

**SOUTH SHORE HOSPITAL
MEDICAL STAFF
BYLAWS/ORGANIZATION & FUNCTION MANUAL**

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SECTION 1: FUNCTIONS OF THE STAFF

1.1 GENERALLY

The required functions of the staff are as described in Section 1.2 below. The medical staff officers, department, or committee chairs that are responsible for each of the activities to be carried out in accomplishing a function are identified in parentheses following the description of the activity.

The medical staff of South Shore Hospital shall be organized as a departmentalized staff including surgery, medicine, neurology, family practice, OB/GYN, pediatrics, orthopedics, anesthesiology, pathology, emergency medicine, radiology/medical imaging and critical care. A chairperson shall head each clinical department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the Medical Executive Committee.

1.2 DESCRIPTION OF MEDICAL STAFF FUNCTIONS

1.2.1 Governance, direction, coordination, and action

- (a)** Receive, coordinate and act upon, as necessary, the reports and recommendations from departments, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities. (Medical Executive Committee and certain medical staff committees)

- (b)** Account to the Board of Directors and to the staff by written recommendations for the overall quality and efficiency of patient care at South Shore Hospital. (President and Medical Executive Committee)

- (c)** Take reasonable steps to obtain professional and ethical conduct and initiate investigations, and pursue corrective action of medical staff

members, when warranted. (President of the Medical Staff and Medical Executive Committee)

(d) Make recommendations on medico-administrative and hospital clinical and operational matters. (President of the Medical Staff and Medical Executive Committee)

(e) Inform the medical staff of the accreditation program and the accreditation and state licensure status of the hospital. (President of the Medical Staff and Medical Executive Committee)

(f) Act on all matters of medical staff business, and fulfill any state and federal reporting requirements. (Medical Executive Committee and certain staff committees)

1.2.2 Medical care evaluation / Performance Improvement (Quality Council)(The Quality Council is a multidisciplinary committee that includes members of the Medical Staff. The Quality Council guides the development, implementation and evaluation of the hospital's quality and safety initiatives. The Quality Council assures there is adequate follow through when opportunities are identified for improvement. It also assures that local success in problem resolution and system enhancements are implemented in other applicable areas of the organization.)

1.2.3 Monitoring activities (Medical Staff Peer Review Committee, Quality Council)

1.2.4 Utilization management

1.2.5 Credentials review (Department chairs, Credentials Committee, Medical Executive Committee)

1.2.6 Information management

- (a)** Review and evaluate medical records to determine that they:
 - (1)** Properly describe the condition and progress of the patient, the therapy, the tests provided and the results thereof, and the identification of responsibility for all actions taken. (Medical Records Committee)
 - (2)** Are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the hospital. (Medical Records Committee)
- (b)** Develop, review, enforce, and maintain surveillance periodically over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein. (Medical Records Committee for review and enforcement of timeliness rules, forms, and policy, etc.)
- (c)** Provide liaison with hospital administration, nursing service, and medical record professionals in the employ of the hospital on matters relating to medical records practices and information management planning. (Medical Records Committee)

1.2.7 Emergency preparedness

- (a)** Assist the hospital administration in developing, periodically reviewing, and implementing a crisis management manual that addresses disasters both external and internal to the hospital. (President of the Medical Staff and Medical Executive Committee)

1.2.8 Planning

- (a)** Participate in evaluating existing programs, services, and facilities of the hospital and medical staff; and recommend continuation,

expansion, abridgment, or termination of each. (President of the Medical Staff, Medical Executive Committee, department chairs)

(b) Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities of services and needs and allocation of present and future resources. (President of the Medical Staff, Medical Executive Committee, department chairs)

(c) Communicate strategic, operations, capital, human resources, information management, and corporate compliance plans to medical staff members. (President of the Medical Staff, Medical Executive Committee, department chairs, and first vice president)

1.2.9 Nominating

(a) Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure. (Medical Executive Committee)

(b) In accomplishing (a), consults with members of the staff, the Medical Executive Committee, and Administration concerning the qualifications and acceptability of prospective nominees of the medical staff and the hospital.

1.3 RESPONSIBILITIES OF DEPARTMENT CHAIRS

The responsibilities of the department chairs shall be:

(a) To oversee all clinically related activities of the department.

(b) To oversee all administratively related activities of the department unless otherwise provided for by the South Shore Hospital.

- (c) To provide ongoing surveillance of the performance of all individuals in the medical staff department who have been granted clinical privileges.
- (d) To ensure that all individuals in the medical staff department practice in a professional, ethical and competent manner.
- (e) To recommend to the medical staff Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the medical staff department.
- (f) To recommend clinical privileges for each member of the department and licensed independent practitioners.
- (g) To assess and recommend to the Medical Executive Committee and hospital administration of South Shore Hospital off-site sources for needed patient care services not provided by the medical staff department or the hospital.
- (h) To monitor and evaluate the quality and appropriateness of patient care provided in the medical staff department and to implement action following review and recommendations by the Medical Staff Peer Review Committee, Quality Council, and/or the Medical Executive Committee.
- (i) To integrate the department into the primary functions of the hospital.
- (j) To coordinate and integrate interdepartmental and intradepartmental services and communication.
- (k) To participate in every phase of administration of the department through cooperation with nursing services and hospital administration in matters affecting patient care.

- (l) To develop and implement medical staff and hospital policies and procedures that guide and support the provision of patient care, treatment and services.
- (m) To recommend to the hospital administrator the sufficient numbers of qualified and competent persons to provide patient care, treatment and services.
- (n) To determine and provide input to the hospital administrator regarding the qualifications and competence of department personnel who are not licensed independent practitioners such as nurse practitioners, physician assistants, certified nurse midwives, registered nurse first assistants, and certified registered nurse anesthetists who are granted privileges to provide patient care, treatment and services and are not members of the medical staff.
- (o) To oversee the orientation and continuing education of all persons in department and services.
- (p) To make recommendations to the Medical Executive Committee and the hospital administrator for space and other resources needed by the medical staff department to provide patient care services.
- (q) To provide continuous assessment and improvement of the quality of care, treatment and services.
- (r) To maintain quality control programs, as appropriate.

1.4 RESPONSIBILITIES OF MEDICAL STAFF OFFICERS

1.4.1 President of the Medical Staff responsibilities: The President of the Medical Staff is the primary elected officer of the medical staff and is the medical staff's advocate and representative in its relationships to the

Board of Directors and the administration of the hospital. The President of the Medical Staff, jointly with the Medical Executive Committee, provides direction to and oversees medical staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the medical staff as outlined in the Medical Staff Bylaws, the Credentials Procedure Manual, the Organization and Functions manual, and the Medical Staff Rules and Regulations. Specific responsibilities and authority are to:

- (a)** Call and preside at all general and special meetings of the medical staff
- (b)** Serve as chair of the Medical Executive Committee and as ex officio member of all other medical staff committees without vote, and to participate as invited by the Board of Directors and the hospital administrator on hospital or Board of Directors committees
- (c)** Enforce Medical Staff Bylaws, the Credentials Procedure Manual, the Organization and Functions Manual, Medical Staff Rules and Regulations, hospital policy
- (d)** Approve the appointment of the department chairpersons, committee chairpersons, and all members of the medical staff standing and ad hoc committees; in consultation with hospital administration, appoints medical staff members to appropriate hospital committees; in consultation with the chair of the Board of Directors, appoint the medical staff members to appropriate Board of Directors committees when those are not designated by position or by specific direction of the Board of Directors or otherwise prohibited by state law
- (e)** Support and encourage medical staff leadership and participation on the interdisciplinary clinical performance improvement activities
- (f)** Report to the Board of Directors the Medical Executive Committee's recommendations concerning appointment, reappointment,

delineation of clinical privileges or specified scope services, and corrective action with respect to practitioners or allied health professionals who are applying for appointment or privileges or scope of services, or who are granted privileges or providing specific services in the hospital

- (g) Continuously evaluate and periodically report to the hospital, Medical Executive Committee, and the Board of Directors regarding the effectiveness of the credentialing and privileging processes
- (h) Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the medical staff in their relations with each other, the Board of Directors, the hospital management, other professional and support staff, and the community the hospital serves
- (i) Communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the Medical Executive Committee, and the Board of Directors
- (j) Attend Board of Directors meetings; attend Board of Directors committee meetings as invited by the Board of Directors
- (k) Ensure that the decisions of the Board of Directors are communicated and carried out within the medical staff
- (l) Perform such other duties, and exercise such authority commensurate with the office as are set forth in the medical staff bylaws

SECTION 2: PROFESSIONAL STAFF COMMITTEES

2.1 DESIGNATION

2.1.1 There will be a Medical Executive Committee as designated in the bylaws and the following committees as determined by and responsible to the

Medical Executive Committee: Bylaws Committee, Cancer Committee, Continuing Medical Education Committee, Credentials Committee, Critical Care Committee, Infection Control Committee, Medical Records Committee, OR Committee, Medical Staff Peer Review Committee, Pharmacy and Therapeutics Committee, Trauma Program Operational Process Performance Committee, and Trauma Services Peer Review Committee.

2.1.2 The principles governing committees are provided in the Medical Staff Bylaws. The President of the medical staff will appoint the chairs and members of ad hoc and/or standing medical staff committees.

2.2 MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the Medical Executive Committee are as set forth in the Medical Staff Bylaws. In addition, the Medical Executive Committee supervises overall medical staff compliance with accreditation and other state and federal regulatory requirements applicable to the medical staff.

2.3 CREDENTIALS COMMITTEE

A. Composition: The Credentials Committee shall be a standing committee comprised of one member of the Board of Directors, Executive Vice President/Chief Operating Officer of the Hospital, Vice President of Regulatory Affairs/Chief Risk Office, Vice President of Nursing/Chief Nursing Officer, members of the Active Medical Staff selected on a basis that will ensure representatives of all major clinical specialties and such additional representatives as may be desired from time to time. The Chairman of the Credentials Committee shall be the Hospital's Senior Vice President/Chief Medical Officer, a member of the Active Medical Staff. The Vice Chairman of the Committee shall be appointed by the President of the Medical Staff after consultation with the Chairman of the Credentials Committee. The President of the Medical Staff shall appoint the physician

members of the Committee. All members of the Credentials Committee shall have voting privileges.

B. Meetings: The committee shall meet on call of the Chair or the President of the Medical Staff.

C. Tenure: Members of the committee shall be appointed for a term of one year.

D. Responsibilities: The responsibilities of the Credentials Committee are as follows:

1. To review and recommend action on all applications and reapplications for membership and status on the South Shore Hospital medical staff
2. To review and recommend action on all requests for privileges for practitioners granted clinical privileges at South Shore Hospital
3. To recommend criteria for the granting of medical staff membership and clinical privileges for South Shore Hospital
4. To develop, recommend, and consistently implement contemporary policy and procedures for all credentialing activities at South shore Hospital

E. Confidentiality: This committee shall function as a peer review committee consistent with federal and state law. All members of the Credentials Committee shall, consistent with the medical staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee. A separate credentials file for each applicant will be maintained in the Medical Staff Office.

2.4 MEDICAL STAFF PEER REVIEW COMMITTEE

- A. Composition:** The Medical Staff Peer Review Committee shall be a standing committee of the Medical Staff and should consist of the Hospital's Senior Vice President/Clinical Affairs and physicians selected to ensure representation of all Medical Staff Departments.
- B. Tenure:** Members of the committee shall be appointed for a one-year term.
- C. Duties:** The Medical Staff Peer Review Committee reviews, evaluates, and monitors the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. The Medical Staff Peer Review Committee refers issues, reports and recommends actions to the Chairman of the appropriate Department. All department peer review committees and Trauma Peer Review Committee will report to the Medical Staff Peer Review Committee. The Medical Staff Peer Review Committee reports to the Executive Committee.
- D. Meeting:** Regular meetings of the Medical Staff Peer Review Committee may be held as often as the Chair decides. Also, the committee may meet on call of the Chair or President of the Medical Staff.

2.5 CANCER COMMITTEE

- A. Composition:** The Cancer Committee shall be multidisciplinary with required members as appropriate to the institution to maintain Certification by the American College of Surgeons Commission on Cancer as a Community Hospital Cancer Program.
- B. Tenure:** Members of the committee shall be appointed for a one-year term,
- C. Meetings:** The committee shall meet at least quarterly and on call of the Chair or the President of the Medical Staff.

D. Responsibilities: The Cancer committee provides program leadership with duties as described in the Standards of the Commission on Cancer.

2.6 PHARMACY/THERAPEUTICS COMMITTEE

A. Composition: The committee shall consist of at least four (4) members of the medical staff. Representatives from pharmacy, nursing service and hospital administration will serve as ex-officio members.

B. Tenure: Members of the committee shall be appointed for a term of one year.

C. Meetings: The committee shall meet quarterly and on call of the Chair or President of the Medical Staff.

D. Responsibility: The committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the hospital. The committee shall assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety, procedures, and all other matters relating to drugs in the hospital. The committee shall be charged with implementation of review of clinical use of antibiotics, including prophylactic use of antibiotics.

2.7 INFECTION CONTROL COMMITTEE

A. Composition: The Infection Committee shall be a multidisciplinary with representatives from the medical staff departments, Administration, Nursing Service, and other key services. The medical staff shall include one (1) representative from each clinical department.

B. Tenure: The members shall be appointed for a one-year term.

C. Meetings: Regular meeting of the Infection Control Committee may be held as often as the Chair decides. Also, the committee may meet on call of the Chair or President of the Medical Staff.

D. Responsibility: The committee shall be responsible for the development and maintenance of a protocol that will insure constant surveillance of all potential sources of hospital infections. The committee will review and analyze infections occurring in the hospital. A report of infections, their outcomes and recommendations shall be made to the Medical Executive Committee.

2.8 ACCREDITATION/BYLAWS COMMITTEE

A. Composition: The Accreditation/Bylaws Committee shall consist of five (5) members of the medical staff, two of whom shall be the past-president and first vice president.

B. Tenure: Members of the committee shall be appointed for a term of one year. Consideration will be given to reappointment of two members to a second term for continuity.

C. Meetings: The committee shall meet on call of the Chair or President of the Medical Staff.

D. Responsibility: The committee shall be responsible for ascertaining that all services in the hospital meet the standards set by the Joint Commission on Accreditation of Hospitals, including incorporating these standards into the medical staff bylaws. The committee further shall be responsible for effecting changes recommended by the Joint Commission. The committee is charged with annual review of the Medical Staff Bylaws for any needed amendments, revisions, and rewriting.

2.9 CRITICAL CARE COMMITTEE

A. Composition: The Critical Care Committee shall consist of not less than three (3) members of the medical staff and one member of the nursing staff.

B. Tenure: Members of the committee shall be appointed for a term of one year.

C. Meetings: The committee shall meet quarterly and on call of the Chair or President of the Medical Staff.

D. Responsibility: The committee has the responsibility for continuing professional supervision of Coronary Care, Intensive Care, and Post Critical Care Units. The committee will review the treatment of individual cases, and may suggest that attending physicians seek consultations when appropriate. The committee will establish an in-service teaching program for hospital personnel and medical staff associated with these special care units.

2.10 MEDICAL RECORDS COMMITTEE

A. Composition: The Medical Records Committee shall consist of a chairperson appointed by the President of the Medical Staff and shall be responsible for general supervision over all medical records and shall meet for review and consideration of medical record problems. The Committee will propose rules and regulations designed to promote the proper keeping of records. These rules once approved by the Medical Executive Committee shall be enforced by the medical staff department chairpersons. Members of the committee will represent different services of the medical staff, ancillary representation, nursing representation, nursing education representation, risk prevention and or compliance representation, other hospital staff as designated by the committee shall consist of at least seven (7) representatives from the Medical Staff and one each from the

Nursing Service and from Hospital management. The Medical Record Director shall be a member of this committee and may be delegated to act as its secretary.

B. Tenure: Members of the committee shall be appointed for a term of one year.

C. Duties: The Medical Records Committee shall be responsible for advising the Medical Executive Committee on appropriate policies and standards for the maintenance and timely completion of medical records, assuring that all medical records reflect realistic documentation of the medical events. The committee shall conduct a monthly review of currently maintained medical records to assure that they properly describe the condition and progress of the patient, the therapy provide, the results thereof, and the identification of responsibility for all actions taken, and that they sufficiently complete at all times so as to meet the criteria of medical comprehension of the case in the event of transfer of physician responsibility for patient care. It shall also conduct a review of record of discharge patients to determine the promptness, pertinence, adequacy and completeness thereof. Communicate chart review results to appropriate medical staff department chairpersons and other appropriate hospital staff. Recommend and approve of the format and placement for all forms appearing in the medical record. Develop and maintain an approved abbreviation list. Assure compliance with State and Federal laws pertaining to documentation of the medical record and release of information. In addition assure compliance with medical record documentation for other regulatory agencies.

D. Meetings: The committee shall meet quarterly and on call of the Chair or President of the Medical Staff.

2.11 CONTINUING MEDICAL EDUCATION (CME)

- A. Composition:** The CME Advisory Committee shall be multidisciplinary with required members to be consistent with the recommendations of the ACCME. The Director of Medical Education will be a member of the Committee.
- B. Tenure:** The members shall be appointed for a one-year term.
- C. Meetings:** The committee shall meet quarterly.
- D. Responsibilities:** The CME Advisory Committee provides program leadership.

2.12 OR COMMITTEE

- A. Composition:** The Chairperson of the OR Committee shall be the Chairperson of Surgery, and the Vice-Chairperson shall be appointed from the Department of Anesthesiology. The Committee shall be composed of representatives from different surgical specialties, anesthesiology, nursing services and administration.
- B. Tenure:** Members of the committee shall be appointed for one-year term by the President of the Medical Staff.
- C. Meetings:** The Committee shall meet at least quarterly and on call of the Chair or the President of the Medical Staff.
- D. Responsibilities:** The OR Committee shall review functions within the surgical area and recommend additions or changes in policy or rules when indicated.

2.13 Reserved (the IRB now reports to the Sr. Vice President/CMO)

2.14 TRAUMA PROGRAM OPERATIONAL PROCESS PERFORMANCE COMMITTEE (TPOPPC)

Trauma Program Operational Process Performance Committee (TPOPPC) shall be a standing committee of the Medical Staff and, the Director of Trauma Services or designee will preside over the meeting. Performance Improvement reports will be presented to the Department of Surgery and the Medical Executive Committee.

A. PURPOSE

The purpose of the TPOPPC is:

- To establish a multidisciplinary approach in providing and improving care to the injured patient,
- To establish performance standards for the trauma service
- To establish clinical standards for care of the injured patient
- To review the performance of the trauma program
- To identify deficiencies in the system
- To find process improvement/problem solving opportunities
- To provide peer review by TPOPPC
- To achieve cost effective, optimal clinical outcomes.
- To provide educational opportunities
- To monitor departmental and hospital compliance with American College of Surgeons Committee on Trauma (ASC COT) guidelines for optimal care of the injured patient.

The responsibilities of the TPOPPC shall be to record minutes of proceedings, evaluate system issues related to quality of care, monitor clinical outcomes, evaluate and monitor utilization of resources, develop and issue policies and procedures, recommend trauma related educational programs based on the results of its evaluation of trauma care and programs on trauma prevention for the community, recommend system improvements, review trauma registry and trend analysis, and support hospital compliance with ACS COT guidelines and the ACS verification processes.

B. COMPOSITION

The members of the TPOPPC shall be Director of Trauma Services, as Chairperson. Core members include: Chairs of Surgery and Emergency Medicine and Chair of Critical Care or designee, a medical staff member from each of the following disciplines: Anesthesiology, Emergency Medicine, Neurosurgery, Orthopedics, Pediatrics, Surgery, Rehabilitation Radiology and Hospitalist/Medicine, Nurse Directors/Managers of the following departments: Emergency Department, Radiology, SICU, Surgery, Quality Management, Trauma Program Manager, Injury Prevention Coordinator, the Trauma Registrar, and Hospital Administration. Additional members include: representatives from Clinical Education, Case Management, Respiratory, Laboratory, Emergency-Preparedness representative, and EMS representative.

Members are to recognize the meeting as a peer review proceeding and as such agree to comply with hospital and medical staff rules and regulations in regards to confidentiality of these proceedings. They will receive/review minutes at the beginning of each meeting and leave minutes for collection at end of meeting. Members will act as a trauma liaison to their department/division and actively participate in trauma related performance improvement activities.

C. MEETINGS

The TPOPPC will be a monthly standing meeting. It will be conducted as a medical peer review proceeding, maintaining confidentiality of proceedings, records and minutes. The TPOPPC will document the appropriate action taken to correct the deficiencies. Core members are required to attend a minimum of 50% of scheduled meetings. Attendance will be recorded. Minutes will be recorded and distributed to the committee members for their review at the next meeting. They will also be copied and distributed to the Medical Executive Committee. A quorum will be a majority of members present and the affected discipline.

2.14 TRAUMA SERVICES PEER REVIEW COMMITTEE (TSPRC)

The Trauma Services Peer Review Committee (TSPRC) shall be a standing committee of the medical Staff and the findings of the Committee will be reported to the Department of Surgery or Department of Orthopedics, Medical Executive Committee and Medical Staff Peer Review Committee if indicated.

A. COMPOSITION: The members of the TSPRC shall be the Director of Trauma Services as chairperson, all surgeons taking call for trauma, a physician from each of the following departments: Emergency Medicine, Orthopedics, Neurosurgery, Anesthesiology, Radiology, specialists invited as deemed necessary, Administration representative, the Trauma Program Manager, and the Injury Prevention Coordinator.

All surgeon members and department designees are to attend a minimum of 50% of scheduled meetings. They are to recognize this meeting as a peer review proceeding and as such, agree to comply with hospital and medical staff rules and regulations in regards to confidentiality of these proceedings. Members are to actively participate in the proceedings and to refer issues to the appropriate chair, department or to the TPOPPC.

B. RESPONSIBILITIES: The responsibilities of the TSPRC shall be:

- to record minutes of proceedings
- conduct meeting as a medical peer review proceeding, maintaining confidentiality of proceedings
- review, evaluate and discuss the quality of care in cases of adverse outcome, including complications and deaths
- focus on those deaths, statistically expected to survive
- refer issues to the appropriate department chair or manager

- refer system issues to the TPOPPC.

C. MEETINGS: The TSPRC will be a monthly meeting usually conducted before the TPOPPC meeting. It will be conducted as a medical peer review proceeding, maintaining confidentiality of proceedings, records and minutes. It will document the appropriate action taken to correct the deficiencies. Attendance will be recorded and minutes will be recorded and distributed to the committee members for their review at the next meeting. A quorum will be a majority of the members present.

2.15 BLOOD UTILIZATION REVIEW COMMITTEE

A. **Composition:** The Blood Utilization Review Committee (BURC) membership will include:

Representation from the medical staff: Hematology, Pathology, Medicine, Surgery, Obstetrics/Gynecology, Anesthesiology, Emergency Medicine and representation from hospital services: Manager of Blood Bank and Support Services, Supervisor of the Blood Bank, Quality Management and Nursing.

B. **Duties:** The Blood Utilization Review Committee is responsible for the blood utilization review process including activity reports, Quantros-generated incident report data, case review, recommendations and follow-up as indicated. The Blood Bank is responsible for the preliminary review of all blood and blood product transfusions and provisions of the Blood Bank Monthly Activity Report. The Blood Utilization Review Committee will:

1. Provide for the systematic, objective review of transfusions and the use of blood and blood products in the hospital.

2. Assist in the promotion and maintenance of high quality patient care through the analysis, review and evaluation of clinical practice as related to blood and blood product transfusions.
 3. Conduct quarterly reviews to include the following:
 - A. Indications for blood transfusions, as propagated on the Blood Product Order Set
 - B. Amount of blood or blood components requested and transfused.
 - C. Actual or suspected adverse effects of transfusion (transfusion reactions).
 - D. Final disposition of units of blood and blood components.
 - E. Physician usage of Blood Product Order Set.
 - F. Cumulative incident report data generated by Quantros system.
 4. Provide BURC minutes, quarterly activity reports and feedback to the Medical Executive Committee and to Quality Council.
 5. Assist to identify educational needs in transfusion medicine and collaborate as necessary with the Medical Staff Department.
 6. Recommend and coordinate changes in hospital procedures or medical staff practices as indicated through analysis.
 7. Communicate Blood Utilization Committee Reviews (cross-match to transfusion ratios and case review information) results to the Credentials Committee and to Department Chairs.
- C. **Meetings:** At a minimum, The Blood Utilization Review Committee shall meet each quarter.

SECTION 3: REVIEW, ADOPTION, AND AMENDMENT

3.1 Biennial review: The Medical Executive Committee will review this policy manual every two years.

3.2 Amendment: This Organization and Functions Manual may be adopted, amended or repealed, in whole or in part, by a resolution of the Medical Executive Committee recommended to and adopted by the Board of Directors.

3.3 Corrections: The Medical Executive Committee may correct typographical, spellings, or other obvious errors in this manual.

3.4 Responsibilities and authority; status as Medical Staff Bylaws

The procedures outlined in the medical staff and South Shore Hospital corporate bylaws regarding medical staff responsibility and authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments thereto apply as well to the formulation, adoption, and amendment of this Organization and Functions Manual. Notwithstanding anything to the contrary elsewhere in these bylaws or in any other document, the following documents of the South Shore Hospital Medical Staff are hereby made, and shall be deemed to be, to the extent required to satisfy Joint Commission requirements (including standards and elements of performance), part of these bylaws, and thereby are specifically subject to the provisions herein contained for the adoption and amendment of these bylaws: Medical Staff Credentials Policy and Procedure Manual, and the Medical Staff Bylaws/Organization and Function Manual.

SECTION 4: CONFIDENTIALITY, IMMUNITY, AND RELEASES

4.1 CONFIDENTIALITY OF INFORMATION

Information submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of: assessing, reviewing, evaluating, monitoring, or improving the quality and

efficiency of health care provided; evaluating current clinical competence and qualifications for staff appointment/affiliation, or clinical privileges or specified services; contributing to teaching or clinical research; or determining that health care services were indicated or were performed in compliance with an applicable standard of care shall, to the fullest extent permitted by law, be confidential. This information will not be disseminated to anyone other than a representative of the hospital or to other health care facilities or organizations of health professionals engaged in an official, authorized activity for which the information is needed. Such confidentiality shall also extend to information that may be provided by third parties. Each practitioner expressly acknowledges that violation of the confidentiality provided here is grounds for immediate and permanent revocation of staff appointment and/or clinical privileges or specified services, provided that, prior to imposition, such revocation is subject to the practitioner's rights under Article VII of the Medical Staff Bylaws or, in the case of an Allied Health Practitioner, under the Allied Health Practitioner Policy.

4.2 IMMUNITY FROM LIABILITY

No representative shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of this hospital or for providing information, opinion, counsel, or services to a representative or to any health care facility or organization of health professionals concerning said practitioner.

4.3 ACTIVITIES

The confidentiality and immunity provided by this article applies to all information or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- (a) Applications for appointment/affiliation, clinical privileges, or specified services

- (b) Periodic reappraisals for renewed appointment/affiliations, clinical privileges, or specified services
- (d) Corrective or disciplinary actions
- (e) Hearings and appellate reviews
- (f) Quality assessment and performance improvement activities
- (g) Utilization review and improvement activities
- (h) Claims reviews
- (i) Risk management and liability prevention activities
- (j) Other hospital, committee, department/division, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct

CERTIFICATION OF ADOPTION AND APPROVAL

APPROVED by the Medical Executive Committee February 24, 2009.

Brian J. Battista, M.D.
President of the Medical Staff

APPROVED by the
Board of Directors of South Shore Health and Educational Corporation
on May 27, 2009.

Kathleen Heffernan, RN, JD
Clerk/Board of Directors

s/mso/bylaws/bylaws 2005/O&F manual 4.27.05, BOD 4.26.06, BOD 5.28.08, 5.27.09