EAST JEFFERSON GENERAL HOSPITAL
RULES AND REGULATIONS

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MEDICAL STAFF
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1.0 CATEGORIES OF THE MEDICAL STAFF

1.1 Members of the Medical Staff are granted either active, courtesy, administrative, members without privileges or emeritus status. Each division may determine the criteria that constitute "regularly care for" in order to assign its members to the active or courtesy staff. If a division has not determined this criteria, "regularly care for" will be defined as a two-year minimum of thirty-six patient contacts, i.e. admissions, consultations, emergency room visits or procedures. A division may also decide to use other "episodes", e.g. attendance at committee meetings, to fulfill the requirement.

1.2 Members of the Medical Staff who request a voluntary resignation must abide by and: :
a) Communicate intent to resign in writing.
b) Agree to fulfill obligations for coverage of Emergency Room Unreferred Call on all schedules published at the time the resignation letter is submitted OR name the physician who will be standing in for Emergency Room coverage. The resigning physician must make arrangements with the physician accepting the responsibility of coverage.
c) Agree to provide care for his/her patients until the resignation is final OR identifies the physician who will care for his/her patients
d) Complete all medical records prior to submission of recommendation to the Board of Directors.

1.2.1 Resignation is not final until approved by the Board of Directors of EJGH.

After the written notice of resignation is received and the resigning member of the Medical Staff does not follow through with his obligations as set forth in these Rules and Regulations and medical staff policies, the physician's resignation will be noted as "Resigned, not in good standing".

2.0 ADMISSION OF PATIENTS

2.1 Patients

Patients are admitted without regard to race, creed, color, sex, sexual preference, national origin, or source of payment. Admission of any patient is contingent on adequate facilities, resources and personnel being available to care for the patient. Emergency admissions will be accepted in compliance with state and federal regulations.

2.2 Admitting Prerogatives

Only members of the Active and Courtesy categories of the Medical Staff may admit patients to the hospital.

2.3 Timely Visitation After Patient Admitted

The attending practitioner or their designee must see the patient and record an admission or progress note within the time frames provided below or within any shorter time frame if the patient's condition requires it:

(a) Patients admitted directly to or transferred into an intensive or critical care area from the admitting office, Emergency Department, or general care area--within 8 hours unless seen immediately prior to admission or transfer to the Intensive or Critical Care area.
(b) Patients admitted via the Emergency Department to a general care area within 24 hours
(c) Elective admissions--24 hours.

3.0 Participation in the On-call Schedule

Each division or group of divisions will provide an on-call schedule providing for continuous coverage for the Emergency Department. If the division or group of divisions cannot provide a satisfactory on-call schedule or if there is an unresolved conflict, the matter will be resolved by the Medical Executive Committee. Each division or group of divisions will determine which members of the medical staff assigned to them will be required to participate in the on-call schedule. Designated practitioners on-call will accept responsibility during the time specified by the published schedule for providing care and/or disposition for any unreferred patients in the Emergency Department who require the services of that division or group of divisions. If a designated practitioner on-call has a conflict with the published schedule, it is their responsibility to find an alternate practitioner within their division or group of divisions to accept the on-call responsibility and notify the Emergency Department and Medical Staff office.

Consistent with the direction provided by each division or group of divisions, the medical staff office will develop the assignment schedules for attendance to unreferred patients and on-call duty in the Emergency Department.

If the designated practitioner defaults in their on-call responsibility, the Chief of the applicable division (or Chair of the applicable department, if multiple divisions are involved) 1) will resolve the problem with the designated on-call practitioner, 2) find an alternate practitioner to accept the responsibility of care and/or disposition, or 3) assume the responsibility themselves. In the absence of such designation for timely, adequate, professional care and/or disposition, the matter shall be brought immediately to the attention of the Chief of Staff for final decision and direction.

Failure of a designated on-call practitioner to meet their responsibilities in the Emergency Department may result in loss of staff membership or such other disciplinary action as specified in the bylaws.

4.0 GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

4.1 Members of the medical staff shall be responsible for the medical care and treatment of each patient that they admit into the hospital and for the prompt completion, legibility and accuracy of those portions of the medical record for which they are responsible.

4.2 Transfer of Responsibility

When primary responsibility for a patient's care is transferred from the admitting or current attending practitioner to another staff member, an order covering the transfer of responsibility does not transfer the attending practitioner’s responsibility for the patient’s care until the order for acceptance or care is assumed by the accepting physician.

4.3 Alternate Coverage

Practitioners must assure timely, adequate professional care for their patients in the hospital by being available or designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges. Each member of the staff who will

be out of town or unavailable must provide a mechanism for communicating with whomever will be providing coverage in their absence. The covering practitioner must have the same clinical privileges at East Jefferson General Hospital. In the absence of such designation, the Chief of Staff, the applicable department chairman or the applicable division chief has the authority to call upon any member of the staff with the requisite clinical privileges. Failure of the attending practitioner to meet these requirements may result in loss of staff membership or such other disciplinary action as specified in the bylaws.

4.4 Limited License Professionals

Dentists, Oral surgeons, psychologists and podiatrists may treat patients under the conditions provided in Section 4.3 of the Medical Staff Bylaws. All LLP's with medical staff privileges are responsible for documenting in the medical record, in timely fashion, a complete and accurate description of the services provided to the patient. Allied Health Professionals may enter orders as specified in 7.3 of the Rules and Regulations.

4.5 Residents in Training

Residents in training are given patient care responsibilities commensurate with the individual level of training, experience and capability detailed in training protocols developed by the applicable training program director and medical school authorities, and as accepted by the Hospital. In all matters of an individual patient's care, residents in training are responsible to the private attending practitioner who maintains ultimate decision-making and patient responsibility. The responsibilities and prerogatives of residents are outlined in Hospital policy.

4.6 Consultations

4.6.1 Guidelines for Calling Consultation

Consultation shall be considered in the following cases:

(a) Any patient known or suspected to be suicidal if not being managed by a psychiatrist:
(b) Cases of difficult or equivocal diagnosis or therapy.
(c) When required by state law.
(d) When requested by the patient or family.

4.6.2 Types of Consultations

Consultations shall be either STAT (Emergency) or Routine (Non-emergent) depending on the patient's clinical condition:

(a) STAT or Emergency Consults are consults which should be answered as quickly as possible but always within 4 hours.
(b) Routine or Non-emergent Consults are Consults which shall be answered by the end of the next day unless otherwise indicated.

4.6.3 Responsibilities

(a) Consultation Requests**:** When requesting consultation, the attending medical staff should indicate in writing the reason for the request and indicate whether the consultation is STAT or Routine. STAT Consults should always be facilitated by physician-to-physician communication.

(b) Consultant's Responsibilities: Any member of the medical staff who has been consulted shall either accept and answer the consultation request or decline the consult. It is expected that any member of the medical staff who is consulted and is unable or unwilling to accept the consultation request shall notify the appropriate nursing unit as soon as possible so that alternative arrangements can be made for the care of the patient.
(c) Division Responsibilities: It is the responsibility of each departmental division to develop a policy that ensures that any request for a STAT consultation be answered in the event that the request is declined by members of that division.

5.0 TRANSFER OF PATIENTS

5.1 Transfers Between Hospital Units

5.1.1 Authorization

No patients will be transferred to or from any area of the hospital without approval of their attending physician.

5.1.2 Transfer Orders

Upon transfer to or from any special care unit (i.e. ICU, CCU, ER, NICU, Operating Room and the Post Anesthesia Care Unit [PACU]) orders shall be entered without a reference to previous orders (i.e., "resume" statements).. Orders for the PACU shall be entered after the patient's transfer to the PACU and not prior to the patient's procedure. All transfers between hospital units require medication reconciliation by the transferring physician.

5.2 Transfer to Another Facility

5.2.1 General Requirements

A patient shall be transferred to another medical care facility only upon the order of the attending practitioner, and only after arrangements have been made for admission with the other facility. Transfers will occur only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to insure continuity of care must accompany the patient.

5.2.2 Transfers Against Medical Advice

A transfer demanded by or for a patient especially in an emergency or critically ill patient against the advice of the attending physician shall require an appropriate release. If the patient or agent refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

6.0 DISCHARGE OF PATIENTS

6.1 Required Order

A patient may be discharged only on the order of the attending practitioner. The attending practitioner is responsible for formulating an appropriate discharge summary and document medication reconciliation.

6.2 Leaving Against Medical Advice

If a patient desires to leave the hospital against the advice of the attending practitioner or without proper discharge, the attending practitioner and the nursing supervisor shall be notified, and the patient will be requested to sign the appropriate release form, attested by the patient or his legal representative and witnessed by a competent third party. If a patient leaves the hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident must be made in the patient's medical record.

6.3 Discharge of Minor Patient

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he shall so state in writing, and the statement must be made a part of the patient's medical record.

7.0 ORDERS

7.1 General Requirements

All orders for treatment or diagnostic tests must be entered clearly, legibly and completely and signed by the practitioner or entered by the practitioner into the hospital computer. All orders entered by a Resident are to be countersigned by the attending physician. Orders, which are illegible or improperly entered, will not be carried out until reentered or reissued as a verbal order to the nurse. Orders for diagnostic tests, which necessitate the administration of test substances or medications, will be considered to include the order for this administration. There must be a documented diagnosis, condition or indication for use of each medication ordered. This documentation may be contained in the History and Physical or progress notes. All orders for medication must include the name, amount, route and frequency. Blanket re-instatement of previous orders is prohibited.

7.2 Verbal Orders

7.2.1 By whom and circumstance

Telephone or other verbal orders may be taken only by a registered nurse or licensed practical nurse for patients under their care, except that the following personnel, if approved in accordance with hospital policy, may take verbal orders for medication, treatment and/or procedures within their respective areas of practice and which they will prepare, deliver or perform: respiratory therapists, physical therapists, registered pharmacists, certified registered nurse anesthetists, clinical dietitians, speech pathologists, occupational therapists, radiation therapists, radiological technologists, and certified social workers. Telephone orders will be accepted only from the responsible practitioner, or their designated resident, when it is not practical for the order to be entered by the responsible practitioner .

7.2.2 Documentation

All verbal orders will be transcribed in the proper place in the medical record, shall include the date, time, name and signature of the person transcribing the order and

the name of the practitioner, and shall be countersigned by the prescribing practitioner within 10 days.

7.3 Orders by Allied Health Advanced Practice Professionals

A hospital Allied Health Advanced Practice Professional (APP) privileged to enter orders may do so only to the extent if any, specified in the position description developed for that category of APP and consistent with the scope of services individually defined for their position. Any authorized order by an APP must be countersigned by the responsible supervising practitioner within the time frame required in said position description or defined scope of services but, in all circumstances, within 24 hours.

7.4 Automatic Cancellation of Orders

All previous orders are automatically discontinued, when the patient goes to surgery or is transferred to a special care unit.

7.5 Stop Orders

7.5.1 Automatic Stop Orders

Certain medications in the absence of a specific order by the physician to continue will have specified automatic stop orders. The types of the specific medications and the maximum duration of administration will be determined by the Pharmacy and Therapeutics Committee and be approved by the Medical Executive Committee.

7.5.2 Exceptions

Exceptions to the stop order rule are made under the following conditions:
(a) The last effective order indicated an exact number of doses to be administered;
(b) The last effective order specifies an exact period of time for the medication; or
(c) The prescribing practitioner re-orders the medication or treatment.

7.5.3 Notification of Stop

The applicable unit (nursing/pharmacy/respiratory therapy) notifies the prescribing practitioner within 24 hours before an order is automatically stopped.

7.6 Blood Transfusions and Intravenous Infusions

Blood transfusions and intravenous infusions must be started by the attending practitioner, his designated resident, or by a registered nurse who has the requisite training and has been credentialed to do so in the hospital. The order must specifically state the rate of infusion. The specific policies governing the ordering and administering of blood and blood products will be governed by the Blood Bank and Transfusion Committee and approved by the Medical Executive Committee.

7.7 Special Orders

7.7.1 Patient's Own Drugs and Self-Administration

Drugs brought into the hospital by a patient may not be administered unless the drugs have been identified and there is an entered order from the attending practitioner or assigned resident to administer the drugs. Self-administration of medications by a patient is permitted on a specific entered order by the authorized prescribing practitioner and in accordance with established hospital policy.

7.7.2 Do Not Resuscitate Orders

A "Do Not Resuscitate" (DNR) order is entered in the orders by the physician or by a phone order given to two nurses when the conditions of an executed living will are met or when implementing the wishes of the patient that is documented in the progress notes and consistent with appropriate clinical practice. When the patient is not competent to make decisions, the person authorized to consent on behalf of the patient may request a DNR order. The attending physician should document the patient's condition and any discussion with the patient and/or family regarding the DNR order in the progress notes.

7.8 Formulary and Investigational Drugs

7.8.1 Formulary

The hospital formulary lists drugs available for ordering from stock. Each member of the medical staff assents to the use of the formulary as approved by the Pharmacy and Therapeutics Committee. All drugs and medications administered to patients, with the exception of drugs for bonafide clinical investigations, shall be those listed in the latest edition: United States Pharmacopoeia; National Formulary, New and Non-Official Drugs; American Hospital Formulary Service, or AMA Drug Evaluations.

7.8.2 Investigational Drugs

Use of investigational drugs must be in full accordance with all regulations of the Food and Drug Administration and must be approved by the Institutional Review Board where appropriate. Investigational drugs shall be used only under the direct supervision of the principal investigator. The principal investigator shall be responsible for receiving all necessary consents and completing all necessary forms and shall prepare and clarify directions for the administration of investigational drugs as to (1) untoward symptoms, (2) special precautions in administration, (3) proper labeling of the container and compliance with all bar-coding hardware and software, (4) proper storage of drug, (5) methods of recording doses when indicated, and (6) method of collection and recording specimens of urine and/or other specimens. A copy of the protocol for the investigational drug must be forwarded to the pharmacy for reference.

7.9 I.V. Sedation

The chief of each clinical division where anesthesia services, including IV Sedation, are provided will be responsible for the anesthesia activities within the department and for assuring that the quality and appropriateness of patient care provided within the department are monitored and evaluated. The Anesthesiology Department will participate in the development of all anesthesia policies.

8.0 INPATIENT MEDICAL RECORDS

8.1 Required Content

The attending practitioner, other medical staff members as applicable, and residents involved in the care of the patient shall be responsible for the preparation of a complete and legible medical record for each patient. The record's content shall be pertinent, accurate, legible, timely, and current, and have adequate documentation for a meaningful review by a physician.

8.2 History and Physical Examination

8.2.1 Generally

A complete history and physical examination must be recorded in the chart or dictated within 24 hours after admission of the patient by a physician licensed to practice in the State of Louisiana. If the history and physical is dictated, the chart must contain an admission note within 24 hours that provides pertinent findings from the history and physical examination. The attending practitioner must indicate the reason for hospitalization and the diagnostic/therapeutic plan. The admission history and physical examination report must include the chief complaint, details of the present illness, all relevant past medical, social and family histories, the patient's emotional, behavioral and social status when appropriate, and all pertinent findings resulting from a comprehensive, current assessment of all appropriate body systems. Each instance in which this history or physical examination is not completed within the time frame specified shall be acted upon in accordance with the Medical Staff Bylaws.

8.2.2 Use of Reports prepared prior to Current Admission

8.2.2.1 External to Hospital

If a qualified member of the hospital's medical staff has obtained a complete history and has performed a complete physical examination within thirty (30) days prior to the patient's admission, a durable, legible copy of the report may be used in the patient's hospital medical record, provided that an interval note is recorded at the time of admission that includes any significant changes in the patient's history or condition.

8.2.2.2 On Prior Admission:

When a patient is readmitted to the hospital within 30 days for the same or a related problem, an interval history and physical examination reflecting subsequent history and changes in physical findings may be used, provided the original information is readily available.

8.2.3 Short Form

A short history and physical examination form may be used for patients admitted for minor surgical procedures and for patients whose hospital stay is not expected to exceed 24 hours. If the patient remains over 24 hours, a standard form must be initiated and completed. The "short-form" history and physical examination must include, at a minimum, the assessment of the following information: vital signs, mental status, heart, lungs and reason for the hospitalization.

8.2.4 History and Physical Examination in the Outpatient Care Setting

Any patient who is seen in the facility for an outpatient, noninvasive test or procedure must have an entered and signed order for the test/procedure and a medical diagnosis as an indication for the test/procedure. A history and physical exam is not indicated for noninvasive tests/procedures unless conscious sedation is anticipated.

All patients receiving conscious sedation and/or undergoing invasive procedures are required to have a history and physical examination performed no more than 30 days before or 24 hours after admissions or registration, but prior to surgery or a procedure requiring anesthesia services. This outpatient history and physical examination must include, at a minimum, the assessment of the following information: vital signs, mental status, heart, lungs and reason for the procedure/test. Invasive procedures include, but are not limited to the following: GI endoscopy procedures, bronchoscopies, bone marrow aspirations, radiology special procedures, lithotripsy procedures, cardiac catheterization procedures, deliveries, or any other surgeries.

8.3 Preoperative Documentation

8.3.1 History and Physical Examination

A relevant history and physical examination is required on each patient having surgery. Except in an emergency so certified in writing by the operating surgeon, surgery or any other potentially hazardous procedure shall not be performed until after the pre-operative diagnosis, history, physical examination, and required laboratory tests have been recorded in the chart. If the history and physical examination have been dictated but are not on the chart at the time of surgery, a note must be entered regarding the proposed surgery and the condition for which it is to be performed, the condition of the heart and lungs, allergies known to be present, other pertinent pathology and information relating to the patient, and that the history and physical has been dictated. If not recorded, the surgery shall not be allowed to proceed. In cases of emergency, the responsible practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure, immediately after the emergency surgery has been completed. All cases in which the requirements of this section are not met shall be acted upon in accordance with the Medical Staff Bylaws.

8.3.2 Laboratory Tests

Appropriate advance lab tests must be performed in a timely fashion as required in the respective Divisional Rules and Regulations before elective surgery. Results of relevant tests must be recorded in the chart before induction of anesthesia.

8.3.3 Preoperative Anesthesia Evaluation

The anesthesiologist must verify and document preanesthesia evaluations of patients in accordance with nationally accepted standards of the specialty. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered.

8.4 Progress Notes

8.4.1 Generally

Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient and should be done on a daily basis and/or countersigned by the supervising physician when recorded by an Allied Health Professional or resident, except in hospital-designated nonacute units. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes by the attending practitioner must be entered at least daily, except in hospital-designated nonacute units. The responsible supervising practitioner must countersign progress notes entered by a physician-directed allied health professional.

8.4.2 By Attending Practitioner When Medical Residents are Involved

It is generally expected that at least every other day during hospitalization, the attending practitioner will personally enter a note indicating involvement in the care of the patient. Countersigning a resident member's note is acceptable and indicates that the attending practitioner reviewed the patient on that given day and agrees with the observations of the resident. If the attending practitioner’s observations do not coincide with the resident member's, the note should be amended or an additional note entered into the chart. If the patient's condition warrants, more frequent notes by the attending practitioner are expected.

8.5 Operative, Special Procedure and Tissue Reports

8.5.1 Operative and Special Procedure Reports

Operative and special procedure reports must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary performing practitioner and any assistants. If the report is dictated and not immediately transcribed or not entered in the record immediately after the procedure, the practitioner must enter a comprehensive operative progress note in the medical record immediately after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend the patient. The complete report must be entered or dictated immediately following the procedure, filed in the medical record as soon after the procedure as possible, and promptly signed by the primary performing practitioner.

8.5.2 Tissue Examination and Reports

All tissues, foreign bodies, artifacts and prosthesis removed during a procedure, except those specifically excluded by policy of the Surgical Case Review Committee, shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the pathologist. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be

accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. An authenticated report of the pathologist's examination shall be made a part of the medical record.

8.6 Obstetrical Record

The current obstetrical record must include a complete prenatal record. The prenatal record may be a durable, legible copy of the attending practitioner's office or clinic record transferred to the hospital before admission, but an interval admission note must be entered that includes pertinent additions to the history and any subsequent changes in the physical findings. All obstetrical patients undergoing surgery must have a history and physical examination recorded as required under Sections 8.2 and 8.3.1 of these Rules and Regulations.

8.7 Entries at Conclusion of Hospitalization

8.7.1 The principal diagnosis, any secondary diagnoses, co-morbidities, complications, principal procedure and any additional procedures must be recorded in full on the discharge summary. The attending practitioner is responsible for establishing the final diagnosis. A discharge summary shall be entered or dictated on all patients admitted over 24 hours except for normal obstetrical deliveries, normal newborn infants and patients with certain selected problems of a minor nature. These latter exceptions shall be identified by the Division of OB/GYN or other appropriate division and approved by the Medical Executive Committee. For these, a final summation-type progress note shall be sufficient to justify the diagnosis and warrant the treatment. The discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet and follow-up care. If no instructions were required, a record entry must be made to that effect.

8.8 Authentication

All clinical entries in the patient's record must be complete, accurate, and individually authenticated by means of an entered signature, electronic signature or identifiable initials.

8.9 Use of Symbols and Abbreviations

Symbols and abbreviations in making entries in the patient’s medical record are discouraged. A list of “Do not use” abbreviations is available in the Medical Staff Office and the Health Information Management Department.

8.10 Ownership and Removal of Records

All original patient medical records, including digital x-rays or films, pathological specimens and slides, are the property of the hospital and may be removed only in accordance with a court order, subpoena or statute, or in accordance with the directive of the Chief Executive Officer or his designee. Copies of records, films, slides, etc. may be released for follow-up patient care only upon presentation of appropriate authorization and payment of any fees for duplication. Unauthorized removal of a medical record or any portion thereof from the hospital is grounds for disciplinary action, including immediate revocation of staff appointment and clinical privileges, as described in the bylaws.

8.11 Access to Records

8.11.1 By Patient

Patient's may, upon entered request to their attending practitioner have access to all information contained in their medical records, unless access is specifically restricted by the attending practitioner for medical reasons or is prohibited by law.

8.11.2 For Statistical Purposes and Required Activities

Patient medical records shall also be made available to authorized hospital personnel, medical staff members or others with an official, hospital-approved interest for the following purposes:

a. Activities concerned with quality assessment.
b. Official surveys of hospital compliance with accreditation, regulatory, and licensing standards.
c. Approved educational programs and research studies.
d. Contractual requirements of third party payors.

Patients' identification and confidential personal/medical information shall be protected in accordance with hospital policy.

8.11.3 To Former Medical Staff Members

Subject to the discretion of the Medical Director, former members of the medical staff shall be permitted access to information from the medical records of their patients for all periods during which they attended such patients in the hospital.

8.11.4 Patient Consent Required Under Other Circumstances

Entered consent of the patient or their legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section.

8.12 Medical Staff Compliance

The Medical Records Committee, under the authority of the Medical Executive Committee, shall maintain a set of policies and procedures circulated to the Medical Staff, which outlines the responsibilities of the Staff with respect to the record-keeping function. The Medical Executive Committee is responsible for enforcement of these policies.

9.0 CONSENTS

9.1 General

The medical record of each patient must contain evidence of general consent for treatment during hospitalization, obtained from the patient or from his or her legal representative.

9.2 Informed Consent

9.2.1 Obtaining informed consent is the responsibility of the physician and it is required prior to:

1. Surgical or other invasive or special procedure, including general anesthesia
2. Use of experimental drugs or procedures
3. Organ donation
4. Radiation therapies or chemotherapy
5. Autopsy
6. Invasive or noninvasive diagnostic testing with material risks or when required by law.

9.2.2 Informed consent must be documented in the medical record, and must include at least the following information:

A. Patient's identity
B. Date when patient or his legal representative were informed.
C. Disclosure to the patient or his legal representative of the diagnosis and its implications
D. Disclosure to the patient or his legal representative of relevant treatment alternatives, if any, and of attendant risks, in detail sufficient to allow an informed decision.
E. Disclosure to the patient or his legal representative of the indications for and the nature and purpose of the procedure, and attendant risks, in detail sufficient to allow an informed decision.
F. Authorization for any required anesthesia.
G. Name(s) of the individual(s) who will perform the procedure or administer the treatment.
H. Authorization for disposition of any tissue or body parts as indicated.
I. The signature of the practitioner who informs the patient and so certifies.

9.2.3 Consent Forms

The hospital consent forms (which must be used in all cases) should comply with the requirements of state law and be compatible with the recommendations of the Louisiana Medical Disclosure Panel and be adopted by the Medical Executive Committee and the Hospital. Medical Staff members may also use additional forms for consent they deem necessary, but these must be in addition to the hospital consent forms.

9.2.4 Signature

A completed consent form must be signed by the patient (or on the patient's behalf by the patient's authorized representative) and witnessed by a legally competent third party (Appendix B).

9.2.5 Telephone Consent

When the patient is unable to give informed consent and the responsible party is not physically present, informed consent may be obtained by telephone if witnessed by a legally competent third party

9.2.6 Emergencies

Clinical circumstances may arise in which it is deemed by the attending physician and/or surgeon to be an emergency and in the patient's best interest to proceed

without informed consent. When such circumstances occur, the attending physician and/or surgeon shall document in the medical record the relevant clinical circumstances, and justification for proceeding without informed consent.

10.0 SPECIAL SERVICES, UNITS, AND PROGRAMS

Special services, units, and programs include, but are not limited to, the following:

10.1 Critical Care Units

a. Coronary Care Unit (CCU)
b. Emergency Department (ED)
c. Intensive Care Unit (ICU)
d. Neonatal ICU/High Risk Nursery
e. Operating Room (OR)
f. Post Anesthesia Care Unit (PACU)

10.2 Special Care

a. Geriatric Behavioral Health Unit
b. Dialysis
c. Labor and Delivery
d. Newborn Nurseries
e. Outpatient Services, which include, but are not limited to:
   (1) Same Day Surgery
   (2) Outpatient Oncology
   (3) Outpatient Ophthalmology
   (4) Outpatient Physical Therapy, Rehabilitation and Cardiac Rehabilitation
   (5) Endoscopy Lab
   (6) Wound Center
   (7) Diabetes Care
g. Rehabilitation Unit
h. Skilled Nursing Facility

10.3 Policies

Appropriate medical staff officers, committees, and clinical divisions, shall develop policies, protocols and admission and discharge policies, specific to each unit, compatible with these Rules and Regulations, Medical Staff Bylaws, hospital policy and relevant state and federal statutes, subject to the approval of the Medical Executive Committee, the Chief Executive Officer or his designee, and the Board of Directors .

11.0 HOSPITAL DEATHS AND AUTOPSIES

11.1 Hospital Deaths

11.1.1 Pronouncement

In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or their designee within a reasonable period of time.

11.1.2 Reportable Deaths

Reporting of deaths to the Coroner's Office shall be carried out when required by and in conformance with local law.

11.1.3 Death Certificate

The attending physician is responsible for signing the death certificate unless the death is a Coroner's case, in which event the death certificate is issued by the Medical Examiner.

11.1.4 Release of Body

The body of the deceased may not be released until an appropriate entry has been made into the medical record by the attending physician, or, in a Coroner's case, upon appropriate instruction from the Coroner, in accordance with state law.

11.2 Autopsies

To the extent that postmortem examination contributes to the understanding of the cause of death in a specific patient, and to the evolution of medical knowledge in general, the Medical Staff is encouraged to obtain autopsy when appropriate. Appropriate consent for autopsy must be obtained from the next of kin, in accordance with applicable state law. Except for Coroner's autopsies, which may be performed otherwise, a hospital pathologist, who shall record a provisional anatomic diagnosis in the medical record within 48 hours, shall perform all hospital autopsies. A complete autopsy protocol shall be made a part of the permanent medical record within 30 days.

Indications for autopsy may include, but are not limited to the following:

1. Unanticipated death
2 Intraoperative or intraprocedural death
3. Death occurring within 48 hours after surgery or invasive diagnostic procedure
4 Death incident to pregnancy or within 7 days following delivery
5. Death occurring while patient is being treated under a new therapeutic trial
6. Death on a psychiatric or chemical dependency service
7. Death in infants or children
8. Death in which a patient sustained an injury while hospitalized.

Since the ultimate goal of autopsy is to improve patient care, the evaluation of autopsy data shall be integrated into the Quality Assurance Program as a part of the permanent medical record evaluated by the relevant clinical department.

12.0 INFECTION CONTROL

12.1 All patients admitted to the hospital will be assessed for appropriate administration of influenza vaccine and pneumococcal vaccine and will receive vaccine if indicated unless the attending physician specifically rescinds the order.

12.2 Cultures

The attending or consulting physician shall order cultures for microbial identification and sensitivity.

12.3 Patients with Infectious/Communicable Diseases

Patients with known communicable disease will be managed using appropriate isolation techniques, as ordered by the attending physician, consistent with the Infection Control Manual of this institution, and guidelines developed by the Medical Staff Infection Control Committee.

12.4 Reporting of Communicable Diseases

Cases of communicable disease shall be reported by the Infection Control Department in accordance with applicable federal and state law, and in accordance with the Infection Control Policy of the institution, and procedures developed by the Medical Staff Infection Control Committee.

12.5 General Authority

The Medical Staff Infection Control Committee, subject to the approval of the Medical Executive Committee and Hospital Administration, may institute appropriate infection control measures to reduce danger to patients, hospital personnel, or Medical Staff.

13.0 Committees

13.1 Standing Committees of the Medical Staff

The Standing Committees of the Medical Staff include the Medical Executive Committee, Credentials Committee, Joint Conference Committee, Appropriateness of Care Committee and Physicians Health Committee. Their composition and duties are described in the bylaws. The composition and duties of other standing committees are described in the rules and regulations.

13.2 Other Committees

As provided for in the bylaws, the medical executive committee may create ad hoc or technical advisory committees to address specific issues.

13.3 Committee Guidelines

13.3.1 All standing, ad hoc and technical advisory committees have recommendation authority. The Medical Executive Committee has the responsibility and authority to render decisions on matters that affect the Medical Staff.

13.3.2 The current Chief of Staff appoints all medical staff committee members, unless otherwise specified.

13.3.3 Appointed members will serve for one year unless otherwise specified.

13.3.4 Any resignations are to be made in writing to the Chief of Staff and should designate the specific positions resigned. Resignations are effective upon receipt by the Chief of Staff.

13.3.5 Members of committees who do not meet attendance requirements will not be re-appointed to the committee.

13.3.6 In order to conduct committee business, a quorum must be present. A quorum shall consist of 50% of the voting members but in no event less than 3 voting members.

13.4 Standing Committees not provided for in the bylaws

13.4.1 Department of Medicine Chiefs Council and Department of Surgery Chiefs Council

13.4.1.1 **Composition:** The Chiefs Councils shall consist of the Chiefs from all divisions with their respective Departments.

13.4.1.2 **Duties:** The Chiefs Councils shall:

13.4.1.2.1 Review and act upon all findings and recommendations of the Divisions within their respective Departments.
13.4.1.2.2 Review and act upon all findings and recommendations of the committees that report to them.
13.4.1.2.3 Form ad hoc or technical advisory committees to address specific issues and make recommendations.
13.4.1.2.4 Direct Divisions within the Department to address specific issues and/or make specific recommendations.
13.4.1.2.5 Review and act upon all findings and recommendations of the Medical Executive Committee that are referred to the Councils.

13.4.1.3 **Meetings:** The Chiefs Councils will meet as necessary but no less than six times a year and will report their findings and recommendations to the Medical Executive Committee.

13.4.2 Surgical Case Review Committee

13.4.2.1 **Composition:** The Surgical Case Review Committee shall consist of at least five representatives from different divisions within the Department of Surgery who shall be recommended by the Chair of the Department of Surgery and will be chaired by the Chief of the Division of Pathology.

13.4.2.2 **Duties:** The Surgical Case Review Committee shall conduct a comprehensive review of cases identified by the Committee's yearly "Scope of Review" as prescribed in the Performance Improvement Plan

13.4.2.3 **Meetings:** The Committee shall meet at least quarterly and report its findings and recommendations to the Medical Staff Appropriateness of Care Committee.

13.4.3 Blood Bank/Transfusion Committee

13.4.3.1 **Composition:** The Blood Bank/Transfusion Committee shall consist of the Blood Bank Medical Director, two other members of the Department of Medicine and two members of the Department of Surgery, recommended by their respective chairs. Additional nonvoting members may include appropriate hospital representatives including administration, nursing, and laboratory.

13.4.3.2 **Duties:** The Blood Bank/Transfusion committee shall:

13.4.3.2.1 Evaluate the appropriateness of all cases in which patients were administered transfusions including the use of any blood products;

13.4.3.2.2 Evaluate episodes of transfusion reactions referred to the committee by the medical director or Quality Management;

13.4.3.2.3 Develop policies and procedures relating to the distribution, handling, use, and administration of blood and blood components for approval by the Medical Executive Committee.

13.4.3.2.4 Review the adequacy of transfusion services to meet the needs of the patients;

13.4.3.2.5 Review ordering practices for blood products; and

13.4.3.2.6 Approve clinically valid criteria in the screening process and in the more intensive evaluation of any known or suspected problems in blood usage.

13.4.3.3 **Meetings:** The committee shall meet at least quarterly and report its findings and recommendations to the Medical Executive Committee.

13.4.4 Pharmacy and Therapeutics Committee

13.4.4.1 **Composition:** The Pharmacy and Therapeutics Committee shall consist of three (3) members of the Department of Surgery, three (3) members of the Department of Medicine, a Hospitalist and a Cardiologist recommended by the Department Chairs and four nonvoting members representing Pharmacy, Nursing, Nutritional Services and Administration.

13.4.4.2 **Duties:** The Pharmacy and Therapeutics Committee shall:

13.4.4.2.1 Conduct drug usage evaluation as a criteria-based ongoing, planned and systematic process for monitoring and evaluating the prophylactic, therapeutic and empiric use of drugs to help assure that they are provided appropriately, safely and effectively:

13.4.4.2.2 Conduct ongoing monitoring and evaluation of selected drugs;

13.4.4.2.3 Approve the policies and procedures relating to the selection of drugs and diagnostic testing materials;

13.4.4.2.4 Develop and maintain a drug formulary or drug list;

13.4.4.2.5 Define and review all significant untoward drug reactions.

13.4.4.3 **Meetings:** The Pharmacy and Therapeutics Committee shall meet at least quarterly and report its findings and recommendations to the Medical Executive Committee.

13.4.5 Medical Records Committee

13.4.5.1 **Composition:** The Medical Records Committee shall consist of four (4) members of the Department of Surgery and four (4) members of the Department of Medicine recommended by the Departmental Chairs and three (3) nonvoting members representing the Nursing Service, Hospital Leadership , and the Health Information Management Department (HIM)

representative(s) . The HIM representative may be delegated to act as its secretary.

13.4.5.2 Duties: The Medical Records Committee shall:

13.4.5.2.1 Be responsible for the review and evaluation of medical records in order to determine whether they meet the criteria defined in these rules and regulations.

13.4.5.2.2 Develop, review, enforce and maintain surveillance over enforcement of Medical Staff and Hospital policies and Rules and Regulations relating to medical records,

13.4.5.2.3 Provide a liaison with the Hospital Administration, Nursing Service and medical record professionals of the Hospital on matters relating to medical records practices.

13.4.5.3 Meetings: The Medical Records Committee shall meet at least quarterly and report its findings and recommendations to the Medical Executive Committee.

13.4.6 Infection Control Committee

13.4.6.1 Composition: The Infection Control Committee shall consist of the Chief of the Division of Infectious Disease or designee, two (2) additional members of the Department of Medicine and two (2) members of the Department of Surgery. Additional nonvoting members may include appropriate hospital representatives, including Administration, Nursing, Laboratory, a representative of the Microbiology Section, and the Infection Control Director.

13.4.6.2 Duties: The Infection Control Committee shall:

13.4.6.2.1 Have the authority to institute any appropriate infection control measures or studies when there is a reasonable danger to any patient or personnel;

13.4.6.2.2 Determine the type of surveillance and reporting programs to be used in infection control;

13.4.6.2.3 Provide standard criteria for reporting all types of infections, including respiratory, gastrointestinal, surgical, wound, skin, urinary tract, septicemias, and those related to the use of intravascular catheters;

13.4.6.2.4 Recommend corrective action based on records and reports of infection and infection potential among patients and hospital personnel;

13.4.6.2.5 Review infections within the hospital, particularly with regard to their proper management and their epidemic potential;

13.4.6.2.6 Establish isolation requirements;

13.4.6.2.7 Monitor inappropriate infection rates.

13.4.6.3 Meetings: The Infection Control Committee shall meet at least quarterly. The Committee shall report its findings and recommendations to the Medical Executive Committee.

13.4.7 Surgical Procedures and Operating Room Committee

13.4.7.1 Composition: The Surgical Procedures and Operating Room Committee shall be a subcommittee of the Department of Surgery Chiefs Council consisting of six Division Chiefs appointed by the Chair of Surgery. Additional nonvoting members include the Operating Room Director, a representative from nursing and a representative from Administration.

13.4.7.2 Duties: The Surgical Procedures and Operating Room Committee shall:

13.4.7.2.1 Establish and promote the Rules and Regulations for the Operating Room with final approval by the Medical Executive Committee.

13.4.7.2.2 Evaluate and coordinate the overall operating room function, efficiency and performance.

13.4.7.2.3 Inspect periodically the equipment of the operating room suite and to make recommendations for equipment purchases to the Physicians Advisory Group.

13.4.7.2.4 Monitor and evaluate standards for Hospital services in surgical procedures, both diagnostic and therapeutic; and

13.4.7.2.5 Investigate any irregularities in surgical procedures and recommend corrective adjustment.

13.4.7.3 Meetings: The Surgical Procedures and Operating Room Committee shall meet at least quarterly and report to the Department of Surgery Chiefs Council.

13.4.8 Continuing Medical Education Committee

13.4.8.1 Composition: The Continuing Medical Education (CME) Committee shall consist of at least three members of the Department of Surgery and three members of the Department of Medicine, recommended by their respective Chairs. Additional nonvoting members shall include appropriate hospital representatives, including the CME coordinator. The CME Committee Chairman shall have a term of no less than two (2) years. Committee members shall serve for no less than two (2) years, with one half of the committee receiving appointment each year.

13.4.8.2 Duties: The Continuing Medical Education Committee shall:

13.4.8.2.1 Coordinate educational activities for the Medical Staff;

13.4.8.2.2 Provide professional library services that meet the informational, educational, and research-related needs of the medical and hospital staffs;

13.4.8.2.3 Assist in the effective utilization of various educational materials including audio-visuals;

13.4.8.2.4 Evaluate CME for compliance with the "Essentials of CME" and award Category I credit when appropriate.

13.4.8.3 Meetings: The Continuing Medical Education Committee shall meet at least quarterly and report its findings and recommendations to the Medical Executive Committee.

13.4.9 Oncology Committee

13.4.9.1 Composition: The Oncology Committee shall consist of at least those members of the Active Staff and hospital representatives as required for accreditation by the American College of Surgeons.

13.4.9.2 Duties: The Oncology Committee shall:

13.4.9.2.1 Work with the Continuing Medical Education Committee to organize educational and consultative cancer conferences.
13.4.9.2.2 Monitor and evaluate the care of Cancer patients in the hospital.
13.4.9.2.3 Actively supervise the Tumor Registry

13.4.9.2.4 Encourage a supportive care system for all patients with cancer.

13.4.9.3 Meetings: The Oncology Committee shall meet at least quarterly and report its findings and recommendations to the Medical Executive Committee.

13.4.10 Bylaws Committee

13.4.10.1 Composition: The Bylaws Committee shall be chaired by the immediate past Chief of Staff. The other members will be the five (5) past Chiefs of Staff excluding Board of Directors members.
Duties: The Bylaws Committee shall:

13.4.10.1.1 Regularly review the Bylaws and Rules and Regulations and request that the Medical Staff consider adoption, amendment, or repeal if the committee deems any of these actions need to be taken.

13.4.10.1.2 Act upon suggestions for revisions or amendments to the Bylaws or Rules and Regulations that may be referred by any committee or department of the Medical Staff, the Medical Executive Committee, or a member of the Active Staff. The suggested changes are to be made in writing and bear the signature of the proposer as well as a second by another member of the Active Medical Staff. This presentation shall include the old wording, the new wording, and an argument in favor of the change. It will be the duty of the Bylaws Committee to review the document as necessary for compliance with the standards of the licensing and crediting agencies and the current practice of the Medical Staff. When the entered document is prepared for submission to the Medical Staff for consideration, there shall also be space provided for an argument against the change from either the Bylaws Committee or the Medical Executive Committee.

13.4.10.2 Meetings: The Bylaws Committee shall meet no less than once a year and shall report its findings and recommendations to the Medical Executive Committee.

13.4.11 Utilization Review Committee

13.4.11.1 Composition:
The Utilization Review Committee (UR) is a standing committee and has recommendation authority only. The committee shall be composed of six representatives from the Department of Medicine and six representatives from the Department of Surgery, recommended by their respective department chairs. It is recommended that individuals serve more than one year and that no more than fifty percent of the committee changes in any one year. Furthermore it is recommended that one member of this committee be an officer on the Medical Executive Committee. Finally, the Care Management Physician Advisor will be a non-voting member of the committee.

13.4.11.2 Duties: The Utilization Review Committee shall:

13.4.11.2.1 Review length of stay data generated by the Care Management Department and review outcome data for EJGH compared to established national standards. The reports of the UR Committee will be forwarded to the Medical Executive Committee and physician.

13.4.11.2.2 Review the data generated by the Care Management Department for accuracy. Furthermore, the committee is entitled to have access to any care management data.

13.4.11.2.3 Utilize EJGH data and National Benchmarks to identify problematic patterns of care, and, when needed recommend changes in physician and/or hospital practices to improve the quality of care provided. The information will not be used for economic credentialing.

13.4.11.2.4 Review the current performance measures (eg: clinical pathways) and recommend additional projects that could improve utilization of resources and patient outcomes. Furthermore, it will collaborate with the physician advisor on performance parameters (eg: length of stay).

13.4.12.2.5 Have access to physician specific data that can be utilized to educate the physician/department/division regarding outcomes.

13.4.11.3 Meetings: The Utilization Review Committee shall meet at least ten times a year and report its findings and recommendations to the Medical Executive Committee.

13.4.13 Electronic Medical Record Committee (EMRC)

13.4.13.1 The Electronic Medical Record Committee (EMRC) is a Medical Staff committee in charge of governance of the development of a comprehensive electronic medical record for patient care within and among the East Jefferson General Hospital medical community. This charge includes all facets of clinical applications within the inpatient medical record, COMPAS, as well as ancillary operations of COMPAS.

Within this charge also lies responsibility for identifying and improving those aspects of COMPAS which influence patient safety. Additionally, the EMRC is in charge of the development and maintenance of an EJGH sponsored outpatient electronic health record (EHR) for the use of the EJGH community.

13.4.13.2 The EMRC has the power of penultimate approval for computerized order sets within COMPAS. The committee will be in charge of guiding order set development, review and revision. Its approval of an order set will result in referral of the order set to the Medical Executive Committee (MEC) for final approval and official release.

The EMRC reports directly to the MEC via the Chief Medical Information Officer (CMIO).

13.4.13.3 Composition:
Medical staff members of the EMRC shall be eight (8) in number, not including the CMIO and the Medical Director. The medical staff members of the EMRC shall be members of the Active Medical Staff who display interest in a long term commitment to the governance and improvement of the COMPAS clinical functions.

Length of service will be 2 years. Appointment will be made by the Chief of Staff (COS). There is no limit to the overall length of service on the committee. No more than half of the physician membership will be allowed to turnover at any 2 year interval. Every effort will be made to have a diverse mixture of procedure and non-procedure oriented physicians as members. Missing more than 1/3 of the scheduled meetings is grounds for dismissal from the committee. Support staff of the EMRC will consist of the CIO, IT Applications Program Manager, IT Site Leader, IT COMPAS Application Manager, Physician Support Team Lead, Physician Support Analyst, , and the Director of HIM.

13.4.13.4 Meetings:
Frequency of EMRC meetings shall be determined by the CMIO, but no less than quarterly.

13.4.14 Cardiac Catheterization Committee

13.4.14.1 The Cardiac Catheterization Committee is a standing committee of the Medical Staff which develops the criteria for privileging of Medical Staff members for cardiac catheterization and related cardiac interventions and reviews the quality performance of the members who have been granted such privileges. It reports its recommendations regarding credentialing physicians for these privileges to the Credentials Committee. It reports quality findings to the Medical Staff Appropriateness of Care Committee.

13.4.14.2 **Composition**:
The committee shall consist of 8 physicians who have privileges in cardiac catheterization. The chairman and members shall be appointed by the Chief of Staff by January 1 each year.

13.4.14.3 **Duties**: The Cardiac Catheterization Committee shall:

13.4.14.3.1 Develop the credentialing criteria for granting and maintaining privileges of Medical Staff members for angioplasty and related intracoronary and cardiac interventions, electrophysiological testing and intervention, permanent pacemaker implantation, intra-aortic balloon pump placement and management, CPS assist pump, pericardiocentesis, and pulmonary arteriography.

13.4.14.3.2 Review annually the data and criteria for privileging in cardiac catheterization of each applicant requesting new privileges and each member seeking to maintain privileges.

13.4.14.3.3 Review each applicant for privileging and annually review the qualifications for continuing cath lab credentialing privileges.

13.4.14.3.4 Make recommendations to the Credentials Committee for any new criteria for privileging, any revisions of existing criteria for privileging, and any exceptions to the criteria for privileging.

13.4.14.3.5 Make recommendations to the Credentials Committee for granting privileges to any applicant who seeks to obtain privileges in the cardiac catheterization laboratory.

13.4.14.3.6 Make recommendations to the Credentials Committee regarding the annual re-credentialing of physicians who have already been granted privileges in cardiac catheterization.

13.4.14.3.7 Establish the performance standards for quality by physicians granted privileges in cardiac catheterization. These standards shall be forwarded for approval to the Medical Staff Appropriateness of Care Committee and the Medical Executive Committee.

13.4.14.3.8 Perform ongoing review of individual physician performance in cardiac catheterization as well as in other areas of practice as determined by the Medical Staff Appropriateness of Care Committee or the Medical Executive Committee.

13.4.14.3.9 Make recommendations based on physician performance reviews to the Medical Staff Appropriateness of Care Committee for quality issues and to the Medical Executive Committee

when requested by the Medical Executive Committee.

13.4.14.3.10 Make recommendations to the Hospital Administration regarding new equipment and procedure alterations.

13.4.14.3.11 Resolve scheduling conflicts when appropriate.

13.4.14.4 Meetings:
The committee shall meet at least quarterly but also as needed to comply with Medical Staff timetables for credentialing and re-credentialing.

13.4.15 Medical Staff Emergency Preparedness Committee

13.4.15.1 **Composition:**
The Medical Staff Emergency Preparedness Committee shall consist of at least five (5) members of the Medical Staff. . Reappointments shall be encouraged to maintain continuity and to accumulate expertise and knowledge. The Chair of the Emergency Preparedness Committee, in the event of a mobilization, cannot also serve as the Chief of Staff.

13.4.15.2 Duties: The Emergency Preparedness Committee shall:

13.4.15.2.1 Review and update the Medical Staff Emergency Preparedness plans annually

13.4.15.2.2 Develop Medical Staff Emergency Preparedness plan that have not yet been developed

13.4.15.2.3 Update Medical Staff on weather elated Emergency Preparedness plan annually and other plans as needed

13.4.15.2.4 Serve as an interface with the hospital Emergency Preparedness Committee and the Medical Staff as it relates to emergency preparedness

13.4.15.2.5 Coordinate the Emergency Medical Staff Emergency Preparedness Plan with the hospital's Emergency Preparedness Plan

13.4.15.2.5 Initiate the Medical Staff Emergency Preparedness Plans as written when needed.

13.4.15.3 Meeting:
At least quarterly and report its finding and recommendations to the Medical Executive Committee.

13.4.16 Peripheral Vascular Procedures Committee

13.4.16.1 The peripheral Vascular Procedures Committee is a committee of the Medical Staff which develops the criteria for privileging of Medical Staff members for peripheral vascular catheterization and related peripheral vascular interventions and reviews the quality performance of the members who have been granted such privileges. It reports its recommendations regarding credentialing for these procedures to the Credentials Committee. It reports quality findings to the Medical Staff Appropriateness of Care Committee.

13.4.16.2 **Composition:**
The committee shall consist of one member from each division of the Medical Staff that has privileges for peripheral vascular procedures. The chairman and members shall be appointed by the Chief of Staff.

13.4.16.3 **Duties:** The Peripheral Vascular Procedures Committee shall:

13.4.16.3.1 Develop the Credentialing criteria for granting and maintaining privileges of Medical Staff members for peripheral vascular (non-cardiac) catheterization and related procedures.

13.4.16.3.2 Make recommendations to the Credentials Committee for any new criteria for privileging, any revisions of existing criteria for privileging, and any exceptions to the criteria for privileging for peripheral vascular catheterization and related procedures.

13.4.16.3.3 Establish the performance standards for quality by physicians granted privileges in peripheral vascular catheterization and related procedures. These standards shall be reviewed annually and forwarded to the Medical Staff Appropriateness of Care Committee.

13.4.16.3.4 Perform ongoing peer review and utilization review of individual physician performance in peripheral vascular catheterization and related procedures as well as in other areas of practice as determined by the Medical Staff Appropriateness of Care Committee.

13.4.16.3.5 Make recommendations based on physician quality performance reviews to the Medical Staff Appropriateness of Care Committee.

13.4.16.3.6 Make recommendations based on physician utilization reviews to the Medical Staff Utilization Review Committee.

13.4.16.3.7 Make recommendations to the Hospital Administration regarding new equipment for performance of peripheral vascular catheterization and related procedures.

13.4.16.4 **Meetings**: The committee shall meet as needed.

13.4.17 ICU Committee

13.4.17.1 Composition:
The ICU Committee will be a medical staff committee composed of physicians only and shall consist of the ICU Medical Director and a second Pulmonologist/Critical Care physician as well as three (3) members of the Department of Surgery and three (3) members of the Department of Medicine as appointed by the Chief of Staff. Non-voting members will consist of the Critical Care Director, Critical Care Educator, Critical Care Clinical Pharmacist and Director of Care Management. Other physicians or departments may be called upon in an ad-hoc capacity as non-voting members.

13.4.17.2 Duties:
The ICU Committee shall:

13.4.17.2.1 Discuss and vote on any proposed changes within ICU/CCU.
13.4.17.2.2 Discuss and ensure education is being provided by the Critical Care Director/Educator as needed.
13.4.17.2.3 Review any cases where peer review would be beneficial for critical care team as a learning experience.
13.4.17.2.4 Evaluate staffing and equipment needs and set action plans as needed.

13.4.17.3 Meetings:
The ICU Committee shall meet at least quarterly and report its findings and recommendations to the Medical Executive Committee.

14.0 LEADERSHIP TRAINING

Medical Executive Committee members, Department Chairs and Division Chiefs are expected to have and document current leadership training during each year of their service. The Hospital and Medical Staff will share the expense for on-site training once a year. Those unable to attend on-site training may attend an appropriate off-site program or an on-line course. Department Chairs and Officers of the Medical Staff are strongly encouraged to attend an off-site program. Expenses for off-site programs will be shared by the Hospital and the Medical Staff and reimbursed consistent with current hospital policy for continuing education.

15.0 MEDICAL STAFF DUES

Each year the Medical Executive Committee, with the approval of the General Staff, will decide the dues for each category, when the dues are due, and when the dues are delinquent.

Special consideration for exemption of payment of Staff dues will be given to any physician who is unable to pay Staff dues because of financial hardship.

Applications for Staff privileges to East Jefferson General Hospital must be accompanied by a check for dues before the application is considered.

Reappointments to the Medical Staff are conditional upon payment of dues.

16.0 ADOPTION

16.1 MEDICAL STAFF

These Rules and Regulations were approved and adopted by the Active Medical Staff on June 1, 2004.

16.2 BOARD OF DIRECTORS

These Rules and Regulations were approved and adopted by the Board of Directors on the recommendation of the Active Medical Staff on June 3, 2004.

17.0 BOARD APPROVAL ON REVISIONS

February 9, 1982
March 2, 1982
March 16, 1982
December 7, 1982
December 21, 1982
March 1, 1983
April 26, 1983
September 27, 1983
***September 24, 1991**
December 16, 1991
June 23, 1992
September 22, 1992
December 22, 1992
March 26, 1997
March 21, 2001
March 20, 2002
September 25, 2002
March 26, 2003
***June 3, 2004**
July 26, 2006
September 27, 2006
November 28, 2007
December 17, 2008
April 22, 2009
August 26, 2009
March 24, 2010
January 26, 2011
December 2011
September 2012
May 2013
March 24, 2015
August 26, 2015
December 21, 2016
July 26, 2017

***Major revision**