C of this Plan to file a written request for a hearing. Such request must be delivered to the Chief Executive Officer either in person or by certified mail.
- E. WAIVER BY FAILURE TO REQUEST A HEARING.** A practitioner who fails to request a hearing within the time and in the manner specified in Section 2D hereof waives any right to such hearing and to any appellate review to which said practitioner might otherwise have been entitled.
- F. EFFECT OF WAIVER.** If a practitioner waives his rights under Section 2E, said practitioner shall be deemed to have accepted the adverse action, which shall then become the final decision in the matter.

SECTION 3 HEARING REQUIREMENTS

- A. NOTICE OF TIME AND PLACE FOR HEARINGS** Upon receipt, the Chief Executive Officer shall deliver each proper request for a hearing to the Chief of Staff and shall notify the Executive Committee. Within fifteen (15) days after receipt, the Chief of Staff shall schedule a hearing by a Judicial Review committee. The Chief Executive Officer shall promptly send the practitioner notice of the time, place, and date of the hearing. The hearing date shall not be less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for hearing; provided, however, that hearing for a practitioner who is under suspension then in effect shall be held as soon as the arrangements for such hearing may reasonably be made, but not later than thirty (30) days from the date of receipt of the request for hearing by the Chief Executive Officer.

- B. NOTICE OF GROUNDS** As a part of, or together with the notice of hearing required by Section 3A above, the Chief of Staff, on behalf of the Executive Committee, shall have the Chief Executive Officer state in writing the act(s) or omission(s) with which the practitioner is charged, including a list of the specific or representative patient records being questioned, the grounds upon which the application was denied, where applicable, and/or the other reasons or subject matter forming the basis for the adverse actions which is the subject of the hearing. If either party, by notice, requests a list of witnesses, then each party, within fifteen (15) days of such request, shall furnish to the other a written list of the names and addresses of the individuals, so far as then actually anticipated, who will give testimony or evidence in support of the party at the hearing. The witness list shall be amended when additional witnesses are identified.
- C. APPOINTMENT OF JUDICIAL REVIEW COMMITTEE** When a hearing is properly requested, the Chief of Staff shall appoint a Judicial Review Committee composed of at least five (5) members of the Active Medical Staff and alternates as appropriate. The members and alternates to serve on the Judicial Review Committee shall not have actively participated in the formal consideration of the matter at any previous level and shall not be indirect economic competition with the practitioner. Knowledge of the matter involved shall not preclude a member of the Active Medical Staff from serving as a member of the Judicial Review Committee. In the event that it is not possible to appoint a fully qualified Judicial Review Committee from the Active Medical Staff, the Chief of Staff may appoint qualified members of the Courtesy Staff or qualified practitioners from outside the Staff. The Chief of Staff shall appoint one of the members of the Judicial Review Committee as Chairman who shall preside in the manner described in Sections 4B and 9B below and handle all pre-hearing matters and preside unless a hearing officer, as described in 9B below, is appointed.
- D. JUDICIAL REVIEW COMMITTEE ACTION** A majority of the members of the Judicial Review Committee or its chairman may act as and for the Judicial Review committee. No committee member may vote by proxy.
- E. POSTPONEMENTS AND EXTENSIONS** The Judicial Review Committee or its chairman shall permit postponements or extensions requested by any affected party on an adequate showing of good cause and if the request therefore is made as soon as is reasonably practicable. Such postponements and extension shall automatically extend for an equal number of days the time periods set forth in Section 3A of this Plan for the hearing by the Judicial Review Committee.

SECTION 4 HEARING PROCEDURE

- A. PERSONAL PRESENCE.** The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails, without good cause to appear and proceed at the hearing, shall be deemed to have waived the rights in the same manner and with the same consequence as provided in Section

2F of this Plan.

- B. PRESIDING OFFICER.** The presiding officer at the hearing shall be the hearing officer, or, if no hearing officer has been appointed pursuant to Section 9 of this Plan, the chairman of the Judicial Review Committee. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence. The chairman of the Judicial Review Committee shall be entitled to vote on the matter, but the hearing officer, if one is appointed, may not.
- C. REPRESENTATION.** The hearing provided for in the Bylaws are in the purpose of inter-professional resolution of matters bearing on conduct or professional competency. Accordingly, neither the practitioner nor the Executive Committee shall be represented at the hearing or the appellate review by an attorney, unless the Judicial Review Committee (at the hearing) or the Board (at the appropriate review), in its discretion, permits both sides to be represented by legal counsel. The foregoing shall not be deemed to deprive any party of its right to assistance of legal counsel for the purpose of preparing for the hearing. Each party may use attorneys to assist in the preparation of its case for the hearing and/or appellate review, including the preparation of written statements. The Judicial Review Committee or the Board (or its designated review committee) may use an attorney to advise it on procedural matters only, including interpretation of the Bylaws, Rules and Regulations and Policies and Procedures, but such attorney shall not participate in the deliberations or decision.

The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of his profession who is duly licensed to practice in the State of Texas and who is not attorney. The Executive Committee or the Board, depending on whose action prompted the hearing, shall appoint an individual to present the facts in support of its adverse action and to examine witnesses.

- D. RIGHTS OF PARTIES.** During the hearing, each of the parties shall have the right to call and examine witnesses, to introduce exhibits, to cross examine any witness on any matter relevant to the issues, to impeach any witness and rebut any evidence, and to ask Judicial Review Committee Members questions which are directly related to determine whether they are impermissibly biased and to challenge such members. If the practitioner who requested the hearing does not testify in his own behalf, he may still be called as if under cross examination by the other party or the Judicial Review Committee. The presiding officer may limit evidence which is cumulative.
- E. EVIDENCE.** The hearing shall not be conducted according to rules of courts of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence upon which responsible persons customarily rely in the conduct of serious

affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit a written memorandum of points and authorities, which shall become part of the hearing record. The presiding officer may order that oral evidence be taken only on an oath or affirmation administered by any person who is entitled to notarize documents in the State of Texas. The Judicial Review Committee may examine witnesses or call witnesses.

F. OFFICIAL NOTE. During the hearing, the presiding officer may take official notice of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts which may be judicially noticed by the courts of the State of Texas. Parties to the hearing shall be informed of the matters to be officially noticed and those matters shall be noted in the hearing records. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed or to refute the noticed matters by evidence or by written or oral presentation authority. The manner of such refutation shall be determined by the Judicial Review Committee, and reasonable time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

G. PRESENTATION, BURDEN OF PROOF AND STANDARD OF REVIEW.

Through its representative, the body or committee whose adverse action occasioned the hearing shall present its evidence first in the matter. The practitioner subject to the adverse action may then present evidence to the contrary. Following the evidentiary presentations, each party may then make a closing argument, with the body or committee whose adverse action occasioned the hearing making the first argument. In making its closing arguments, each party shall have available to it an equal amount of time to be determined in the sole discretion of the Judicial Review Committee. In reaching its decision, the Judicial Review Committee shall uphold the adverse action unless it finds the affected practitioner has demonstrated, by clear and convincing evidence, that the adverse action was either arbitrary, capricious, or lacked a substantial basis in fact. If the Judicial Review Committee determines that the affected practitioner has demonstrated, by clear and convincing evidence that the adverse action was either arbitrary, capricious, or lacked a substantial basis in fact, then the Judicial Review Committee may:

1. reverse the adverse action; or
2. modify the adverse action; or
3. refer the matter back to the body or committee which took the adverse action with the instruction that the matter be reconsidered in accordance with the findings of the Judicial Review Committee.

H. RECORD OF HEARING. A court reporter shall record the proceedings to permit an informed and valid judgment to be made by any group that later may be requested to review the record and render a recommendation or decision in the matter. The hospital shall bear the cost of the reporter=s appearance and the parties shall equally split the cost of the transcript.

- I. PRESENCE OF JUDICIAL REVIEW COMMITTEE MEMBERS.** A majority of the Judicial Review Committee members must be present throughout the hearing and deliberations. If a committee member is absent from any part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.
- J. RECESSES AND ADJOURNMENT.** The Judicial Review Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence and final arguments, the hearing shall be closed. The Judicial Review Committee shall then, within the time specified in Section 5B hereof and outside the presence of the parties or their representatives or any other persons, conduct its deliberations and render a decision. The hearing shall then be declared finally adjourned.

SECTION 5 JUDICIAL REVIEW COMMITTEE DECISION AND FURTHER ACTION

- A. BASIS OF DECISION.** The decision of the Judicial Review Committee shall be based on the evidence produced at the hearing. This evidence may include, but shall not be limited to, oral testimony of witnesses; memoranda of points and authorities presented in connection with the hearing; any material contained in the Medical Staff's credentials files regarding the practitioner; any and all applications, references, and accompanying documents; all officially noticed matters; and any other evidence deemed admissible under Section 4E of this Plan. The Judicial Review Committee shall also be entitled to consider all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to or advancement in the Medical Staff and for clinical privileges.
- B. JUDICIAL REVIEW COMMITTEE DECISION.** Within thirty (30) days after closing of the hearing (ten days in the case of a staff member currently under suspension) pursuant to Section 4J hereof, the Judicial Review Committee shall render a written decision in the matter and shall forward the same, together with the hearing record and all other documentation considered, to the Chief Executive Officer. The Judicial Review committee's decision shall contain findings of fact, which shall be in sufficient detail to enable the parties, the Board or any other appellate review body to determine the basis for the Judicial Review committee's decision on each matter contained in the notice of charges. The decision shall be supported by reference to the hearing record and all other documentation considered by the Committee.
- C. NOTICE OF DECISION.** The Chief Executive Officer shall promptly send a copy of the Judicial Review Committee's decision to the practitioner by personal delivery or by certified mail, to the Chief of Staff, to the Executive Committee, and to the Board.
- D. EFFECT OF DECISION.** If the Judicial Review Committee's decision is adverse to the practitioner in any of the respects listed in Section 2A and 2B, the notice

required by Section 5C hereof, shall inform the practitioner of his right to request an appellate review by the Board as provided in Section 6 of this Plan. If the Judicial Review Committee decision reverses or modifies the action which occasioned the hearing, the notice required by Section 5C hereof shall inform the Executive Committee or the Board, as the case may be, of the right to request an appellate review by the Board as provided in Section 6 of this Plan. In the event that each party fails to request an appellate review within the time and in the manner specified in Section 6A of this Plan, the Judicial Review Committee's decision shall be deemed final the matter shall be considered closed.

SECTION 6 INITIATION AND REQUIREMENTS OF APPELLATE REVIEW

- A. REQUEST FOR APPELLATE REVIEW.** Within thirty (30) days following receipt of the notice of the Judicial Review Committee decision, either party may file a written request for an appellate review by the Board. Such request shall be delivered to the Chief Executive Officer either in person or by certified mail and it shall include a brief statement of the reasons for the appellate review. The reasons for the appellate review shall be: (a) substantial failure of any person to comply with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the decision so as to deny the practitioner a fair hearing; (b) the lack of substantive rationality of a Medical Staff Bylaws, Rules and Regulations or Policies and Procedures relied upon by the Judicial Review Committee in reaching its decision; and/or (c) action taken arbitrarily, unreasonable, or capriciously.
- B. WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW:** A party who fails to request an appellate review within the time and in the manner specified in Section 6A above waives any right to such review. In the event that each party fails to request an appellate review within the time and in the manner specified in Section 6A of this Plan, the Judicial Review committee's decision shall be deemed final and the matter shall be considered closed.
- C. NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW.** Upon receipt of a proper and timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board. Within thirty (30) days of receipt of such request, the Board shall schedule and arrange for an appellate review. The appellate review shall be conducted not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the appellate review request. The Board, through the Chief Executive officer, shall deliver promptly to the practitioner notice of the time, place and date of the review.
- D. POSTPONEMENTS AND EXTENSIONS.** The chairman of the Board or chairman of the Board's designated Appellate Review committee shall permit postponements or extension of the appellate review only on good cause and if the request therefore is made as soon as is reasonable practicable. Such postponements and extensions shall automatically extend for an equal number of days the time periods set forth in

Section 6C of this Plan for the appellate review. In all cases, the Section 6C time periods shall be extended until the transcript of the Judicial Review Committee hearing is completed.

- E. APPELLATE REVIEW COMMITTEE.** The Board shall determine whether the appellate review shall be conducted by all members of the Board who have not previously participated in the matter in any way, or by an Appellate Review Committee of at least five (5) members appointed by the Chairman of the Board. If an Appellate Review committee is appointed, it must contain a minimum of two physician members who have not previously participated in any decision, hearing or other proceeding on the matter. One of the committee members shall be named as chairman by the Chairman of the Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appellate Review committee, so long as the person did not participate in a prior hearing on the same matter. For purposes of this subsection, participating in an initial decision to recommend adverse action shall not be deemed to constitute participation in a prior hearing on the same matter.
- F. POWERS OF APPELLATE REVIEW COMMITTEE AND STANDARD OF REVIEW.** The appellate review body shall have all the powers granted to the Judicial Review Committee and such additional powers as are reasonably appropriate to the discharge of its responsibilities. The appellate review body shall be charged with conducting a review of the initial adverse action and shall employ the same standard of review with respect to that adverse action as specified in Section 4G of this plan for use by the Judicial Review Committee.

SECTION 7 APPELLATE REVIEW PROCEDURE

- A. NATURE OF PROCEEDINGS.** The proceedings by the Board to its Appellate Review Committee shall be in the nature of an appellate review based upon the record of the hearing before the Judicial Review Committee, that committee's decision, and all other documentation considered by the Judicial Review committee. The Appellate Review Committee shall also consider the written statements, if any, submitted pursuant to Section 7B of this Plan and such other material as may be presented and accepted under Sections 7D and 7E. Except as specified in Section D hereof, no oral statements or arguments will be allowed and neither of the parties nor their representatives shall be present during the appellate review.
- B. WRITTEN STATEMENTS.** The party requesting the appellate review may submit a written statement detailing the findings of fact, conclusions and procedural matters with which the party disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the Board through the Chief Executive Officer at least fifteen (15) days prior to the scheduled date of the appellate review, except if such time limit is expressly waived by the Board. The Chief Executive Officer shall send a copy of the statement to the

other party. A written statement in replay may be submitted to the Board through the Chief Executive Officer. The Chief Executive Officer shall provide a copy thereof to the party requesting the appeal.

- C. PRESIDING OFFICER.** The chairman of the Board or its designated Appellate Review Committee shall be the presiding officer. The presiding officer shall determine the order of procedure during the review, make all required rulings, and maintain decorum.
- D. ORAL STATEMENTS.** The Board or its designated Appellate Review Committee may, in its sole discretion, permit the parties to appear personally and make oral statements in favor of their positions. Any party who appears personally shall be required to answer questions put to him by any member of the appellate review body. If one of the parties is allowed to make any oral statements under this Section D, then the other party must be allowed to appear at the same time to respond to such statements.
- E. CONSIDERATION OF NEW OR ADDITIONAL MATTERS.** New or additional evidence not presented during the Judicial Review Committee hearing may be introduced if requested by the Board or its designated Appellate Review Committee in the exercise of its sole discretion or if accepted by the Board or its designated Appellate Review Committee after a foundation showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights and cross-examination or confrontation provided at the Judicial Review committee hearing. The Appellate Review Committee alternatively may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall be given the opportunity to rebut new or additional evidence presented by the other party.
- F. PRESENCE OF MEMBERS AND VOTE.** A majority of the Board or its designated Appellate Review Committee must be present through the review and deliberations. If a member of the Board or review committee is absent from any part of the proceedings, said member shall not be permitted to participate in the deliberations or the decision.
- G. RECESSES AND ADJOURNMENT.** The Board (or its designated review committee) may recess the review proceedings for the convenience of its members, to obtain new or additional evidence or communication, or for any other reasonable purpose as determined in its sole discretion, and may reconvene the proceedings without additional notice. The Board (or its designated review committee) shall within the time set forth at Sections 6C and 8A hereof, conduct its deliberations outside the presence of all other persons and shall render a written decision as provided in this Plan.
- H. REFERRAL TO JUDICIAL REVIEW COMMITTEE.** The Board or its designated

Appellate Review Committee may refer the matter back to the Judicial Review Committee for further review and recommendation to be returned to the Board within no more than thirty (30) days and in accordance with its instructions.

- I. **CONCLUSION.** The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein above have been completed or waived.

SECTION 8 FINAL DECISION OF THE BOARD

- A. **BOARD ACTION.** If the Appellate Review Committee conducts the appellate review, within fifteen (15) days after the conclusion of its review, it shall forward its proposed decision to the full Board. Within fifteen (15) days of its receipt of the Appellate Review Committee's proposed decision, the Board shall render the final decision in writing. In rendering the final decision after review of the Appellate Review Committee's proposed decision, the Board shall either adopt the Appellate Review Committee's decision, modify that decision, or refer the matter back to the Judicial Review committee for further review as set forth in Section 7H. In no case, however, shall the Board's modification of the Appellate Review Committee's decision result in the imposition of a greater penalty or restriction upon the affected practitioner than that which would have resulted from the implementation of the initial adverse decision. If the Appellate Review is held by the full Board, the Board itself must render its final decision in writing within thirty (30) days after conclusion of the review proceeding.
- B. **FINAL DECISION.** The final decision of the Board shall be effective immediately and shall not be subject to further review. The Board shall, through the Chief Executive Officer, deliver a copy of its final decision, in person or by certified or registered mail to the affected practitioner and to the Chief of Staff and Executive Committee.

SECTION 9 GENERAL PROVISIONS

- A. **HEARING OFFICER.** At the request of either party or the Judicial Review Committee, a hearing officer may be appointed by the Chief Executive Officer to preside at the hearing. A hearing officer may or may not be an attorney at law but must be experienced in conducting hearings. The hearing officer, if selected, shall act as the presiding officer of the hearing. The hearing officer must not act as a prosecuting officer or as an advocate for the practitioner, hospital, Executive Committee, or Board. If requested by the Judicial Review Committee, the hearing officer may participate in the deliberations of such body, but the hearing officer shall not be entitled to vote.
- B. **NUMBER OF HEARINGS AND REVIEWS.** Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one evidentiary hearing and one appellate review with respect to each adverse action.

- C. RELEASE.** By requesting a hearing or appellate review under this Plan, a practitioner agrees to be bound by the provisions of Article IX, Section 4 of the Bylaws relating to immunity from liability in all matters relating thereto.
- D. WAIVER.** If at any time after receipt of notice of an adverse action or decision, a practitioner fails to make a required request or appearance or otherwise fails to comply with the provision of this Plan or to proceed with the matter, the practitioner shall be deemed to have consented to such adverse action or decision and to have voluntarily waived all rights to which he might otherwise have been entitled under this Plan with respect to the matter involved.
- E. EXHAUSTION OF REMEDIES.** If an adverse ruling is made with respect to a practitioner's staff membership, staff status, or clinical privileges at any time, regardless of whether said practitioner is an applicant or a Medical Staff Member, applicant must exhaust the remedies afforded by these Bylaws, Policies and Procedures and Rules and Regulations before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or any claim against the hospital or participants in the decision process.
- F. VALIDITY OF BYLAWS.** The hearing and appellate review provided for in this Article are not intended and shall not be used as a means of challenging the substantive validity of any provision of the Medical Staff Bylaws, Policies and Procedures or Rules and Regulations in all proper cases. A practitioner must seek and obtain a final determination by the Board on all such questions before resorting to formal legal action challenging the substantive validity of any provision of the Medical Staff Bylaws, Policies and Procedures or Rules and Regulations.

ARTICLE II. ONGOING PROFESSIONAL PRACTICE EVALUATION POLICY

PURPOSE

1. The purpose of this policy is to:
 - a. Define the framework to be utilized to implement ongoing professional practice evaluations, including a defined structure for internal reporting to support the ongoing professional practice evaluation and enhance quality of care and patient safety.
 - b. Define criteria to be used on an ongoing evaluation of professional practice. (*Note: Per The Joint Commission requirements, the indicators will fall generally into the following six areas of general competence developed by the ACGME: Patient Care, Medical/Clinical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and System-Based Practice*)
 - c. Identify professional practice trends that impact quality of care and patient safety;
 - d. Define interventions to be implemented to improve professional practice;
 - e. Define those circumstances in which an external review or focused review

- may be necessary; and
- f. Define the medical staff's leadership role in the organization's performance improvement activities related to practitioner performance and ensure that when the findings are relevant to an individual's performance, the findings in the ongoing evaluations of competence are in accordance with recognized standards.
2. The information used in the ongoing professional practice evaluation may be acquired through the following:
 - a. Periodic chart review
 - b. Direct observation
 - c. Monitoring of diagnostic and treatment techniques
 - d. Discussion with other individuals, involved in the care of the patient, including consulting physicians, assistants at surgery, nursing and administrative personnel.
 3. It is not intended that this policy supersede any provisions of the Medical Staff Bylaws. If the performance of the practitioner is sufficiently egregious, the Chief of Staff or CEO shall determine, within his/her sole discretion, whether the provisions of this policy need not be followed, whereupon the provisions of the Bylaws, and not this policy, shall govern.
 4. Relevant information from the practitioner performance review process will be integrated into performance improvement initiatives and will be considered in the reappointment process.
 5. The findings of the process are considered privileged and confidential.

PROCEDURE

I. Screening

- A. Case Manager, or designee will perform concurrent and retrospective chart review using medical staff approved screening criteria.
- B. Any physician, allied health member or hospital staff may report any concerns regarding the professional performance of a practitioner directly to the Director of Performance Improvement.

II. Criteria/Diagnostic Indicators

- A. Criteria for referral include the following:
 - a. Inpatient, outpatient, ED and ambulatory cases will be screened for the presence of predefined diagnostic indicators; individual case review will be conducted when outliers are identified or a trend exceeds threshold parameters (see Attachment A); or
 - b. Event associated with a practitioner exceeding his/her clinical privileges
- B. Indicators may be added or deleted at the recommendation of the Medical Executive Committee, Medical Staff Sections, and/or Credentials Committee.
- C. The applicable Medical Staff Section and the MEC will approve indicator criteria and threshold parameters.

- D. The list of indicators will be reviewed on an ongoing basis and in conjunction with this policy.

III. Definitions and Responsibilities

A. Screeener

1. *Definition* – Case Manager, or designee
2. *Responsibility* – If a case meets the diagnostic indicator criteria, the screener will complete the Ongoing Professional Practice Review Form or an occurrence report. The form or occurrence report will be forwarded to the Director of Performance Improvement.

B. Performance Improvement Director/Designee

1. *Definition* – Individual responsible for coordinating and facilitating review activities
2. *Responsibility* -
 - a. Identifies appropriate peer screeners and provides medical record to be reviewed to the peer screener;
 - b. Trends data related to individual practitioner performance for cases scored 0,1 or 2 by the peer screener;
 - c. Forwards to the designated Medical Staff Committee all cases scored a 3,4 or 5 by the peer screener;
 - d. Provides summary reports to the Credentials Committee and MEC of ongoing performance review issues/activities; and
 - e. Tracks individual performance review activities.

C. Peer Screener

1. *Definition* - Practitioner from the same discipline and with essentially equal qualifications as the individual under review (for example, physician and physician, dentist and dentist, etc) or a practitioner with privileges to perform the same service or procedure(s) as that under review.
2. *Responsibility*-
 - a. Reviews the medical record for the case and assigns a score of 0-5 on the Ongoing Professional Practice Review Form and returns the completed form to the Performance Improvement Director (see description of scores, Section VII) ; and
 - b. Documents on the form pertinent findings that support the assigned review score, and identifies opportunities for improvement and any need for further action.

D. Section Chief

1. *Definition* – Defined in Medical Staff Bylaws
2. *Responsibility*
 - a. Conducts a closed session to address ongoing and focused practitioner reviews for all cases assigned a 3, 4 or 5 by the Peer Screener.
 - b. Provides summary reports to the MEC, on practitioner performance activities;
 - c. The Section Chief may send any questionable determinations for further review or may request an external review at this time.
 - d. Presents cases findings as appropriate at medical staff committee meetings as part of the performance improvement process.

E. Review Panel (Closed Session)

1. *Definition* – The Review Panel consists of members involved in the closed session and may include others as designated by the *Section Chief*, or MEC
2. *Responsibility* –
 - a. Reviews cases (scored a category 3, 4 or 5) or when threshold parameters are exceeded;
 - b. Documents a final score on reviewed cases (unless case forwarded for external review); and
 - c. The Review Panel minutes will reflect findings, conclusions, recommendations, and actions taken. Minutes will also reflect if any additional action is indicated.

F. Credentials Committee

1. *Definition* – Defined in Medical Staff Bylaws
2. *Responsibility* - At the time existing privileges are revised or renewed, or when revoking existing privileges prior to or at the time of renewal, or when new privileges are requested, considers all documented cases which have been reviewed and when threshold parameters have been exceeded.

G. Medical Executive Committee

1. *Definition* – Defined in Medical Staff Bylaws
2. *Responsibility* -
 - a. Serves as oversight committee for medical staff performance improvement activities;

- b. Reviews findings of ongoing practice review, specifically as it pertains to cases scored a 3, 4 or 5 and takes actions as appropriate;
- c. Considers all documented cases, which meet the criteria for review
- d. Reports and recommends to the Governing Board regarding ongoing professional practice review activities, as appropriate.

H. Individual Under Review

1. *Definition* - The individual whose performance is being reviewed
2. *Responsibility* - This individual is to provide a response to all cases scored 3, 4 or 5, or for any case requested by the, designated Medical Staff Committee conducting the review or the Medical Executive Committee.

IV. **Method for Selecting Reviewer Panels, Including Specific Circumstances**

C. Assignments –

1. The Performance Improvement Director will identify a peer screener.
2. Peer Review Panels are identified as those individuals on the designated Medical Staff Section.
3. If the Section Chief is the individual being reviewed, the Chief of Staff will determine the peer screener and may recommend an alternative peer review panel

C. Conflict of Interest - Within the context of the review process, a conflict of interest will preclude an individual from making a performance review determination in the evaluation of the performance of another practitioner. A conflict of interest may exist if the reviewer has significant financial interest in the hospital or direct professional or personal involvement in the case under evaluation. In those cases the Chief of Staff will assign an alternate peer screener.

C. Special Panels – If requested by the Chief of Staff, MEC, or designated Medical Staff Committee, a special panel of peers may be assigned to review the case.

C. External Review - External performance review is required under the following circumstances:

1. *Conflict of Interest* - The review may not be conducted by any peer on staff due to a potential conflict of interest that cannot be appropriately resolved by the MEC or Board of Directors.
2. *Lack of Internal Expertise* - There is no peer on staff with similar or like privileges in the specialty under review; however, prior to submitting a

case for external review, a determination shall be made by the Section Chief or Chief of Staff as to whether a member of the Individual's Section is qualified to conduct an internal review.

3. *Ambiguity* – There is confusion when internal reviews reach conflicting or vague conclusions.
4. *Litigation* – When the hospital faces a potential medical malpractice suit, corporate legal counsel or risk management may recommend external review.
5. *New Technology/Technique* – There is a new technology/technique involved that the hospital does not have the expertise to assess whether the practitioner possesses the required skills associated with the new technology/technique.
6. *Miscellaneous* – The designated Medical Staff Section, Medical Executive Committee or Governing Board recommends an external review (With the exception of the Governing Board, the MEC has final decision if an external review is required);

V. Notification Review Determinations

- A. The individual under review will receive written notification on cases scored a 3, 4 or 5, or when trends exceed threshold parameters on established indicator criteria. The individual's Section Chief, the Chief of Staff, or the CEO shall provide written notification. The written notification shall set forth the meeting requirements of the individual under review, i.e., whether a time is set to meet with the physician reviewer or the date a meeting is set for review to be discussed in the appropriate Section or MEC.
- B. All action/follow-up, as determined by the peer reviewer, will be in a written response or meeting with the involved practitioner.
- C. All correspondence will be confidential.
- D. Copies of letters and notifications will be kept on file.

VI. Effectiveness of Review Process

- A. Consistency – Cases meeting the criteria for reviewable circumstances as stated above will undergo review, conducted according to this defined procedure.
- B. Timeliness
 1. *Routine Performance Review* – Time review initiated to time case closed should closely adhere to a 90-day timeframe. However, there may be circumstances when this timeline is exceeded due to external review process. The time frame should be adhered to as reasonable.
 2. *Fast Track* – Circumstances may arise in which the review process

must be expedited. This includes cases, which meet the organization's sentinel event definition. In other cases the determination for fast-tracking may be left to the discretion of the Chief of Staff, designated medical staff committee chairperson or Medical Executive Committee. The timeframe for a Fast Track Review should not exceed 30 days from the time the event is determined to be a sentinel event. This time frame should be adhered to as reasonable.

- C. Defensible – The conclusions reached during the review process are to be supported by rationale that specifically address the issues for which the review was conducted, including, as appropriate, reference to the literature and relevant clinical practice guidelines.
- D. Balanced – Minority opinions and views of the individual under review are to be considered and recorded.
- E. Useful – The results of review activities are to become part of the practitioner's quality profile and to be used for credentialing and privileging decisions and, as appropriate, in performance improvement activities.
- F. Ongoing – The review conclusions are tracked over time, and actions based on review conclusions are monitored for effectiveness by the Medical Executive Committee.

VII. Scoring

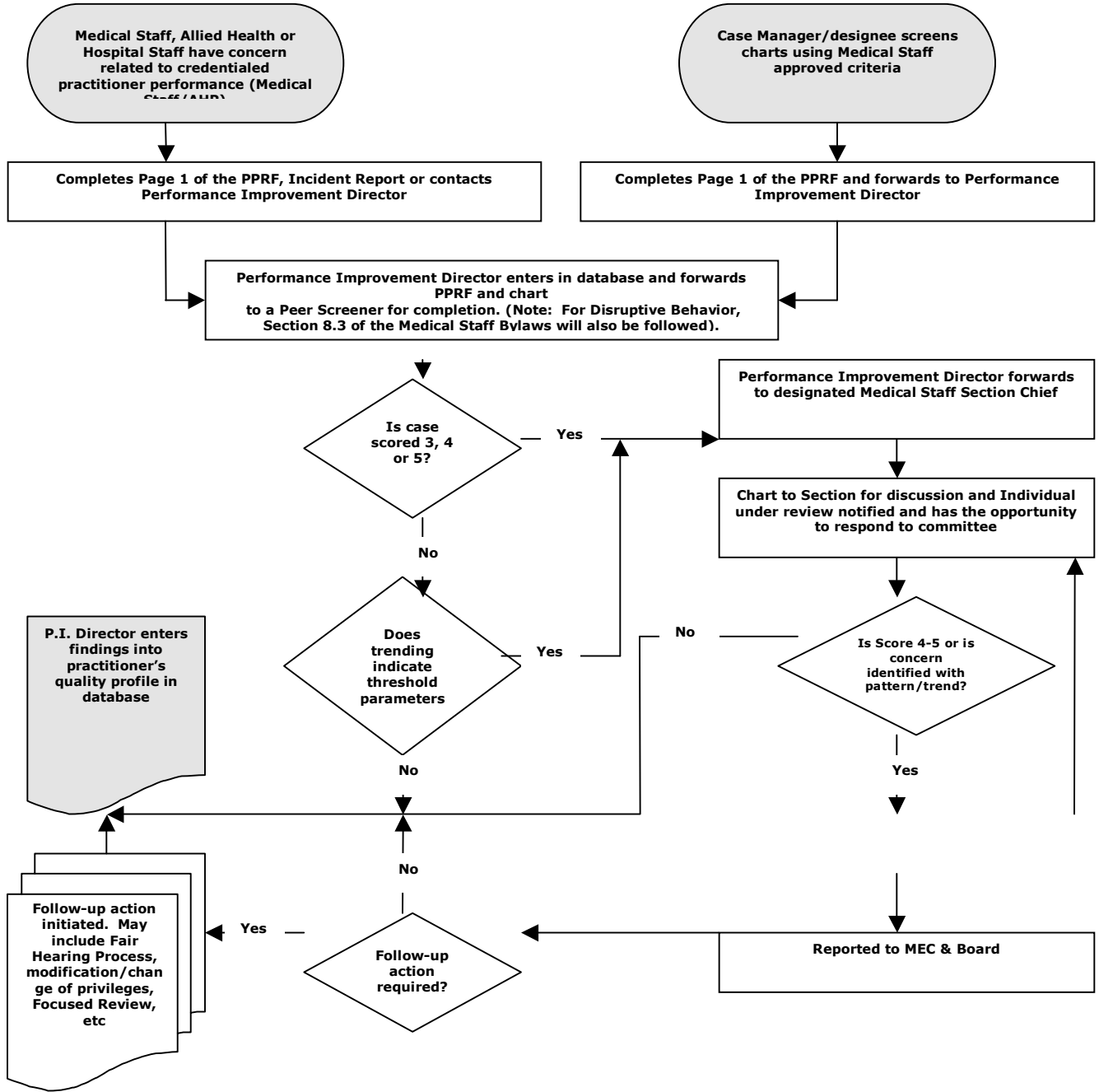
SCORE	DEFINITION
0	No problem with documentation or quality of care
1	Minor problem with process/documentation/acts of omission or commission, but patient outcome not affected
2	Problem with process/documentation/acts of omission or commission, disease, or symptoms unchanged or delayed in improvement or potential for adverse consequence
3	Problem with process/documentation/acts of omission or commission, disease, or symptoms caused, exacerbated or allowed to progress
4	Problem with process/documentation/acts of omission or commission, longevity, and/or functional quality of life shortened or adversely affect by medical action or inaction
5	Death attributable to acts of omission or commission

VIII. Performance Improvement

- A. Members of the medical staff are involved in activities to measure, assess, and improve performance on an organization wide basis, including the ongoing professional practice review process defined herein.
- B. The review process involves monitoring, analyzing, and understanding those special circumstances of practitioner performance, which require further evaluation.
- C. When findings of this process are relevant to an individual's performance, the medical staff is responsible for determining their use in ongoing evaluation of a practitioner's competence, in accordance with accrediting organization standards

on renewing or revising clinical privileges.

IX. Ongoing Professional Practice Review Flowchart



Supporting Documents

- Professional Practice Review Form (PPRF)
- Physician Performance & Aggregate Review Forms

ARTICLE III. FOCUSED PROFESSIONAL PRACTICE EVALUATION POLICY

Purpose

To clearly define a time-limited process for evaluating privilege-specific competence of a practitioner when:

- a. The practitioner does not have documented evidence of competently performing the requested privilege at Odessa Regional Medical Center; and
- b. There is a question regarding a currently privileged practitioner's ability to provide safe, high quality patient care.

Scope

This policy applies to all Medical Staff and Allied Health Professionals privileged through medical staff mechanisms at the hospital.

Definitions

- ***Focused Professional Practice Evaluations (Focused Review)*** – A time-limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for the following:
 - Whenever a question arises regarding a practitioner's ability to provide safe, high quality patient care (effective immediately); and
 - All initially requested privileges granted after January 1, 2008.
- ***Ongoing Professional Practice Evaluation*** – A documented summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process factors into decisions to maintain, revise or revoke existing privilege (s). See *Ongoing Professional Practice Evaluation Policy for specifics*.
- ***Practitioner*** – For purposes of this policy, practitioner is defined as individuals with Medical Staff or Allied Health privileges at Odessa Regional Medical Center.

Policy

1. **Criteria/Triggers for Focused Review** - The criteria/triggers that indicate the need for performance monitoring are as follows:
 - a. All initially requested privilege after January 1, 2008 (includes new privileges requested by currently privileged practitioners);
 - b. Peer Review Case findings Score of 4 or 5; and
 - c. Validated acceptable performance threshold not met for three of four most recent reporting periods (See, *Ongoing and Focused Professional Practice Evaluation Criteria/Indicators*)

Method for Establishing a Monitoring Plan Specific to Requested Privilege

- a. The Section Chief and/or Credentials Committee are responsible for developing the monitoring plan.
- b. The measures employed to resolve performance issues or establish

current competence will be clearly defined on the Focused Professional Practice Evaluation Performance Improvement Plan (Attachment A).

2. **Method for Determining the Duration of Performance Monitoring**
 - a. The Section Chief and/or Credentials Committee determine the monitoring duration.
 - b. The period of performance monitoring to further assess current competence is based on the evaluation of a practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege.

3. **Criteria to Determine Method of Monitoring –**
 - a. The Section Chief and/or Credentials Committee are responsible for determining the monitoring method.
 - b. Criteria to consider when determining the type of monitoring to be conducted include:

Criteria to Determine Monitoring Method	Method of Monitoring
Issue Identified With: <ul style="list-style-type: none"> <input type="checkbox"/> Documentation <input type="checkbox"/> Procedural Privilege <input type="checkbox"/> Cognitive Skill Privilege 	<ul style="list-style-type: none"> <input type="checkbox"/> Chart Review <input type="checkbox"/> Direct Observation <input type="checkbox"/> Monitoring of diagnostic and treatment techniques and clinical practice patterns <input type="checkbox"/> Simulation <input type="checkbox"/> Proctoring <input type="checkbox"/> External Review <input type="checkbox"/> Discussions with other individuals, involved in the care of the patient, including consulting physicians, assistants at surgery, nursing and administrative personnel.
Issue Identified With: <ul style="list-style-type: none"> <input type="checkbox"/> Documentation <input type="checkbox"/> Procedural Privilege <input type="checkbox"/> Cognitive Skill Privilege The following also apply: <ol style="list-style-type: none"> a. <i>Conflict of Interest</i> - The review may be conducted by any peer on staff due to a potential conflict of interest that cannot be appropriately resolved by the MEC or Board of Directors. b. <i>Lack of Internal Expertise</i> - There is no peer on staff with similar or like privileges in the specialty under review. 	

Criteria to Determine Monitoring Method	Method of Monitoring
<p>c. <i>Ambiguity</i> – There is confusion when internal reviews reach conflicting or vague conclusions.</p> <p>d. <i>Litigation</i> – When the hospital faces a potential medical malpractice suit, corporate legal counsel or risk management may recommend external review.</p> <p>e. <i>New Technology/Technique</i> – There is a new technology/technique involved that the hospital does not have the expertise to assess whether the practitioner possesses the required skills associated with the new technology/technique.</p> <p>f. <i>Miscellaneous</i> – The Department Chairperson, Medical Executive Committee or Board of Directors recommends an external review (With the exception of the Board of Directors, the MEC has final decision if an external review is required);</p>	
<p>Issue Identified With:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Documentation <input type="checkbox"/> Procedural Privilege <input type="checkbox"/> Cognitive Skill Privilege <input type="checkbox"/> Practitioner Behavior <input type="checkbox"/> Complaints 	

4. **Consistent Implementation**

- a. The focused professional practice evaluation will be consistently implemented in accordance with the criteria and requirements defined by the medical staff.
- b. The Section Chief, Credentials Committee and MEC are responsible for ensuring the measures employed to resolve performance issues are consistently implemented.

5. **Notification Review Determinations**

- a. The Section Chief will report findings of the focused review activities to the Credentials Committee and the MEC. Based on the final report and with input from the Section Chief, the Credentials Committee will recommend to the MEC any changes to privileges.
- b. The Section Chief will meet with the practitioner under review to update

him/her on the findings.

- c. The final report of findings will be maintained in the physician's Peer Review/ Quality Profile and maintained as confidential.
- d. Notifications of changes to existing privileges will be made in accordance with the organization's *Privilege Notification Policy*.

6. **Confidentiality** - The activities of the Focused Professional Practice Evaluation are considered privileged and confidential.

Supporting Documents

- Ongoing Professional Practice Evaluation Policy
- Ongoing and Focused Professional Practice Evaluation Indicators/Criteria
- Medical Staff Bylaws
- Fair Hearing Plan
- Allied Health Grievance Policy

References:

JCAHO CAMH – MS.4.30

ARTICLE IV. MODERATE SEDATION POLICY AND PRIVILEGES

SECTION 1 PURPOSE

The purpose of this policy is to establish a safe and consistent standard of care for the administration of medications to provide moderate sedation to patients undergoing diagnostic and/or invasive procedures. The administration of drugs to produce sedation can have the unintended effect of compromising patient's protective reflexes; therefore, these guidelines are intended to ensure the safe use of sedation.

This policy does not apply to the administration of medications for routine pain management or for sedation of patients on ventilators.

SECTION 2 DEFINITIONS

- A. Minimal sedation (anxiolysis):** A drug--induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.
- B. Moderate sedation/analgesia (conscious sedation) -** A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
- C. Deep sedation/analgesia -** A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following

repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. *This level of sedation should not be the goal of moderate sedation, but undertaken only with the assistance of a qualified anesthesia provider.*

- D. Anesthesia-** Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

SECTION 3 PARTICIPATING DEPARTMENTS

Moderate sedation may occur in the GI Lab, Surgery, Radiology, ICU, NICU, Cath Lab, and Emergency Department.

SECTION 4 PRIVILEGING

- A.** Only a qualified physician - one who is trained in professional standards and techniques to administer pharmacologic agents to predictably achieve desired levels of sedation and to monitor patients carefully in order to maintain them at the desired level of sedation, and who meets the criteria set by the medical leadership of the hospital - may administer drugs to cause moderate sedation. The physician may do so only to patients with a pre-procedure ASA score of I or II. Patients with an ASA score of III or greater require an anesthesia consultation.
- B.** Individuals administering moderate sedation are qualified and have the appropriate credentials to manage patients should they slip to a deeper level of sedation. Included in the qualifications of individuals providing moderate sedation are competency-based education, training and experience in:
- 1) Evaluating patients prior to performing moderate sedation.
 - 2) Performing the moderate sedation to include methods and techniques required to rescue those patients who slip into a deeper-than-desired level of sedation or analgesia. Specifically, practitioners who have appropriate credentials and are permitted to administer moderate sedation are qualified to rescue patients from deep sedation, meaning they are competent in managing a compromised airway to include providing adequate oxygenation and ventilation. (The specific qualifications and privileging criteria for administering moderate sedation are determined by the medical staff.)

SECTION 5 REQUIREMENTS FOR MONITORING STAFF

- A.** A sufficient number of qualified personnel (in addition to the licensed independent practitioner performing the procedure) are present during a procedure using moderate sedation to:
- (1) Appropriately evaluate the patient prior to administering moderate sedation.
 - (2) Administer the medications used to produce moderate sedation.
 - (3) Perform the procedure.
 - (4) Monitor the patient.
 - (5) Recover and discharge the patient from the post-sedation recovery area.
- B.** Minimal staffing includes the physician and monitoring R.N., who must be with the patient at all times and may not engage in tasks that would compromise continuous monitoring during the procedure. Additional staffing is based on the patient's acuity, procedure performed and the potential response to the medication ordered.

SECTION 6 EQUIPMENT

Appropriate equipment for care and resuscitation is available for monitoring vital signs, including heart and respiratory rates and oxygenation using pulse oximetry equipment.

A code cart with defibrillator, suction, airways, ambu bag and reversal agents must be readily available where the procedure will be performed. Heart rate and oxygenation are continuously monitored by pulse oximetry. Respiratory frequency and adequacy of pulmonary ventilation are continually monitored. Blood pressure is measured at regular intervals. EKG is monitored in all patients. Supplementary oxygen is readily available via nasal prongs or mask.

SECTION 7 PRE-PROCEDURE RESPONSIBILITIES

- A.** The pre-procedure responsibilities of the physician are to:
- 1) Complete the Pre-moderate Sedation Assessment form to include:
 - a) past medical history (including previous adverse experiences with sedation/anesthesia)
 - b) physical exam specific to the procedure to be performed and to include vital signs and mental status
 - c) examination of the heart and lungs by auscultation
 - d) review of airway, breathing and circulation
 - e) clinical impression or diagnosis
 - f) operative and other invasive procedure plan
 - g) pertinent lab or test results
 - h) current medications and dosages
 - i) physical risk status assessment- ASA score
 - j) plan for moderation sedation (e.g. IV sedation with monitoring)
 - k) Time of last food and fluid intake. (The patient shall be NPO for at least four (4) hours prior to procedure for non-urgent/non-emergent cases. [EXCEPTION: oral medication] Children may have clear liquids up to 2-3 hours prior to procedure.)

- 2) Obtain and document appropriate informed consent for procedure and sedation
- 3) Communicate the moderate sedation plan to involved care providers
- 4) Reassess the patient immediately prior to administration of sedation and document that he or she remains a candidate for the procedure and sedation.

ASA Classifications:

- ASA-1 Normal healthy patient
- ASA-2 Patient with mild systemic disease
- ASA-3 Patient with severe systemic disease
- ASA-4 Patient with an incapacitating disease which is a constant threat to life
- ASA-5 Moribund patient not expected to survive
- ASA-6 Declared brain-dead patient whose organs are being removed for donor purposes

- **For Emergency Operations, the letter “E” is added**

- B.** The pre-procedure responsibilities of the RN are to
- 1) Verify appropriate informed consent
 - 2) Check to ensure all required equipment is available and operating correctly.
 - 3) Establish venous access (if not already obtained) prior to sedation and maintain it through discharge.
 - 4) Assess the patient's vital signs: baseline blood pressure, heart rate, respiratory rate, heart rhythm, oxygen saturation, level of consciousness, and Aldrete score, documenting all measurements on the moderate sedation flowsheet.
 - 5) Assess the patient for pain and provide appropriate education and interventions if indicated.
- C.** Final verification process to confirm correct patient, procedure and site:
- 1) Prior to starting the procedure, there is a “Time Out” called and the final surgical/procedural site verification will be performed by the entire assisting team.
 - 2) The RN will read aloud and cross check with the surgical consent and site marked :
 - a) The patient's name
 - b) The surgical procedure and site
 - 3) The Physician and assisting team will confirm verbally that the information is correct. Where applicable, imaging studies will also be available at this time for site verification.
 - 4) The confirmation and final surgical site verification will be recorded by the RN on the Moderate Sedation Flowsheet.
 - 5) Discrepancies in the identification of the patient or difference in understanding of the intended surgery/procedure, will be resolved prior to the commencement of the procedure.

SECTION 8

INTRA-PROCEDURE RESPONSIBILITIES

The intra-procedure responsibilities of the RN are to:

- A. Monitor and document the patient's vital signs, O2 sat, and LOC every 5 minutes or more frequently, if necessary during the procedure.
- B. Assess the patient continuously for changes in condition and/or untoward responses or effects, and immediately report any of the above to the responsible physician.
- C. Administer medications ordered by the physician. An RN may not administer medications classified as anesthetics, including but not limited to Ketamine, Brevital, Fentanyl, and Propofol, except in an emergency situation when requested by an anesthesiologist or CRNA who is physically present during the administration and will continue to remain with the patient after the administration of the drug.

SECTION 9 POST-PROCEDURE

- A. The post-procedure responsibilities of the physician are to document a post-procedure/post-anesthesia note, including pre-procedure and post-procedure diagnoses, procedure findings, complications, blood loss or specimen removed (if any) and plan of care.
- B. The post-procedure responsibilities of the RN are to:
 - 1) Monitor and document the patient's vital signs and O2 saturation every five - fifteen minutes until the patient reaches discharge criteria as defined by Aldrete score of 8-10 or pre-procedure score.
 - 2) Report significant variations in physiologic parameters to the physician immediately. These include, but are not limited to, a variation $\pm 20\%$ in BP or pulse; serious arrhythmia; oxygen saturation $\geq 5\%$ below baseline; dyspnea, apnea, or hypoventilation; diaphoresis; inability to arouse the patient; the need to maintain the patient's airway mechanically; and other untoward or unexpected patient responses.
 - 3) Complete the Moderate Sedation PI Data Collection Form and forward to the Director of Acute Care.
 - 4) At time of patient discharge from the procedural area, the RN should ensure the patient has met the following criteria:
 - a) For inpatients/outpatients going back to their nursing unit, meet discharge criteria as defined by Aldrete score of 8-10 or pre-procedure score.
 - b) If being discharged from the procedural unit to home, in addition to the above, meet discharge criteria for the nursing unit if appropriate, and be discharged in the company of a responsible adult or have made other suitable arrangements for transportation home. Patients should not drive until after a night's sleep. Appropriate home going instructions and a phone number to call in case of questions or emergency will be provided by the discharge nurse.

SECTION 10 QUALIFICATIONS/ COMPETENCY OF THE MONITORING REGISTERED NURSE

- A.** Demonstrates knowledge of anatomy, physiology, pharmacology, cardiac dysrhythmia, and complications related to moderate sedation and medications.
- B.** Understands the principles of O₂ delivery, respiratory physiology, transport and uptake, and demonstrates the ability to use O₂ delivery devices.
- C.** Anticipates and recognizes potential complications of conscious sedation in relation to the type of medication being administered.
- D.** Possesses the knowledge and skills to assess and intervene in the event of complications or undesired outcomes and to institute nursing interventions in compliance with orders (including standing orders) or institutional protocol or guidelines.
- E.** Demonstrates skill in airway management and holds current basic life support completion card.
- F.** The institution has in place an educational/competency validation mechanism that includes a process for evaluating and documenting the individual's demonstration of the knowledge, skills, and abilities related to the management of patients receiving moderate sedation. Evaluation and documentation of competency occur on an annual basis.

SECTION 11 PERFORMANCE IMPROVEMENT

The patient's response to care provided throughout the sedation-supported procedure is documented in the patient's record. Outcomes of patients undergoing moderate and deep sedation are collected and analyzed in the aggregate in order to identify opportunities to improve care. This information is reported monthly to the hospital Performance Improvement Committee. Performance measurement indicators include the following:

- A.** Documentation requirements pre-procedure, intra-procedure, and post-procedure.
- B.** Sedation events related to airway, cardiovascular, pulmonary, medication, equipment, and miscellaneous other items.
- C.** Outcomes:
 - 1) Patient management requiring assistance of anesthesia, respiratory therapy, or code blue activation.
 - 2) Unanticipated intubation
 - 3) Hospitalization required
 - 4) Hospitalization prolonged or required transfer to a more intensively monitored level of care.
 - 5) Disability
 - 6) Death
 - 7) Other

ARTICLE V. COMMITTEES OF THE MEDICAL STAFF

SECTION 1 GENERAL FUNCTIONS OF COMMITTEES

- A. Keep records and minutes of all committee meeting activities.
- B. Observe confidentiality policies.

SECTION 2 APPOINTMENTS

All members of committees other than the Executive and Nominating Committees shall be appointed by the Chief of Staff, unless otherwise provided in the Bylaws. Committee appointment shall be for two years unless otherwise provided in the Bylaws, although committee members may be reappointed. A Chairman and Vice Chairman shall be appointed for two year terms by the Chief of Staff.

A. SPECIAL COMMITTEES AND FUTURE STANDING COMMITTEES

There shall be such other standing and special committees, responsible to the Executive Committee, as may from time to time be necessary and desirable to carry out the Medical Staff functions set forth in these Bylaws. The Executive Committee may, by resolution and upon approval by the Board, establish a standing or special committee to perform one or more of the required Medical Staff functions. The Chief of Staff shall appoint the membership of such committees, subject to the approval of the Executive Committee.

B. SPECIAL MEETINGS

A special meeting of any committee may be called by the committee's chairman, or a committee member, or the Chief of Staff.

C. NOTICE OF MEETINGS

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting shall be given to each committee members not less than seven (7) days before the time of such meeting. A meeting may be called by common consent without seven (7) days' notice provided a quorum is present and the decisions and findings of the committee shall be valid.

D. ANNUAL EVALUATION

Each January each committee shall review the previous year's activities and the need for changes in functions and/or procedures.

E. QUORUM

The greater of three (3) members or 25% of the committee membership shall constitute a quorum at any meeting of such committee.

EXCEPTION: Committees of the Medical Staff that include hospital staff/members of the community as integral members of the committee, i.e., Performance Improvement Committee and Ethics Committee, shall be considered to have a quorum with the attendance of the Chair of the Committee, who must be a member of the Medical Staff and 25% of the ancillary staff who are considered members of the committee.

F. MANNER OF ACTION

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of the committee. No action of a committee shall be valid unless taken at a meeting at which a quorum is present, except that any action may be taken without a meeting if a written consent setting for the action so taken is signed by a majority of committee members entitled to vote.

G. RIGHTS OF EX-OFFICIO MEMBERS

An ex-officio member of a committee shall have all the rights and privileges of a regular member except he shall not be counted in determining the existence of a quorum and shall not be entitled to vote.

H. MINUTES

Minutes of each regular and special committee meeting shall be prepared and shall include a record of the members attending and the result of vote taken on each matter. The minutes shall be signed by the committee chairman and made available to committee members. Committee minutes will be maintained by the Medical Staff Coordinator.

I. ATTENDANCE

The Chairperson has the right to limit attendance of non-members to committee meetings and to invite non-members before the committee as needed to clarify issues.

SECTION 3 COMMITTEES

A. HOSPITAL-WIDE PERFORMANCE IMPROVEMENT COMMITTEE

1. **COMPOSITION:** The Hospital-Wide Performance Improvement Committee shall consist of:
 - Chairman (appointed by the Chief of Staff)
 - A minimum of two (2) medical staff members representing all Sections
 - Representative of Administration
 - Representative of Nursing Administration
 - Director of Health Information Management

2. **RESPONSIBILITY**

Utilizing a multi disciplinary approach, the committee is responsible for the approval and coordination of activities of the Performance Improvement Teams as indicated by need or as problems arise.

3. FUNCTIONS

Coordinate the development and approval of screening criteria.

Recommend continuing education programs based on continuous quality improvement activities.

Serve in an advisory capacity to the Director of Health Information Management.

Perform, review, or analyze data generated by:

- Team reports for performance improvement activities
- Perform all review functions based on the hospital-wide performance improvement plan.
- Perform annual review of all performance improvement activities.
- Report the results and effectiveness of committee review to the Executive Committee.
- Refer results of all committee activities to section chairpersons and request responses where appropriate.
- Monitor the effectiveness of action taken by department chairmen.
- Report to the Executive Committee the:
 - (1) Committee findings and conclusion
 - (2) Committee recommendations for action
 - (3) Action taken by department chairmen
 - (4) Effectiveness of action taken.

4. MEETINGS

The Performance Improvement Committee shall meet monthly or at least ten times per year. The Committee shall maintain a permanent record of its proceedings and action and shall report its recommendations to the Executive Committee.

B. INSTITUTIONAL REVIEW COMMITTEE

PURPOSE OF INSTITUTIONAL REVIEW BOARD

The purpose of the Institutional Review Board (IRB) is to (1) approve or disapprove biomedical research, investigational studies and clinical trials involving human subjects; (2) conduct periodic review of such research, studies, and trials; and (3) provide these Policies and Procedures for the protection of the rights and welfare of such human subjects.

MEMBERSHIP OF COMMITTEE

1. The Institutional Review Board shall have not less than five (5) members and no more than ten (10) members. Members shall be appointed by the Chief of Medical Staff. Each member may vote.
2. The members shall elect a chairperson at the first meeting of the IRB in alternate calendar years. The chairperson shall serve a term of two (2) years and may be elected to successive terms. A vacancy shall be filled by the members for the remainder of the term at the next meeting following such vacancy. The chairperson may also vote.
3. The members shall have varying backgrounds to promote complete and adequate review of research activities. Members shall be sufficiently qualified through experience, expertise and diversity, including considerations of race, gender, cultural backgrounds, and sensitivity to such issues as community attitudes, so as to promote respect for the committee's advice and counsel in safeguarding the rights and welfare of human subjects.
4. Membership shall include the following:
 - a) Community Representative(s)
 - b) Pharmacist
 - c) Hospital Administrator
 - d) Physician
 - e) Attorney (ad hoc)
 - f) Member of Clergy (ad hoc)
 - 7) Director of Risk Management
 - 8) V.P. of Patient Care Services
5. The Institutional Review Board may, in its discretion, invite individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available on the Institutional Review Board. These individuals may not vote.
6. No member may participate in the Institutional Review Board's initial review of continuing review or monitoring of any study or investigation in which the member has a conflict of interest. The Institutional Review Board shall determine whether a member has a conflict of interest from information submitted by the member.
7. A quorum of the Institutional Review Board shall be necessary for the transaction of business. A quorum shall consist of a majority of the members. A concurrence of a majority of the members voting at any meeting shall be necessary in matters relating to the business of the Institutional Review Board.
8. Following the last meeting of each calendar year the minutes of the meetings of the Institutional Review Board held that year shall be sent to the Governing Board. Names of subjects shall be deleted.

MEETINGS

The Institutional Review Board will meet on an ad hoc basis. It may meet more often and shall meet at the call of the chairperson or the hospital administrative team.

C. ETHICS COMMITTEE

COMPOSITION: The Ethics Committee shall consist of:

Chairman (a member of the Medical Staff appointed by the Chief of Staff)

Vice Chairman (elected by committee members)

Representatives of the following:

Board

Clergy

Hospital Social Services

Nursing

Risk Manager

Legal Profession (on a consultative basis)

RESPONSIBILITY:

Serve in an advisory capacity to the hospital and medical staff regarding medical ethical issues.

FUNCTION:

- Encourage ethically informed, responsible, and compassionate decision-making and practice throughout the hospital.
- Attempt to organize a systematic forum for addressing ethical issues arising from patient care, reduce the anxiety of physicians and family members involved in decision to withhold courses of treatment, and diminish the risk of liability for all involved parties.
- Provide the option of an independent review of cases presenting ethically difficult or ambiguous treatment decisions.
- Attempt to minimize conflict among health care professionals regarding patient care decisions.
- Provide health care professionals with current information on court decisions, legislation, and economic issues that affect their professional activities and thereby assist in dispelling uncertainty, secrecy, and fear of lawsuits that characterize management of ethically difficult or ambiguous cases.
- Define types of cases for review and develop general guidelines for particular cases and situations.
- Provide consultations to practitioners, patients and family in ethically difficult or ambiguous situations upon request.

- Arrange for prognosis review upon request.
- Perform retrospective review of certain categories of cases.

MEETINGS: Ad hoc.

D. FIRE/SAFETY EMERGENCY PREPAREDNESS COMMITTEE

- 1. COMPOSITION** - The Fire/Safety/Emergency Preparedness Committee shall consist of:

Chairman

Representative from Administration

Representative from the following departments:

Laboratory, Food and Nutrition, Medical Records, Central Supply, Express Care Services, Human Resources, Education, Radiology, Social Services, Engineering/Security, Respiratory Therapy, Infection Control, Environmental Services, and Perioperative Services.

- 2. RESPONSIBILITY:**

Coordinate the development and evaluation of the hospital disaster plan including disaster drills and safety program.

- 3. FUNCTIONS:**

- Develop a hospital disaster plan covering internal and external disasters.
- Develop a program designed to protect human and capital resources consistent with the conditions and risks inherent in the facility.
- Coordinate the operations of the hospital disaster plan with community disaster plans.
- Establish capabilities and limitations of emergency services and hospital during a disaster.
- Initiate and implement action through the chairperson and/or safety director, when conditions exist that pose an immediate threat to life, health or property.
- Plan, conduct and supervise educational programs for physicians, nurses, technicians, custodial personnel.
- Develop and implement, through the safety director, policies and procedures for the prevention and control of unsafe practices, hazardous materials and hazardous

conditions within the hospital and on its property. Also, coordinate the development of individual department safety rules and practices.

- Conduct disaster drills at least semi-annually (one to include designated victims)
- Conduct and document a post-disaster drill evaluation.
- Review and revise the departments' safety plans annually.
- Establish methods for measuring the effectiveness of the safety program; establishing ad hoc committees as necessary to evaluate safety issues.
- Report any instances of noncompliance with applicable federal, state or local laws, regulations or codes concerning building safety and employee health to administration.
- Report the committee activities, conclusions and recommendations to the operations executive committee and share committee findings with the Executive Committee of the Medical Staff.

MEETINGS: Monthly

E. PHARMACY & THERAPEUTICS COMMITTEE

COMPOSITION: The Pharmacy & Therapeutics Committee shall consist of

Chairman
 Pharmacist
 2 Physician members
 Laboratory Representative
 Dietician

RESPONSIBILITY: Serve in an advisory capacity to the hospital and medical staff regarding matters pertaining to the use of drugs.

FUNCTION: Monitor:

- Significant adverse drug reactions.
- Appropriateness of drug use; prophylactic, therapeutic, empiric.
- Appropriateness, safety, and effectiveness of drugs.
- Review of high volume, high risk, and problem-prone medications.
- Develop the drug formulary preventing unnecessary duplication when possible.
- Evaluate requests for additions and deletions to the formulary.
- Approve policies regarding selection, procurement, distribution and safety procedures relating to drugs.
- Develop criteria to define and identify adverse and significant adverse reactions.
- Review and trend significant adverse reactions.
- Monitor food and drug interactions.

- Evaluate and, when no other mechanism exists, the approval of protocols concerning the use of investigational or experimental drugs.

MEETINGS: Quarterly, or more often if needed.

SECTION 4 AGENDA

- A. REGULAR COMMITTEE MEETINGS:** The order of business at a regular committee meeting shall be:
- (1) Call to order.
 - (2) Approval of the minutes of the last regular meeting and all special meetings.
 - (3) Old business, including elections, and follow-up where appropriate.
 - (4) New business.
 - (5) Performance Improvement issues.
 - (6) Report from Administration.
 - (7) Adjournment.
- B. SPECIAL MEETINGS:** The agenda at special meetings shall be:
- (1) Reading of the notice calling the meeting.
 - (2) Transaction of the business for which the meeting was called.
 - (3) Adjournment.
- C. ROBERTS RULES OF ORDER:** All Medical Staff Meetings shall be conducted pursuant to Roberts Rules of Order.

ARTICLE VI. HARASSMENT

Harassment by a medical staff member against any individual, e.g., against another medical staff member, hospital employee, visitor, or patient on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated. "Sexual Harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as the display of derogatory cartoons, drawings, pictures or posters, or the inappropriate touching of oneself or other in another's presence). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities. All allegations of sexual harassment shall be immediately investigated by the Medical Staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of Medical Staff Privileges or Membership, if warranted by the facts.