MEDICAL STAFF ORGANIZATION MANUAL

HSHS HOLY FAMILY HOSPITAL GREENVILLE, ILLINOIS
an Affiliate of
Hospital Sisters Health System

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated.

1.C. DELEGATION OF FUNCTIONS

Functions assigned to an identified individual or committee may be delegated to one or more designees.

ARTICLE 2

CLINICAL DEPARTMENTS

2.A. CLINICAL DEPARTMENTS

The Medical Staff will be organized into the following departments:

(1) Medicine; and

(2) Surgery/Anesthesia

Subspecialties may be organized as a section of a clinical department and will be directly responsible to the clinical department within which it functions.

2.B. FUNCTIONS AND RESPONSIBILITIES OF CLINICAL DEPARTMENTS

The functions and responsibilities of departments and department chairs are set forth in Article 4 of the Medical Staff Bylaws.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees that carry out, among other things, ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board. The standing committees of the Medical Staff include the Bylaws Committee, Credentials Committee, Medical Staff Executive Committee, Surgery/Anesthesia Committee, Medical Staff Quality Committee, and Peer Review Committee. Members of the Medical Staff may also be invited to participate on Hospital committees, which include, but are not limited to, the additional committees listed herein.

(2) Procedures for the appointment of committee chairpersons and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

3.B. DUTIES, MEETINGS, REPORTS, AND RECOMMENDATIONS

(1) At a minimum, each committee will perform the duties set forth below and any additional duties which may be assigned by the Medical Staff Executive Committee.

(2) Unless otherwise stated in this Manual or the Medical Staff Bylaws, each Medical Staff committee will meet as often as necessary to fulfill its duties and will make a report or submit minutes to the Medical Staff Executive Committee and the Chief Executive Officer. Each committee may report directly to the Medical Staff Executive Committee, for its consideration and appropriate action, any situation involving questions of clinical competency, patient care and treatment, case management, professional ethics, infraction of Hospital or Medical Staff Bylaws, policies or rules, or unacceptable conduct on the part of any individual member of the Medical Staff.

3.C. BYLAWS COMMITTEE

3.C.1. Composition:

The Bylaws Committee will consist of at least two persons appointed from the Active Staff. The Chief Executive Officer and Chief Nursing Officer shall serve on the committee, *ex officio*, without vote.

3.C.2. Functions:

The Bylaws Committee will perform the following functions:

(a) annually review the Medical Staff Bylaws, Rules and Regulations, and other associated documents and make recommendations as appropriate to the Medical Staff Executive Committee to ensure that current Medical Staff practices are stated and that the documents comply with relevant laws, regulations, and accreditation standards;

(b) receive and consider all recommendations for changes in these documents made by the Board, any committee of the Medical Staff, any individual appointed to the Medical Staff, and the Chief Executive Officer; and

(c) formulate recommendations on such matters as may be referred to it by the Board, Quality Care Committee, the Medical Staff Executive Committee, or the Chief Executive Officer.

3.D. CREDENTIALS COMMITTEE

3.D.1. Composition:

The Credentials Committee will consist of at least two (2) Active members of the Medical Staff. The Chief Executive Officer, Chief Nursing Officer, and Chief Medical Officer shall also serve on the Committee, *ex officio*, without vote.

3.D.2. Functions:

The Credentials Committee will perform the following functions:

(a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, perform investigations of and interviews with applicants as may be necessary, and report its findings and recommendations;

(b) review the credentials of all applicants for Allied Health Staff appointment, perform investigations of and interviews with applicants as may be necessary, and report its findings and recommendations in accordance with the Credentials Policy;

(c) review, as may be requested by the Medical Staff Executive Committee, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff and/or granted privileges and, as a result of such review, make a report of its findings and recommendations; and

(d) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.A.5 (“Clinical Privileges for New Procedures”) and Section 4.A.6 (“Clinical Privileges That Cross Specialty Lines”) of the Credentials Policy.

3.E. MEDICAL STAFF QUALITY COMMITTEE

3.E.1. Composition:

The Medical Staff Quality Committee (MSQC) will include at least three members of the Medical Staff, including representation from the Department of Medicine, Department of Surgery/Anesthesia, and the Emergency Department.

3.E.2 Functions:

The MSQC will perform the following functions:

PHARMACY and THERAPEUTICS

Pharmacy and Therapeutics review will include the following functions:

(a) annually review pharmacy policy and procedures;

(b) review appropriateness of empiric and therapeutic use of drugs through the analysis of individual or aggregate patterns of drug practice;

(c) develop and recommend to the Medical Staff Executive Committee rules and regulations relating to the selection, distribution, handling, use, and administration of drugs in the Hospital;

(d) review and analyze all medication errors and recommend policies and procedures to prevent and reduce the same;

(e) review all significant drug reactions;

(f) develop and periodically review and update the Hospital formulary;

(g) review the appropriateness, safety, and effectiveness of the prophylactic, empiric, and therapeutic use of antibiotics in the Hospital;

(h) inform the Medical Staff and nursing care personnel of any changes in the Hospital formulary, development of standard dosing or drug monitoring protocols, and recent problems with dosing, interactions, and inappropriate use of drugs;

(i) promote educational programs on drugs and drug therapy for the Medical Staff, nursing care personnel, and other appropriate personnel; and

(j) establish guidelines for the education, in-service training and supervision of all individuals administering drugs in the Hospital; and

(k) as necessary, develop or review control and reporting procedures for investigational

or experimental drug use in the Hospital.

UTILIZATION REVIEW

The MSQC will review actions and recommendations of the Hospital Utilization Review Committee and assist in implementation of any recommendations.

INFECTION CONTROL

Infection control review will include at least the following:

(a) annually review infection control policies and procedures;

(b) supervise infection control in all phases of the Hospital's activities through surveillance of Hospital infection potentials;

(c) recommend to Hospital Management, Nursing Service, and the Medical Staff, through reports to the Medical Staff Executive Committee, educational programs based on needs assessment determined by its monitoring activities;

(d) review and analyze actual infections;

(e) promote an ongoing preventative and corrective program designed to minimize infection hazards; and

(f) submit written reports at least quarterly to the Medical Staff Executive Committee on the committee's activities and on the quality of care reflected by the committee's activities.

EMERGENCY DEPARTMENT

Review of Emergency Department services will include at least the following:

(a) annually review, monitor for compliance, and recommend for implementation policies and procedures for medical care operation of the emergency department;

(b) review, analyze, and evaluate the quality of medical care rendered in the emergency department;

(c) formulate policies and procedures for the review, analysis, and evaluator of the quality of emergency medical records;

(d) determine the guidelines for clinical practice of the members of Emergency Department;

(e) review the clinical work performed by the members of the Emergency Department to determine the extent to which it conforms to or deviates from the medical appropriateness guidelines:

(f) make recommendation to the Medical Staff Committee on matters pertaining to the establishment and enforcement of medical appropriateness guidelines for the provision of emergency services.

(g) Make recommendations to the Medical Staff Committee on medical education that has been attained by members of the Emergency Department and Hospital staff and that may be required to improve the quality of care rendered by the Department.

SURGICAL-PATHOLOGY-TRANSFUSION

The Surgical-Pathology-Transfusion review will include at least the following:

(a) review the clinical practice of blood and blood product utilization and transfusions within the Hospital and evaluate variations based on pre-determined guidelines;

(b) annually review and recommend to the Medical Staff Executive Committee appropriate guidelines for whole blood, blood component, and blood product utilization and policies relating to blood transfusions and the preparation and handling of blood within the Hospital;

(c) provide the nursing service and Medical Staff with education on the changes in clinical or pathological laboratory testing or changes in lab/blood usage by way of written communication to Medical Staff members, minutes sent to the meetings

of the Medical Staff or oral report to Medical Staff members at a scheduled meetingof the Medical Staff; and

(d) investigate all transfusion reactions occurring in the Hospital and make recommendations to the Medical Staff Executive Committee on policies and procedures to reduce transfusion reactions.

QUALITY/RISK MANAGEMENT

Quality and Risk Management review will include at least the following:

The Quality/Risk Management Committee will support leaders in planning, implementing, and evaluating performance improvement activities. This portion of the MSQC's review reflects commitment by the ministry to objectively and systematically monitor and evaluate the quality and appropriate delivery of patient care, treatment, and services, and their associated outcomes consistent with the mission, vision and values of the Hospital SistersHealth System.

The MSQC will submit written reports to the Medical Staff Executive Committee on a monthly basis on the committee's activities and on the quality of care reflected by the committee's activities.

3.F. MEDICAL STAFF EXECUTIVE COMMITTEE

The composition, functions, and requirements for meetings of the Medical Staff Executive Committee are included in Section 5.B of the Medical Staff Bylaws.

3.G. SURGERY/ANESTHESIA COMMITTEE

3.G.1. Composition:

The Surgery/Anesthesia Committee will consist of Active Staff with privileges in Surgery and Anesthesia. The committee will also include the OR Medical Director, CRNAs practicing at the Hospital, Director of Surgery, Director of Quality, and other consultants/staff as may be appropriate. A minimum of one active medical staff member shall sit on this Committee.

3.G.2. Functions:

The Surgery/Anesthesia Committee will meet quarterly and will perform the following functions:

(a) formulate policies and procedures for anesthesia and surgery services and annually evaluate them;

(b) analyze and evaluate the quality, timely completion, and completeness of the surgical portion of medical records;

(c) determine the guidelines for clinical surgical practice that each member with privileges in surgery is expected to meet;

(d) recommend to the Credentials Committee guidelines to be used in assignment and reappointment of surgical privileges;

(e) review the clinical work done in surgery to determine the extent to which it conforms to or deviates from the pre-determined guidelines;

(f) make recommendations to the Medical Staff Executive Committee on matters pertaining to the establishment and enforcement of medically appropriate guidelines of care and medical education to ensure the continuing improvement of the quality of care rendered by the Surgery/Anesthesia Department;

(g) submit written reports at least quarterly to the Medical Staff Executive Committee on the committee's activities and on the quality of care reflected by the committee's activities.

3.H. PEER REVIEW COMMITTEE

3.H.1. Composition:

The Peer Review Committee will consist of one member of Active Medical Staff. The committee will also include the Chief Nursing Officer, Director of Quality, and other staff as appropriate.

3.H.2. Functions:

The Peer Review Committee will meet on an as needed basis.

ARTICLE 4

AMENDMENTS

The process for amending this Medical Staff Organization Manual is set forth in Section 8 of the Medical Staff Bylaws.

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Adopted by the Medical Staff on:

Date: _____

_____
President of the Medical Staff

Approved by the Board on:

Date: _____

_____
Chairperson, Board of Directors