

RULES AND REGULATIONS

Section 1. Admission and Discharge of Patients

For purposes of this section only, the term practitioner shall signify Members of the Medical Staff or their properly credentialed and privileged allied health practitioner:

- A Member of the Medical Staff shall be responsible for the medical care and treatment of the patients for whom he or she is the admitting or primary physician, whether inpatients or outpatients.

The Practitioner will perform and record an appropriate history and physical examination, daily progress notes and an appropriate discharge summary for all such patients. He or she will complete the patient's medical record promptly and completely in accordance with Section 2 of these Rules & Regulations.

The Practitioner will be responsible for confirming, recording on the appropriate currently used form, and following the patient's advanced directives and desires for End of Life Care.

The Practitioner will be responsible for transmitting reports of the patient's condition to the referring practitioner and to relatives as designated by the patient.

Whenever these responsibilities are transferred and assumed by another Member of the Medical Staff, a note documenting the transfer of responsibility will be written by the transferring Member.

- B. No patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated by the admitting physician or appropriately privileged and licensed AHP.
- C. A physician admitting patients must have his principal office and residence within a 25 mile radius of the Hospital. This requirement would not include Emergency Medicine Physicians who are admitting patients to an attending physician, or those physicians whose Clinical Privileges are limited to assisting in surgery and visiting patients only. Exceptions to the 25 mile limit may be granted on the establishment of co-admission coverage by a Member of the Medical Staff with appropriate Clinical Privileges contingent upon approval by the responsible department or supervisory committee and the Executive Committee.
- D. Each Medical Staff Member must assure timely, adequate, professional care for his patients in the Hospital by having available, during his absence, an eligible alternate physician with whom prior arrangements have been made and who has at least comparable Clinical Privileges at the Hospital. Failure of an attending physician to meet these requirements may result in loss of Clinical Privileges. In case of failure to name such associate, the chair of the department concerned or the President of the Medical

Staff shall have the authority to call an appropriate Member of the Active Staff to assume care of the patient.

- E. Emergency Admission: Following an emergency admission, the attending Medical Staff Member may be required to furnish documentation of need for this admission. Failure to furnish this documentation, or evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee for appropriate action.
- F. Inter Institution Patient Transfers: Transfer priorities shall be made on the basis of the patient's clinical condition by a responsible physician. In all cases, the "Transfer to Another Health Care Facility" Patient Care Policy E-28 will be followed.
- G. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure protection of the patient from self harm and to assure the protection of others whenever his patients might be a source of danger.
- H. For the protection of patients, the Medical Staff, nursing personnel and the Hospital, certain principles are to be met in the care of the potentially suicidal patient. Any patient known or suspected to be suicidal in intent, should be transferred to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the Hospital and all reasonable measures taken to safeguard the patient and the staff. Any patient known or suspected to be suicidal should have consultation by a Member of the psychiatric Staff.
- I. Admissions to all critical care units: If any question as to the validity of admissions to, or discharge from, the critical care units should arise, that decision is to be made through consultation with the chair of the appropriate department or division, and the medical director of the critical care units.
- J. The attending Medical Staff Member is required to document the need for continued hospitalization after specific periods of stay, as covered by the Utilization Review Department and approved by the particular clinical department and the Medical Executive Committee. This documentation must contain:
 - 1. Adequate documentation of the reason for continued hospitalization, (a simple reconfirmation of the patient's diagnosis is not sufficient);
 - 2. The estimated period of time the patient will need to remain in the Hospital;
 - 3. Plans for post-hospital care.
- K. The admitting physician will be the attending physician unless documented in the record otherwise. The attending physician will be responsible for overall coordination of care unless documented otherwise.

Section 2. Medical Records

- A. A fully dictated history and physical examination or completed electronic medical record history and physical template shall be completed no more than thirty (30) days before or twenty-four (24) hours after an admission for each patient by a physician and assure the completion of a complete H&P work-up in the chart for each patient prior to a surgical or invasive procedure.

An updated medical history and physical examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the H&P are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed and privileged individual in accordance with state law, Medical Staff Bylaws, these Medical Staff Rules & Regulations and hospital policy. (Refer to MS-139 Documentation Standards for History and Physical Examination for details.)

- B. The history and physical examination must be recorded before an operation or any potentially hazardous diagnostic procedure.
- C. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Physicians or properly credentialed and privileged allied health practitioners, shall see their patients daily and document a progress note. If non-acute areas are made a part of the medical center, the Medical Executive Committee may elect to require less frequent visits in these areas. If a properly credentialed and privileged allied health practitioner discharges a patient in the absence of the physician, a discussion regarding the appropriateness of the discharge will take place prior to discharge and this discussion will be documented in the medical record. Patients for whom a discharge order has been written, but who remain in the acute hospital because of the unavailability of appropriate placement elsewhere, should require progress notes and physician visits at least weekly.
- D. Patients in the Hospital on an "Observation status" or if receiving general, spinal, major regional anesthesia, or deep or moderate sedation require a history and physical examination, as delineated in MS-139.

The timing of the initial visit by the attending practitioner, in those cases where an initial assessment has been made by the Emergency Department physician, will depend on the patient's condition. In any event, the patient must be seen at least daily until discharged.

- E. Restraints will only be used in accordance with "Restraint for Patient Safety" Patient Care Policy # C-9.
- F. A dated and timed post procedure progress note should be completed and placed in the medical record immediately following surgery, or any invasive diagnostic or therapeutic

procedure, stating the required elements, which are, primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis. Complete operative reports shall be dictated or recorded immediately following surgery for outpatients as well as inpatients and the report promptly signed electronically by the surgeon and made a part of the patient's current medical record. Operative reports shall include preoperative and postoperative diagnosis, description of findings, techniques used, tissue removed or altered, and a detailed account of the findings at surgery as well as details of the surgical technique.

- G. A consultation shall show evidence of the review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. All consultations shall be dictated, and this report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

When operative procedures are involved, the consultation note shall, except in an emergency situation so verified on the record, be recorded prior to the operation.

Any time a consultation is requested for a patient, an order will be recorded listing the name (or service line) of the consultant (this will place the patient on the consultant's patient list). The attending or requesting physician will personally contact the consulting physician or their AHP. Service line (*i.e.*, interventional radiology, perinatology, palliative care, etc.) consult notification will be performed by hospital personnel. The consultant is expected to see the patient within 24 hours and provide an appropriate report.

- H. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital before admission, but an interval admission note must be recorded that includes pertinent additions to the history and any subsequent changes in the physical findings.
- I. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. The practitioner's manual signature may be used only on the records that are created in paper format. In lieu of the practitioner's manual signature, the authentication of appropriate portions of the medical record may be accomplished by use of a computer key provided the practitioner has filed a signed statement that he or she is the only person in possession of this key and the only person using it. For clinical entries created in the patient's electronic medical record, electronic authentication is the standard form of signature.
- J. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the Medical Information Services Department.
- K. A discharge diagnosis shall be recorded at the time of discharge on all patients. Patients must be seen within 24 hours prior to discharge by the physician or an appropriately privileged allied health professional designee.

- L. A discharge summary shall be recorded or dictated, within ten (10) days of discharge, by the physician or his properly credentialed and privileged allied health practitioner on all medical records of patients hospitalized over 48 hours, except for normal obstetrical deliveries, normal newborn infants, and certain selected patients with problems of a minor nature. These latter exceptions shall be identified by the Medical Executive Committee and, for these, a final summation-type progress note shall be sufficient to justify the diagnosis and warrant the treatment and end results. All summaries shall be authenticated by the responsible practitioner.
- M. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- N. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Administrator. In case of readmission of a patient, all previous records or copies thereof shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee.
- O. Access to all medical records of all patients may be afforded to Members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the appropriate department and the Medical Executive Committee before records can be studied. Subject to the discretion of the Administrator former Members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
- P. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the medical records physician liaison. Incomplete records which result from a physician's death shall be completed as accurately as possible by the medical records personnel, with the approval and assistance of the Medical Staff. When all means of completion have been exhausted, a statement will be filed with the record to the effect that means of completing the record have been depleted.
- Q. All physician or AHP orders shall be dated, timed and signed, and recorded in the patient's chart using appropriate media.
- R. The patient's medical record should be completed at the time of discharge. Records will be considered delinquent if the time frames outlined below are not met:
1. History and physical recorded within 24 hours of admission;
 2. Operative report recorded immediately following surgery and heart catheterization;

3. Discharge summary recorded within ten (10) days of discharge;
4. All completed documents or portions of charts identified as needing manual or electronic signatures within fourteen (14) days after discharge.
5. Reasons for Suspension of Medical Privileges Based on Medical Record Issues.

The following list of document and medical chart deficiencies may trigger a medical records suspension as further delineated below:

History and Physicals

Operative and Procedure Reports

Discharge Summaries

Unsigned Verbal Orders

Lack of Chart Completion

Retrospective Coding Queries

When a chart is identified as being delinquent as herein defined, the practitioner shall be notified by mail that his Clinical Privileges shall be suspended if such delinquent records are not completed by seven (7) days from the date of the notice (see Bylaws 6.3-4 for definition of those Clinical Privileges to be suspended). Such practitioner shall remain suspended until the records are completed. A third such suspension within any consecutive 12-month period will result in notification to the Medical Executive Committee, which may make recommendation for corrective action at its discretion.

- S. An appropriate and legible medical record shall be prepared for each patient.

Section 3. General Conduct of Care

- A. General Statement for Catholic Quality of Care.

The primary objective of Saint Agnes Medical Center is to provide services to alleviate human suffering and to restore health within a healing community which respects the dignity of the person and promotes the quality of life.

We believe that each person is a unique individual loved and given life by God. Our concept of excellence in total care embraces the physical, psychological, emotional and spiritual needs of all patients and the civic community served and is fulfilled within the Mission and Core Values of the Hospital.

- B. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks,

benefits and alternatives inherent in any special treatment or surgical procedure shall be obtained.

- C. Therapeutic orders, including electronic written and verbal, may be given by authorized Members of the Medical Staff and allied health staff who are specifically authorized to give orders.
- D. Verbal orders of authorized practitioners shall be accepted, dated and timed and documented by qualified personnel within the scope of their license. Receipt of verbal orders for scheduling of procedures or tests may be accepted by non-licensed staff within the scope of their job description.
- E. All physician verbal orders should be electronically signed within fourteen (14) days, except medication orders, which must be electronically signed within 48 hours. Verbal restraint orders must be electronically signed within 24 hours.
- F. All medication orders shall have a specific stop date as defined in the Patient Care and Pharmacy Medication Policies unless originally ordered for a specific number of doses or for a specific period of time. No drug will be discontinued until the attending physician has been notified.
- G. Medications brought to the Hospital by the patient must be checked and verified by the attending practitioner or pharmacist before they are used.

The practitioner's orders must be documented. Orders which are improperly documented will not be carried out until appropriately documented or understood by the nurse or person responsible for carrying out the order.

Members of the Medical Staff will comply with the standard policy on blanket reinstatement of previous orders for medications.

- J. All drugs and medications administered to patients shall be those approved by the US Food and Drug Administration or on the current Hospital formulary. Non-formulary medications and drugs may be used as defined in the Patient Care and Pharmacy Policies. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals" and all regulations of the Food and Drug Administration.
- K. The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the serious nature of the illness and the question of doubt as to the diagnosis and treatment rests with the practitioner responsible for the care of the patient. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. Allied Health Professionals may not serve as consultants unless specifically authorized by the Interdisciplinary Practices Committee.
- L. It is the duty of the organized Medical Staff through its departmental chair and Medical Executive Committee to see that those with Clinical Privileges do not fail in the matter of

calling consultants when needed. Except in an emergency, consultation is recommended in the following situations:

1. When the patient is a poor risk for operation or treatment;
2. When the diagnosis is obscure after ordinary diagnostic procedures have been completed;
3. When there is doubt as to the choice of therapeutic measures to be utilized;
4. In unusually complicated situations where specific skills of other practitioners may be needed;
5. In instances in which the patient exhibits severe psychiatric symptoms.

Additional requirements for consultation may be specified by the individual department.

- M. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she shall call this to the attention of her superior who in turn may refer the matter to the administrator for nursing. If warranted, the administrator for nursing may bring the matter to the attention of the attending practitioner and, if the situation is not resolved, to the chair of the department wherein the practitioner has Clinical Privileges. Where circumstances are such to justify such action, the chair of the department may himself or herself request a consultation.

Section 4. Emergency Services

- A. The Medical Staff shall adopt a method of providing medical coverage in the Department of Emergency Medicine. This shall be in accord with the Hospital's basic plan for the delivery of such services, including the delineation of Clinical Privileges for all physicians who render emergency care.
- B. Physician Members of the Department of Emergency Medicine shall be under the direction of the director, who shall be responsible for the professional activities of Members of the department and the quality of patient care rendered by such Members. Unless otherwise stipulated, Members of the Department of Emergency Medicine will not be responsible for patients admitted to the Hospital during the period of hospitalization. The extent of responsibility for follow-up care rendered by Members of the Department of Emergency Medicine shall be determined, from time to time, by the Medical Executive Committee on advice from the Director of the Department of Emergency Medicine.
- C. Members of the Medical Staff, including Provisional Staff Members, will share in providing consultation services in order to provide quality patient care. The manner of coverage and extent of responsibility for patient care, rendered to patients in the Department of Emergency Medicine by Members of the Staff serving as consultants, shall be determined by the Medical Executive Committee with advice from the appropriate departmental supervisory committee. If mandatory service on a rotational

basis is deemed necessary, the Medical Executive Committee shall be authorized to require such service as a condition for Staff membership. Subject to approval of the Medical Executive Committee, each division, department, specialty may establish criteria for exclusion from Emergency Department call duties by its members. However, if coverage within a specific division, department, specialty becomes burdensome to those remaining on call, those criteria must be modified to the satisfaction of the majority of Members who will be on the call schedule. If such a compromise cannot be agreed upon, every Member must share in call, or the issue will revert to the Medical Executive Committee, whose decision shall be final. Any physician whose Clinical Privileges are being monitored for cause, will automatically be removed from the Department of Emergency Medicine Consultant Roster. A physician being monitored for a specific procedure will remain on the roster except that he or she will not be permitted to perform the procedure for which monitoring was instituted.

- D. Services rendered by Members of the Medical Staff acting as consultants to the Department of Emergency Medicine shall be reviewed routinely by the appropriate department or supervisory committees, in conjunction with review of other clinical work of the department.
- E. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record, if such exists. The record shall include:
 - 1. Adequate patient identification;
 - 2. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
 - 3. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the Hospital;
 - 4. Description of significant clinical, laboratory, and roentgenologic findings;
 - 5. Diagnosis;
 - 6. Treatment given;
 - 7. Condition of the patient on discharge or transfer;
 - 8. Final disposition, including instruction provided to the patient and/or his family, relative to necessary follow-up care.

Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

- F. Physicians taking Emergency Department calls, whether on voluntary or mandatory basis, will be bound by the provisions of Paragraph 1317 of the Health & Safety Code, State of California, and/or any other statutes which may supersede it, and therefore may

not refuse to provide emergency services based upon, or affected by the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

Section 5. Disaster Services

There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's plan to support disaster readiness and its capabilities in conjunction with other emergency facilities in the community. The plan shall be developed by a disaster planning committee, which includes representation from the Medical Staff. The plan shall be approved by the Medical Executive Committee and the Board of Trustees. Disaster privileges shall be granted in accordance with Medical Staff Policy MS-117. All physicians shall have the responsibility for implementing the hospital disaster plan.

Section 6. Deceased Patients

When a patient expires, the attending physician or any physician Member of the Medical Staff, or a nursing supervisor or competent designee if no physician is readily available will pronounce the patient dead and record this by a written note in the patient's chart. All autopsies will be performed only upon written consent of a relative or legally authorized agent. Medical Staff Members are encouraged to seek permission and document that effort for autopsy examination on all patients where there is likelihood of obtaining information useful to the clinician, the family or the Medical Staff. Special effort should be made to secure permission for autopsy in any of the following circumstances:

1. When death is not an anticipated outcome;
2. When the cause of death is not known;
3. In situations where autopsy may help allay concerns of the family;
4. When death occurs following a surgical procedure or invasive diagnostic procedure done during the same hospitalization;
5. When death occurs in patients who are participants in formal clinical trials; and
6. All obstetrical and neonatal deaths.

Section 7. Staff Meetings

The regular quarterly meeting of the Medical Staff shall be held on the second Tuesday of March, June, September, and December. The December meeting will be designated as the annual meeting. If necessary, the Executive Committee may change the date of a meeting.

Section 8. Medical Staff Committees

Quorums

1. Quality Council

The Quality Council shall require one third of its voting members in attendance or by teleconference to establish a quorum

2. Committees

All meetings are required to have a minimum of three (3) voting members in attendance, of whom at least two are Members of the Active staff to establish a quorum. Unless otherwise specified, the committee members eligible to vote shall be limited to those who are Active Members of the Medical Staff or whose regular presence on the committee is prescribed by Federal or State Regulations, or accrediting agency.

A. Interdisciplinary Practices Committee

The Interdisciplinary Practices Committee shall be established in accordance with Title 22, Section 70706 (or successor provision) of the California Administrative Code.

1. Composition

The Interdisciplinary Practices Committee shall consist of, at a minimum, the director of nursing, the Administrator or designee, and an equal number of physicians appointed by the President of the Medical Staff and registered nurses appointed by the director of nursing. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be represented on the committee. The chair of the committee shall be a physician member of the Active Medical Staff, appointed by the President of the Medical Staff.

2. Duties

The Interdisciplinary Practices Committee shall perform functions consistent with the requirements of law and regulation. The Interdisciplinary Practices Committee shall maintain a permanent record of its proceedings and activities, and shall report to the Medical Executive Committee. Allied Health Professionals at Saint Agnes Medical Center are governed by an authorized but separate document entitled "Allied Health Professionals Policies & Procedures" incorporated by reference herein.

3. Meetings

The Interdisciplinary Practices Committee shall meet at the call of the chair at such intervals as he or she or the Medical Executive Committee shall deem appropriate.

B. Pharmacy and Therapeutics Committee

1. Composition

The Pharmacy and Therapeutics Committee shall consist of representatives of the Medical Staff, a voting representative from the pharmaceutical service, and non-voting representatives from nursing service and Hospital administration. Consultative representatives from nutrition resources and respiratory therapy will serve as needed.

2. Duties

The duties of the Pharmacy and Therapeutics Committee shall include:

- (i) Assisting in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital, including antibiotic usage.
- (ii) Advising the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs.
- (iii) Making recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
- (iv) Periodically developing and reviewing a formulary or drug list for use in the Hospital.
- (v) Evaluating clinical data concerning new drugs or preparations requested for use in the hospital.
- (vi) Establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
- (vii) Reviewing untoward drug reactions.
- (viii) Maintaining a record of all activities relating to pharmacy and therapeutic functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities.

3. Meetings

The committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Staff Quality Council.

C. Infection Control Committee

1. Composition

The oversight of the infection surveillance, prevention and control program shall be vested in a multi-disciplinary committee, which shall include representatives from the Medical Staff, administration, nursing department and infection control personnel. The committee shall provide advice on all proposed construction and shall be responsible for the provision of current, updated information on infection control policy and procedures for the facility. Consultative representatives from environmental services, SPD (supply, processing and distribution), nutrition resources, microbiology, engineering/maintenance, pharmacy, surgery, and respiratory therapy will serve as needed.

2. Duties

The duties of the Infection Control Committee shall include:

- (i) Developing a hospital wide infection control program and maintaining surveillance over the program.
- (ii) Developing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data and follow up activities.
- (iii) Developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.
- (iv) Developing written policies defining special indications for isolation requirements.
- (v) Coordinating action or findings from the Medical Staff's review of the clinical use of antibiotics.
- (vi) Acting upon recommendations related to infection control received from the President of the Medical Staff, the Medical Executive Committee, departments and other committees.
- (vii) Reviewing sensitivities of organisms specific to the facility.

3. Meetings

The Infection Control Committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its

proceedings and shall submit reports of its activities and recommendations to the Medical Staff Quality Council.

D. Bylaws Committee

1. Composition

The Bylaws Committee shall consist of at least five Members of the Medical Staff, including the President Elect and the Immediate Past President of the Medical Staff.

2. Duties

The duties of the Bylaws Committee shall include:

- (i) Conducting a review of the Medical Staff Bylaws every two (2) years, as well as a review of the Rules and Regulations and Policies and Procedures of the Medical Staff.
- (ii) Receiving and evaluating suggestions for modification of these documents.
- (iii) Submitting recommendations to the Medical Executive Committee for changes in these documents.

3. Meetings

The Bylaws Committee shall meet as often as necessary at the call of its chair, but at least annually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

E. Cancer Committee

1. Composition

The Cancer Committee shall be a standing, multidisciplinary policy-advisory and administrative body concerned with the entire spectrum of care for patients with cancer and designed to meet the American College of Surgeons Commission on Cancer accreditation requirements. The structure shall consist of physician Members representing surgery, pathology, medical oncology, radiation oncology, and imaging. Also included are representative from administration, nursing, social services, quality management, cancer registry, and other representative as necessary to meet the American College of Surgeons Commission on Cancer requirements.

2. Duties

The Cancer Committee shall:

- (i) Plan, initiate, stimulate and assess all cancer related activities of the hospital.
- (ii) Develop patient management guidelines, review and evaluate the quality and appropriateness of patient care either directly or by interaction with and review of audit data from other committees.
- (iii) Formulate and execute on-going quality improvement activities pertaining to pretreatment evaluation, including accurate cancer staging; document patterns of recurrence of specific malignancies; review patient care evaluation studies.
- (iv) Identify prevention, detection and education needs of professionals and public; assure the availability of consultative, supportive and rehab services to all patients.
- (v) Serve as advisory/steering committee for the cancer program and liaison to the Cancer Registry; organize, promote implement and evaluate educational and consultative tumor boards; support clinical trials and internal treatment protocols.
- (vi) Carry out other appropriate responsibilities based on ACoS or other regulatory bodies as deemed appropriate to be defined by the Cancer Committee. Rules and regulations delineating these responsibilities will be maintained by the Cancer Committee.

3. Meetings

The Cancer Committee shall meet as needed, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall report its activities and recommendations to the Medical Staff Quality Council.

F. Nominating Committee

The Nominating Committee's appointment, composition and duties shall be provided in Article VIII of the Bylaws.

G. Institutional Review Board

1. Composition

The Institutional Review Board ("IRB") shall be composed of no fewer than seven individuals, including at least three physicians. Members of the IRB will represent administration, the Medical Staff, and nursing service. Members of the IRB will be appointed in accordance with Code

of Federal Regulations, Title 45, Public Welfare, Part 46. At least one layperson not associated with the Hospital will be a member of the IRB. A quorum must include a lay member of the IRB. Appropriate specialists may be requested by the IRB to serve as consultants without vote. An effort shall be made to appoint members with expertise in areas, which are most often the subject of studies. No member of the IRB with a conflicting interest in a particular study may participate in a voting capacity in any IRB action on that study or any related study.

2. Duties

The purpose of the IRB is to review and monitor clinical investigational studies when such studies involve human subjects who are inpatients or outpatients at this Hospital or when home care is provided. The IRB will carry out the charges set forth in specific federal regulations. The functions of the IRB will include:

- (i) Review and evaluation of the investigational protocol provided by the sponsor in any study.
- (ii) Monitoring of the investigational protocol to assure that it is carried out in the Hospital in the manner intended.
- (iii) Assuring the protection of human subjects by the use of appropriate informed consent processes and forms for each patient, suitable to each study.
- (iv) Respond as appropriate to complaints regarding clinical investigational studies.

3. Meetings

The IRB shall meet as often as necessary, but no less than yearly. Reports of all meetings shall be submitted to the Medical Staff Quality Council and all actions will be reported to the Board of Trustees.

H. Critical Care Committee

1. Composition

The Critical Care Committee shall consist of Medical Staff Members as appointed by the President of the Medical Staff. The Committee shall also include the Director of Critical Care Units and representatives from Nursing and Administration. Physician Members of the committee will be appointed by the President of the Medical Staff, The Medical Director of the Critical Care Units shall act as chair of the committee.

2. Duties

The Critical Care Committee shall:

- (i) Develop written policies and procedures concerning the scope and provision of care in the Critical Care Units, including admission and discharge criteria to the Critical Care Units. These policies and procedures will be reviewed on a regular basis.
- (ii) Review and evaluate the quality and appropriateness of patient care within the Critical Care Units.

3. Meetings

The Critical Care Committee shall meet as often as necessary at the call of its chairperson, but at least quarterly. It shall maintain a permanent record of its proceedings and shall report its actions and recommendations to the Medical Staff Quality Council.

I. Physician Well-Being Committee

1. Composition

The Physician Well-Being Committee shall be composed of at least three members, a majority of whom, including the chair, shall be physician Members of the Active Medical Staff. Each member shall serve a term of two (2) years and may be reappointed. Insofar as possible, while serving on this committee, members shall not serve as active participants on other peer review or performance improvement committees.

2. Duties

The duties of the Physician Well-Being Committee shall include:

- (i) Receiving reports related to the health, well-being, or impairment of Medical Staff Members and, as it deems appropriate, investigating such reports. For matters involving individual Medical Staff Members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. These activities shall be confidential; however, if information received by the committee clearly demonstrates that the health or known impairment of a Medical Staff Member poses an unreasonable risk of harm to patients or other persons, that information shall be referred for corrective action to the appropriate department chair and to the President of the Medical Staff, and to the Administrator.
- (ii) Providing suggestions and advice to other appropriate committees or officers regarding reasonable safeguards concerning a

physician's continued practice in the Hospital while undergoing treatment.

- (iii) Considering general matters related to the health and well-being of the Medical Staff, including educational programs or related activities in coordination with other appropriate committees.

3. Meetings

The Physician Well-Being Committee shall meet as often as necessary, but at least quarterly. It shall maintain such records of its proceedings as it deems advisable, and shall report its activities on a quarterly basis to the Medical Executive Committee. Any records, regarding individual physicians shall be kept strictly confidential and maintained independently from the general records of the committee.

The foregoing paragraphs notwithstanding, the Medical Executive Committee may, at any time, and for any length of time, delegate the functions of the Physician Well-Being Committee to the Fresno-Madera Medical Society Committee on Well-Being for Physicians, so long as the latter committee's membership includes at least two Members of the Saint Agnes Medical Center Medical Staff.

The Medical Society Committee, while acting on matters concerning any Member of Saint Agnes Medical Center, shall be deemed a peer review committee of the Medical Staff.

J. Quality Council

1. Composition

The Quality Council shall consist of one representative from the Medical Executive Committee and one designee from each department of the Medical Staff for a term of two (2) years.

The chair of the Quality Council shall be the President-Elect. Representatives of Administration and the Medical Staff shall serve as voting and non-voting Members. The number of voting administration members shall not be greater than the number of voting physician Members.

Additional physicians shall be appointed for a two (2)-year term by the President of the Medical Staff to serve as liaisons between the Medical Staff and hospital administration on matters relating to monitoring and evaluation functions, which are reported to the Quality Council. These physicians will be voting Members of the Quality Council.

The Utilization Review Committee shall be a sub-committee of the Quality Council. No physician Member of the Utilization Review Committee shall have a financial interest in this or any Hospital.

2. Duties

The duties of the Quality Council shall include, but not be limited to:

- (i) Facilitating in Performance Improvement program;
- (ii) Reviewing departmental improvement activities, including trends related to the use of blood and blood components, surgical and invasive procedures, medication use, medical records, and medical library;
- (iii) Collaborating with the Medical Center in the prioritization, identification, measurement, assessment and improvement of care;
- (iv) Providing oversight and supervision for improvement efforts on behalf of the Medical Staff departments and monitoring and evaluating committees;
- (v) Being an educational resource for the Medical Staff;
- (vi) Coordinating and assisting in the utilization review function across the Medical Staff departments; promoting quality of patient care and assurance of appropriate and efficient use of available health services.
- (vii) Developing proposed policies and procedures for, and continuously evaluating the appropriateness of blood and blood product usage, including the screening, distribution, handling and administration, and monitoring of blood and blood components effects on patients.

3. Meetings

The Quality Council shall as often as necessary, but at least quarterly. Reports and recommendations are sent to the Medical Executive Committee. Additionally, pertinent issues, findings and improvements are shared with the Medical Staff departments on an ongoing basis. The Utilization Review Committee shall meet at least quarterly.

K. Utilization Review Committee

The Utilization Review Committee is a sub-committee of the Quality Council Committee. The Utilization Review Committee shall consist of sufficient Members of the Medical Staff to afford fair representation.

1. Duties

The duties of the Utilization Review Committee shall include:

- (i) Conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices; use of medical and hospital services and related factors, which may contribute to the effective utilization of services. The committee shall communicate the result of its studies and other pertinent data to the Quality Council Committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety.
- (ii) Establishing a utilization review plan, which shall be approved by the Quality Council Committee and the Medical Executive Committee.
- (iii) Obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's case management system.

2. Meetings

The Utilization Review Committee shall meet as often as necessary at the call of the chair, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall make regular reports of its activities and recommendations to the Medical Staff Quality Committee.

L. Professional Practice Committee

1. Composition

- (i) The Professional Practice Committee shall be composed of the following individuals:
 - (a) Three standing members of the Medical Staff consisting of the Immediate Past President, the President Elect, and a physician who has been an Active Staff Member for more than ten (10) years and who is currently an Active or Honorary Staff Member of the Medical Staff.
 - (b) A psychiatrist or psychologist who is preferably a member of the Physician Well-Being Committee.
 - (c) The Department chair of any Member under review shall become a member of the committee for the duration of the review in action.

- (d) The Administrator or designee shall serve as a participating but non-voting Member.
 - (e) Additional Medical Staff Members may be appointed to the committee at the discretion of the President of the Medical Staff. These individuals shall also have been Members of the Medical Staff for more than ten (10) years.
- (ii) The chair of the committee shall be the Immediate Past President of the Medical Staff. The President-Elect shall serve as Vice Chair.

2. Duties

The duties of the Professional Practice Committee shall include:

- (i) Assisting the Medical Executive Committee and department chair in fulfilling the responsibilities of the Medical Staff and hospital to maintain a safe, respectful, and mutually cooperative environment for patients, family, staff, physicians and visitors, all the while being sensitive to the rights of the individual practitioners.
- (ii) facilitating consistent, fair, and equitable treatment of practitioners when dealing with physician's disruptive behaviors, impairments, and failure to meet Medical Staff responsibilities.
- (iii) Making written requests to the Medical Executive Committee for formal investigations in accordance with Article VI of the Bylaws and conducting investigations in accordance with Article VI of the Bylaws, upon authorization of the Medical Executive Committee.
- (iv) Making written recommendation in appropriate cases for summary restriction or suspension to the President of the Medical Staff or to the Medical Executive Committee, together with documentation supporting such recommendation.

3. Meetings

The Professional Practice Committee shall meet as often as necessary. It shall maintain a record of its proceedings and shall submit reports of its activities and recommendations to the Medical Executive Committee.

M. Credentials Committee

1. Composition

The Credentials Committee shall consist of a chair and not less than nine Members of the Active Medical Staff, each appointed by the Medical

Executive Committee for a two (2)-year term. Insofar as feasible, there shall be one representative from each department, and other Members may be appointed or invited as directed by the President of the Medical Staff.

2. Duties

The Credentials Committee shall:

- (i) Review and evaluate the qualifications of each practitioner applying for initial appointment, taking into account all available information and department recommendations. Review and evaluate the qualifications of each practitioner applying for reappointment or modification of Clinical Privileges when requested by the department chair.
- (ii) Submit required reports and provide information to the Medical Executive Committee and appropriate department, on the qualifications of each practitioner, with respect to appointment, membership category, department affiliation, and Clinical Privileges when appropriate. Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.
- (iii) Assist in establishing qualifications for practitioners for initial appointment, and in conjunction with the appropriate department establish qualifications for new clinical procedures.

3. Meetings

The Credentials Committee shall meet as often as necessary at the call of its chairperson, but at least quarterly. A permanent record of its proceedings shall be maintained and all actions and recommendations shall be reported to the Medical Executive Committee.

N. Continuing Medical Education Committee

1. Composition

The Continuing Medical Education Committee shall be composed of physician Members and other health professionals of the medical and hospital staff whose number shall be appropriate to the size of the hospital and quantity of annual program activities. The composition shall include a chairperson who shall serve a minimum of two (2) years, and committee members who shall serve for a minimum of a two (2) year term. The Director of Medical Education should serve as at least an ex-officio member of the committee.

2. Duties

The Continuing Medical Education Committee shall perform the following duties:

- (i) Develop, plan, implement, coordinate and promote ongoing special clinical and scientific programs for the Medical Staff. This includes:
- (ii) Identifying the educational needs of the Medical Staff to maintain, develop or increase the knowledge, skills and professional performance of physicians to improve care, or improve the quality of care.
- (iii) Developing a planning process that links identified educational needs with a desired result;
- (iv) Formulating clear, measurable objectives for each program;
- (v) Selecting appropriate teaching methods and knowledgeable faculty for each program;
- (vi) Identifying funding sources, speaker agreements and financial disclosure (if any);
- (vii) Evaluating the effectiveness of each program; and
- (viii) Documenting staff attendance at each program.
- (ix) Review requests prospectively for CME initiated by Medical Staff Departments and Medical Staff Planning Committees. This includes:
- (x) Confirmation of planning process, objectives, audience, teaching method, program
- (xi) Evaluation methodology, funding sources, speaker agreements and financial disclosure.
- (xii) Approve or disapprove CME requests based on needs of the Medical Staff, planning Process, objectives, and overall program quality.
- (xiii) Assist in the developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.
- (xiv) Establish liaison with the quality assessment and improvement program of the hospital to be appraised of quality issues in patient care, which may be addressed by a continuing medical education activity.

- (xv) Maintain close liaison with hospital Medical Staff, clinical staff and department committees focused on patient care.
- (xvi) Initiate recommendations to the Medical Executive Committee on the Medical Staff's need for library and educational resources.
- (xvii) Advise administration of the financial needs of the continuing medical education program.

3. Meetings

The Continuing Medical Education Committee shall meet as often as necessary, but at least quarterly. It shall maintain minutes of the program planning discussions and report to the Medical Executive Committee.

O. Medical Staff Quality Committee

1. Composition

The Medical Staff Quality Committee ("MSQC") will be comprised of fifteen (15) voting Members who are active Members of the Medical Staff from the following specialties: General Medicine/Hospitalist medicine (2), Critical Care, Neurology, Gastroenterology, Cardiology, General Surgery, Orthopedic Surgery, Cardiothoracic Surgery, additional Surgical subspecialties (2), OB/GYN, Emergency Medicine, Anesthesiology, and Imaging. Practitioners from other specialties may be invited to the meeting as needed. Current department chairs and voting MEC members are not eligible to be MSQC members. The chair and members shall be appointed by the President of the Medical Staff in accordance with the MSQC Charter.

2. Duties

The MSQC shall:

- (i) be responsible for measuring and evaluating all areas of practitioner competency for care provided at Saint Agnes Medical Center and its facilities under the responsibilities of the Medical Staff unless otherwise indicated in this charter.
- (ii) Although the MSQC will be a source of competency data, credentialing and privileging decisions are the responsibility of the department chairs.
- (iii) Performance measurement and evaluation for hospital systems and processes are the responsibility of the appropriate hospital committee or department.

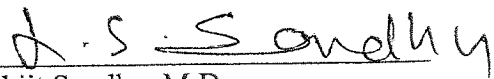
- (iv) Define practitioner performance indicators and targets for the General Competencies in collaboration with the appropriate departments and specialties as approved by the MEC.
- (v) Evaluate practitioner performance for these indicators to determine if improvement opportunities exist either through case review or using aggregate data for patterns and trends.
- (vi) Assure accountability by the Medical Staff departments for the development of improvement plans when appropriate.
- (vii) Oversee any other Medical Staff specialty specific peer review activities.
- (viii) Interim Medical Staff Evaluations. In order to fulfill The Joint Commission standard concerning medical care evaluation, performance improvement and patient safety activities, the MSQC, in conjunction with Hospital Administration and other committees of the Medical Staff, shall perform the following actions for each Practitioner's Medical Staff appointment cycle:
 - (a) Perform ongoing professional practice evaluations ("OPPE") of all Members of the Medical Staff and focused professional practice evaluations ("FPPE") when concerns arise from OPPE based on the general competencies defined by the Medical Staff;
 - (b) Set expectations and define both individual and aggregate measures to assess current clinical competency of all Members of the Medical Staff, provide feedback to the Members of the Medical Staff and develop plans for improving the quality of clinical care provided in the Hospital; and
 - (c) Actively be involved in the measurement, assessment, and improvement of activities of Practitioner performance that include, but are not limited to, the following:
 - (1) Medical assessment and treatment of patients;
 - (2) Use information about adverse privileging decisions for any Practitioner privileged through the Medical Staff process;
 - (3) Use of medications;
 - (4) Use of blood and blood components;

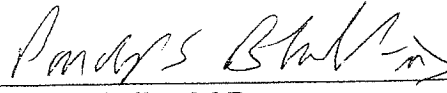
- (5) Operative and other procedures;
- (6) Education of patients and families;
- (7) Accurate, timely and legible completion of patients' medical records to include the quality of medical histories and physical examinations;
- (8) Appropriateness of clinical practice patterns;
- (9) Significant departures from established pattern of clinical performance;
- (10) Use of developed criteria for autopsies;
- (11) Sentinel event data;
- (12) Patient safety data;
- (13) Coordination of care, treatment and services with other Practitioners and hospital personnel, as relevant to the care, treatment and services of an individual patient; and
- (14) Findings of the assessment process relevant to individual performance.

3. Meetings

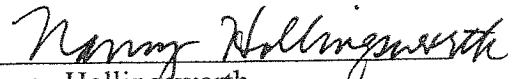
The MSQC shall meet as often as necessary at the call of its chairperson, but at least monthly. A permanent record of its proceedings shall be maintained and all actions and recommendations shall be reported to the Medical Executive Committee.

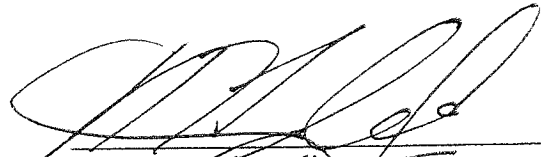
ADOPTED by the Medical Staff on: June 13, 2017.


Lakhjit Sandhu, M.D.
President of the Medical Staff


Pardeep Bhullar, M.D.
Secretary and Treasurer

APPROVED by the Board of Trustees and effective on July 28, 2017


Nancy Hollingsworth
Administrator


Thomas Ferdinandi
Chair, Board of Trustees

REPLACING the Rules and Regulations dated March 28, 2014.