MEDICAL STAFF ORGANIZATION MANUAL
OF THE BYLAWS OF THE MEDICAL STAFF

UNIVERSITY OF NORTH CAROLINA HOSPITALS

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Article I:
Definitions

The following definitions apply to terms used in this Manual:

"**Board of Directors**" means the Board of Directors of the University of North Carolina Health Care System.

"**Hospital"** means The University of North Carolina Hospitals and all the activities, services and programs thereof, including, as appropriate to the context, the outpatient clinics, services, and programs of the University of North Carolina School of Medicine and the University of North Carolina Health Care System.

"**Housestaff**" means all physicians and dentists who are in recognized residency training programs sponsored by The University of North Carolina Hospitals. Housestaff are eligible for Medical Staff Committee membership and for participation in Medical Staff conferences, seminars, and teaching programs.

"**Medical Review Committee**" means the Board of Directors and its committees, all Medical Staff Committees, all Ad Hoc Committees, and all Departments and Divisions when involved in evaluating the quality, cost of, or necessity for Hospitalization or health care, including credentialing of Practitioners.

"**Medical Staff**" means all physicians and dentists with clinical privileges to treat patients at the Hospital.

"**Practitioner**" means a member of the Medical Staff, an Independent Allied Health Professional, or a Dependent Allied Health Professional with clinical or practice privileges at the Hospital.

"**President**" means the executive and administrative head of UNC Hospitals.

"**Physician**" includes both physicians and dentists, unless the context indicates otherwise.

"**Professional Review Activity**" means any activity of the Hospital with respect to an individual Practitioner (1) to determine whether an applicant or Practitioner may have clinical privileges at the Hospital or membership on the Medical Staff; (2) to determine the scope or conditions of such privileges or membership; or (3) to change or modify such privileges or membership.

"**Professional Review Body**" means, as appropriate to the circumstances, the Board of Directors, the Medical Staff Executive Committee, the Credentials Committee, any Ad Hoc Investigation Committee, any Hearing Committee, any Appellate Review Committee, the President of the Hospital, the Chief of Staff, any department, division, or service Chair, and any other person, committee, or entity having authority to make an adverse recommendation with

respect to, or to take or propose an action against, any applicant or Practitioner when assisting the Board of Directors in a Professional Review Activity.

Article II:
Departments and Services

Section 1. Clinical Departments and Services

The Medical Staff is organized into the following departments: Anesthesiology; Dentistry; Dermatology; Emergency Medicine; Family Medicine; Internal Medicine; Neurology; Neurosurgery; Obstetrics and Gynecology; Ophthalmology; Oral Maxillofacial Surgery; Orthopedics; Otolaryngology/Head and Neck Surgery; Pathology and Laboratory Medicine; Pediatrics; Physical Medicine and Rehabilitation; Psychiatry; Radiation Oncology; Radiology; Surgery; and Urology. Dentists are appointed to the Department of Dentistry or Oral Maxillofacial Surgery and may hold joint appointments in other departments. Each clinical department may be subdivided at the discretion of the Department Chair.

Section 2. Functions and Responsibilities of Medical Staff Departments

Functions and responsibilities of the Departments and the Department Chairs are set forth in Article XII of the *Bylaws of the Medical Staff*.

Article III:
Committees

Section 1. General Committees

Appointment, rights and responsibilities of members and Chairs, as well as committee functions and process are set forth in Article XIV of the *Bylaws of the Medical Staff*.

Section 2. Standing Committees

Each standing committee listed below is established for the purpose of evaluating the quality, cost of, and/or necessity of hospitalization or health care, including medical staff credentialing.

a. Clinical Documentation Committee

The Clinical Documentation Committee consists of one (1) representative from each clinical department, and the Departments of Audit Services, Information Services, Legal Services, Medical Information Management, and Nursing; a member of the Housestaff; and the President, or his/her designee. The responsibilities of the Committee are as follows:

(1) To develop and maintain appropriate Hospital standards of medical record content and format for both inpatient and outpatient purposes. These standards should be broad enough so as to foster an appropriate

degree of flexibility, yet specific enough so as to produce a proper level of uniformity. In addition, these standards shall be designed so as to be supportive of Quality Improvement programs and of the national standards;

(2) To monitor and evaluate the fulfillment of the above standards, through a program of record review for content, format, completeness and promptness of records of discharged patients. Such a program must incorporate a mechanism for corrective action regarding incomplete or inadequate records; and

(3) To advise the Medical Staff Executive Committee on the impact of the electronic medical record and on the quality of documentation, practitioner workflow, access to the record, and compliance with policies and procedures affecting the privacy and security of medical records.

b. Credentials Committee

The Credentials Committee consists of members of the Medical Staff appointed to ensure representation of the major clinical specialties, the Hospital-based specialties, the Medical Staff at large, and other personnel involved in the credentialing process. The size of the Committee shall be determined by the Chief of Staff with the approval of the Executive Committee. The responsibilities of the Committee are as follows:

(1) To investigate the credentials of all applicants seeking appointment to the Medical Staff and to make written recommendations relative to membership and the delineation of clinical privileges to the Executive Committee;

(2) To review all information available regarding the current competence of Medical Staff members, and to make recommendations relative to reappointment and renewal of clinical privileges;

(3) To investigate any breach of ethics of which it becomes aware;

(4) To investigate the credentials of all Independent or Dependent Allied Health Professionals and make recommendations for their scope of practice privileges; and

(5) To review and approve credentialing policies and procedures as necessary, but at least annually;

A subcommittee of the Credentials Committee, the Emerging Technology Subcommittee, shall be appointed by the Chief of Staff to develop criteria and make recommendations for practitioners requesting clinical privileges to utilize emerging technologies such as robot-assisted surgery and cyberknife.

c. Environmental Health and Safety Committee

The Environmental Health and Safety Committee consists of representatives from: Hospital Administration; the Medical Staff; Nursing; Plant Engineering; Radiation

Safety; Hospital Epidemiology; the Director of Occupational Health and the Director of Safety. The Committee assures continuous emphasis on and attention to the health and safety of the Hospital's patients, visitors, employees, and Medical Staff and coordinates all related efforts. It shall meet at least bi-monthly.

Four subcommittees will report to and make recommendations to the Committee: Laser Safety; Medical Device Safety; Personnel and Environmental Safety; and Radiation Safety.

d. Ethics Committee

The Ethics Committee consists of representatives from multiple disciplines within the lay and professional communities, in numbers determined by the Chief of Staff. The responsibilities of the Committee are as follows:

(1) To educate the Medical Staff and other Hospital personnel about ethical matters;

(2) To provide a discussion forum for the review of ethical issues relative to the care of patients;

(3) To provide advice and counsel relative to the formulation of ethics policies and/or guidelines; and

(4) To serve as a resource for the Medical Staff, Nursing, allied health staff, patients and/or families relative to ethical matters concerning Hospitalization and treatment.

e. Graduate Medical Education Committee

The Graduate Medical Education Committee (GMEC) consists of the Chair of the Graduate Medical Education Committee, the Director of the Office of Graduate Medical Education, the Patient Safety Officer, Residency Program Directors from each Department of the Medical Staff, with at least one Hospital-sponsored ACGME approved residency training program, peer-selected Resident Physicians, three subspecialty Program Directors, the Program Director from Medicine/Pediatrics, and the Program Director from Preventive Medicine. Additional representatives are identified from Nursing, AHEC, Dentistry, Pharmacy, and members of Hospital Administration with responsibility for Graduate Medical Education. The Executive Associate Dean for Graduate Medical Education, also serving as the ACGME Designated Institutional Official (DIO), shall be the Chair of the Committee.

The minimum voting membership of the GMEC is determined by the Accreditation Council for Graduate Medical Education (ACGME), and specified in the ACGME Institutional Requirements. In addition to the minimum voting members specified in each revision of the ACGME Institutional Requirements, other voting members are appointed by the Executive Associate Dean for Graduate Medical Education, with approval by the Medical Staff Executive Committee.

Committee meetings are open to all Program Directors or Division Chiefs of Hospital-sponsored ACGME approved residency training programs, and to Site Directors of

residency programs identified as Major Participating Sites. The Committee will provide a means of communication between the Medical Staff, the Board of Directors, and the Office of Graduate Medical Education of the Hospital, and monitor and advise on graduate medical education issues. The responsibilities of the Committee are defined by the Accreditation Council for Graduate Medical Education, and include the following:

(1) To establish institutional policies for graduate medical education;

(2) To serve as a liaison between residency program directors and the administrators of other institutions participating in programs sponsored by UNC Hospitals;

(3) To regularly review all residency training programs to ensure compliance with institutional policies and the requirements of their ACGME review committee;

(4) To establish and implement policies and procedures to ensure due process in connection with the discipline of residents;

(5) To ensure appropriate and equitable funding for resident positions, including benefits and support services;

(6) To establish and implement policies and procedures for the discipline of residents and the adjudication of complaints and grievances relative to the graduate medical education programs; and

(7) To ensure appropriate working conditions for residents.

f. Hospital Infection Control Committee

The Hospital Infection Control Committee is responsible for the surveillance of Hospital infection potentials, review and analysis of the actual infections and the promotion of a preventive and corrective program designed to minimize infection hazards. The Committee, after consultation with the applicable Department Chair, or his/her designee, and Hospital Administration, is authorized to institute any control measures or studies deemed appropriate to respond to any danger to patients or personnel. Membership consists of at least seven (7) representatives of the Medical Staff, the Hospital Epidemiologist, and one (1) representative each from the Department of Nursing, the Department of Pharmacy, and Hospital Administration. The responsibilities of the Committee are as follows:

(1) To oversee infection control in all phases of Hospital activity, including: operating rooms, delivery rooms, recovery rooms, special care units; sterilization procedures by heat, chemicals, or otherwise; isolation procedures; prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment; testing of Hospital personnel for carrier status; methods of disposal of infectious materials; other situations as requested by the Executive Committee;

(2) To document the selection of surveillance methodologies;

(3) At least annually, to evaluate, revise as necessary, and approve the type and scope of surveillance activities by reviewing the following: data trend analysis generated by surveillance activities during the past year; effectiveness of prevention and control intervention strategies in reducing the nosocomial infection risk; services instituted; and procedures, priorities, or problems identified in the past year;

(4) To approve the plan to be used in the annual evaluation of the program for infection surveillance, prevention, and control;

(5) To review the clinical use of antibiotics, including prophylactic use, for inpatients, ambulatory care patients and emergency care patients; and with the advice of the Clinical Management Committee, for the establishment of criteria for the prophylactic and therapeutic use of antibiotics in problem areas; and

(6) To refer to the Clinical Management Committee all findings suggesting patient care problems, which are further reviewed by the coordinating committee of the quality improvement program.

g. Joint Conference Committee

The Joint Conference Committee consists of an equal number of members of the Board of Directors and the Medical Staff. The President is an ex-officio member of the Committee with voting privileges. Representatives from the Medical Staff are the Chief of Staff and three (3) to five (5) members of the Executive Committee appointed by the Chief of Staff. The Chair of the Board of Directors appoints the remaining members of the Committee and its Chair.

The Committee serves as a liaison group between the Board of Directors and the Medical Staff relative to medico-administrative matters, and to make recommendations as it may deem in the best interest of the Hospitals.

h. Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee consists of at least nine (9) representatives from the Medical Staff, the Director of Hospital Pharmacy, and one (1) representative from both the Department of Nursing and Hospital Administration. The Pharmacy's Drug Information Specialist serves as a non-voting secretary of the Committee. The Committee represents the organizational line of communication and the liaison among the Medical Staff, Department of Nursing and Department of Pharmacy relative to all drug matters. The responsibilities of the Committee are as follows:

(1) To review and approve drug utilization policies and practices within the Hospital, which are developed by the Department of Pharmacy and Committee members in order to ensure optimum clinical results and a minimum potential for hazard;

(2) To assist in the formulation of policies and procedures regarding the evaluation, appraisal, selection, procurement, storage, distribution, and use of drugs, drug safety procedures and all other drug-related matters in the Hospital;

(3) To serve as an advisory group to the Medical Staff and the Director of Pharmacy on matters pertaining to the selection of drug entities;

(4) To make recommendations concerning drugs to be stocked on the nursing units;

(5) To develop and review periodically a formulary for use in the Hospital;

(6) To conduct and review the results of drug usage evaluation studies;

(7) To evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;

(8) To establish the standards concerning the use and control of investigational drugs and research in the use of recognized drugs;

(9) To review adverse drug events occurring among Hospital patients; and

(10) To review policies and procedures of the Department of Pharmacy relating to patient care.

i. Quality Council

The Quality Council consists of the members of the Medical Staff Executive Committee, the UNC Hospitals Vice Presidents, the UNC Physicians & Associates leadership, the Director of Performance Improvement, the Patient Safety Officer, the Director of Risk Management, and representatives from Rex Hospital and Chatham Hospital. The responsibilities of the Council are:

(1) To coordinate and monitor performance improvement activities of UNC Health Care System (excluding Rex);

(2) To coordinate and monitor clinical outcomes and progress toward meeting strategic quality goals to produce measurable improvements in clinical care;

(3) To coordinate and monitor patient safety activities to eliminate and reduce potential harms that may occur in the delivery of health care services; and

(4) To coordinate and monitor patient satisfaction and customer service activities.

j. Standing Order Committee

The Standing Order Committee has at least seven (7) members and consists of broad representation from the Medical and Nursing staff of UNC Hospitals. It includes members who work primarily in both inpatient and outpatient settings.

Other members are drawn from key departments, including Legal, Pharmacy, and Informatics. The Chief of Staff or his or her designee will chair the Committee. The Committee will meet at least every other month.

Standing Orders are orders that are signed by either the Chief of Staff or a member of the medical staff other than the attending physician (and physicians under his or her supervision) and many include orders for medications, laboratory tests, and procedures.

The responsibilities of the Committee are as follows:

(1) To initially review and approval any Standing Order;

(2) To yearly review and approve all existing Standing Orders;

(3) To provide recommendations for the acceptance of Standing Orders to the Medical Staff Executive Committee; and

(4) To assure that all Standing Orders conform to the standard of medical care and are within the competency of the person actually complying with the order.

k. Trauma Advisory Committee

The Trauma Advisory Committee membership includes: the Trauma Medical Director, and representatives, or their designees, from General Surgery, Orthopaedic Surgery, Neurosurgery, Emergency Medicine, and Anesthesiology. The Trauma Medical Director may add others to this core group as needed for system review, such as Blood Bank, Laboratory, and Radiology representatives, and/or other departmental representatives. The Committee meets at least quarterly and participation includes attendance by aforementioned core representatives at a minimum 50% of Committee meetings. Records are kept, including minutes and attendance, within the Trauma Program Office.

The Trauma Advisory Committee addresses Trauma Program operational and systems issues, including pre-hospital, interdepartmental, and inter-hospital issues that affect all phases of care provided to injured patient. The responsibilities of the Committee are as follows:

(1) To review on an ongoing basis the practices and procedure of trauma care;

(2) To develop and approve clinical management guidelines, policies and protocols to improve the quality of care rendered to trauma patients;

(3) To review both periodic and focused audit, trends and patient data to ensure compliance with all policies and procedures concerning trauma care; and

(4) To identify and correct overall program deficiencies to optimize patient care.

To improve the quality of care rendered to all trauma patients, the Committee also performs peer review functions through a Multidisciplinary Trauma Conference, with participation by the Trauma Medical Director and representatives, or their designee, from: General Surgery, Orthopaedic Surgery, Neurosurgery, Emergency Medicine, and Anesthesiology, to improve trauma care. Performance improvement benchmarks for patient case review are based on the current ACS Guidelines for trauma care, as well as the rules and regulations per the North Carolina Office of Emergency Medical Services. The Multidisciplinary Trauma Conference meets at least quarterly and participation must include attendance by aforementioned representatives at a minimum 50% of the Multidisciplinary Trauma Conference meetings. The Trauma Medical Director may add others to this core group as deemed appropriate/needed for review. Conclusions and recommendations from these meetings are shared with other medical care providers involved in specific cases in an effort to improve patient care, prevent future delays or complications and/or provide education for the improvement of trauma care. Performance improvement issues that are referred to other departments must have clear, written documentation back to the Trauma Program via the Trauma Clinical Coordinator of resolution of the issues. Records are kept, including minutes and attendance, to include department affiliation, in the Trauma Program Office. The responsibilities of the Multidisciplinary Trauma Conference are as follows:

(1) To discuss and resolve patient management issues, including preventable or possibly preventable morbidities and/or mortalities;

(2) To address complex system issues not resolved in other forums;

(3) To review selected patient cases, deaths, complications, and sentinel events with the objectives of identification of issues and appropriate responses; and

(4) To develop and provide a formal method for communication between departments.

I. Utilization Management Committee

The Utilization Management Committee consists of the Clinical Care Management Medical Director, and the Director of Clinical Care Management, as well as representatives from the medical staff, Clinical Care Management, and other departments including but not limited to Medical Information Management, Risk Management, and Quality Management. The responsibilities of the Utilization Management Committee include:

(1) To assure that inpatient and ancillary services are provided regardless of the patient's ability to pay and are of optimal quality, timely, appropriate, cost-effective, medically necessary, and could not be performed more appropriately and efficiently in another setting or facility;

(2) To ensure that all admissions and continued stays are appropriate, based on the patient's need for inpatient treatment, and consistent with the Hospitals' admission and discharge rules;

(3) To oversee the Utilization Management Program, and to evaluate at least annually its written plan, criteria, and length-of-stay norms; and

(4) To assess the appropriate allocation of the Hospitals' clinical resources and make recommendations to correct any identified problems.

Section 3. Committees for Special Services and Functions

As Hospital interests require, appropriate committees shall be established to perform special services and functions. As applicable, these committees are established for the purpose of evaluating the quality, cost of, and/or necessity of hospitalization or health care, including medical staff credentialing. These committees may include, but are not limited to, the following:

a. Adult Nutrition Support Committee

The Adult Nutrition Support Committee consists of one (1) representative each from, but not limited to: the Departments of Internal Medicine, Obstetrics and Gynecology, and Surgery; Hospital Administration; Pharmacy; Nursing; Epidemiology; Dietary; and the School of Pharmacy. The responsibilities of the Committee are as follows:

(1) To develop policies and procedures for parenteral nutrition (peripheral and central), which optimize patient care and staff education and minimize costs;

(2) To encourage and assist in the implementation of these policies and procedures through existing committees and other Hospital organizations; and

(3) To inform and educate appropriate personnel and staff about new products or procedures for nutrition support.

b. Adult Sedation Committee

The Adult Sedation Committee is responsible for oversight of policies and procedures affecting procedural sedation for adults. The Committee consists of physicians and nurses from departments and clinical areas where adults may undergo procedural sedation provided by non-anesthesiologists. The Committee is chaired by a member of the Active Staff from one such department and may also include an anesthesiologist and administrative personnel with expertise in patient safety. The size of the Committee shall be determined by the Chief of Staff with the approval of the Executive Committee.

The responsibilities of this Committee are as follows:

(1) To develop and maintain sedation policies and practices applicable to procedural sedation of adults.

(2) To develop and maintain training and competency requirements for non-anesthesia personnel who will provide procedural sedation for adults.

(3) To perform continuous quality and performance reviews of adult sedation practice in the hospitals and clinics.

(4) To address other aspects of quality and patient safety related to airway management and cardiopulmonary support of adults who undergo procedures in locations other than the operating rooms.

(5) To report findings and recommendations to the Chair of Anesthesiology for review and potential MSEC consideration.

c. Bylaws Committee

The Bylaws Committee consists of the Chief of Staff, the President, and the Senior Vice-President for Legal Services. The Committee is responsible for maintaining current and up-to-date Bylaws, Rules and Regulations.

d. Cardiopulmonary Resuscitation Committee

The Cardiopulmonary Resuscitation Committee consists of seven (7) members, including one representative each from the Departments of Anesthesiology, Internal Medicine, Pediatrics, Surgery, Nursing and Pharmacy. The President, or his designee, shall also be a member of this Committee. The Committee is responsible for developing and maintaining an appropriate cardiopulmonary resuscitation program throughout the Hospital, including continual monitoring of the program and its related training considerations.

e. Committee for the Protection of the Rights of Human Subjects

The Committee for the Protection of the Rights of Human Subjects of the University of North Carolina at Chapel Hill, School of Medicine shall act as the designated Medical Staff committee for activities that involve the rights of human subjects. When acting as a Medical Staff committee, the Committee shall keep minutes and report its activities and findings to the Executive Committee.

f. Emergency Preparedness and Planning Committee

The Disaster Committee consists of representatives from: the Departments of Anesthesiology, Emergency Medicine, Internal Medicine, Radiology, and Surgical Specialties; Hospital Administration; Hospital Police; Public Relations; Plant Engineering; and two nurses representing the Emergency Room and the Nursing Office. Guests from Civil Service agencies of the community may be invited to meetings at the discretion of the Chair.

The purpose of the Committee is to oversee the preparation and management of the Hospital relative to situations involving mass casualties. The responsibilities of the Committee are as follows:

(1) to define what constitutes a mass casualty situation;

(2) to assess the capability of the Hospital to handle mass casualties of various types and degrees;

(3) to designate the areas of the Hospital to be used for disaster purposes;

(4) to assign medical and Hospital personnel to serve in various capacities as may be deemed appropriate in the event of a disaster;

(5) to provide for coordination with neighboring Hospitals, fire and police departments, and other outside agencies;

(6) to conduct drills to sharpen the response capability of all personnel; and

(7) to coordinate the disaster plans of the Department of Emergency Medicine, Plant Engineering, Nursing and Administration.

g. Intensive Care Unit Advisory Committee

The Intensive Care Unit Advisory Committee consists of one (1) representative each from: the Departments of Anesthesiology, Internal Medicine, Neurology, Obstetrics and Gynecology, Pathology and Laboratory Medicine, Pediatrics, Surgery; and Nursing; Respiratory Therapy; the Hospital Epidemiologist; and the President or his/her designee. The Head of Critical Care Services shall serve as Chair. The responsibilities of the Committee are as follows:

(1) To develop policies for the management of the Intensive Care Unit so that standards of professional care may be maintained at the highest level;

(2) To develop and coordinate an orientation program for all new professional members of the Intensive Care teams; and

(3) To develop and coordinate a continuing education program for individuals involved in Intensive Care.

h. North Carolina Cancer Hospital Executive Committee

The Clinical Cancer Program Executive Committee membership shall include representatives from: General Surgical Oncology; Otolaryngologic Oncology; Thoracic Oncology; Urologic Oncology; Gynecologic Oncology; Pediatric Oncology; Bone Marrow Transplantation; Medical Oncology; Radiation Oncology; Diagnostic Radiology; Pathology and Laboratory Medicine; the Cancer Liaison Program; UNC Lineberger Comprehensive Cancer Center; Oncology Services Administration; Nursing; and such other members as deemed appropriate by the Dean of the School of Medicine and/or the Chief of Staff. Committee responsibilities include:

(1) Develop and evaluate the annual goals and objectives for clinical, educational, and programmatic activities related to cancer;

(2) Promote a coordinated, multidisciplinary approach to patient management;

(3) Ensure that educational and consultative conferences cover all major sites and major issues;

(4) Ensure that an active supportive care system is in place for patients, families, and staff;

(5) Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes;

(6) Promote clinical research;

(7) Supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up;

(8) Perform quality control of registry data;

(9) Encourage data usage and regular reporting;

(10) Ensure that the content of the annual report meets requirements;

(11) Publish the annual report by November 1 of the following year; and

(12) Uphold medical ethical standards.

The Committee is responsible to the Medical Staff Executive Committee and the Dean of the School of Medicine.

The Committee delegates certain functions to the following subcommittees, which report to the Executive Committee:

Advisory Subcommittee. Membership of this subcommittee includes representatives from General Surgical Oncology, Medical Oncology, Radiation Oncology, Diagnostic Radiology, Pathology, the Cancer Liaison Program, the Cancer Registry, Hospital Administration, CQI Department, Nursing, Patient Support and Education, and Social Work. The subcommittee meets quarterly.

Oncology Strategic Planning Subcommittee. Membership of this subcommittee includes representatives from Pediatric Oncology, General Surgical Oncology, Radiology, Medical Oncology, Radiation Oncology, UNC Lineberger Comprehensive Cancer Center, the Planning Office, the Managed Care Office, Oncology Services Administration, Nursing, Marketing, and UNC Physicians & Associates. The subcommittee meets monthly.

Protocol Review Subcommittee. Membership of this subcommittee includes representatives from Radiation Oncology, Bone Marrow Transplantation, Pediatric Oncology, Medical Oncology, Thoracic Oncology, Pharmacology, Gynecologic Oncology, Internal Medicine, Urologic Oncology, the Clinical Trials

Office, Biostatistics, Otolaryngolic Oncology, and Nursing. The subcommittee meets twice a month.

Other subcommittees may be appointed by the Chair of the Committee to aid in executing its duties and meeting its objectives.

i. Pediatric Nutrition Support Committee

The Pediatric Nutrition Support Committee consists of one (1) representative each from, but not limited to: the Departments of Pediatrics, Neonatology, and Surgery; Pharmacy; Nursing; Epidemiology; Dietary; and the School of Pharmacy. The responsibilities of the Committee are as follows:

(1) To recommend policies and procedures for parenteral nutrition (peripheral and central), which optimize patient care and staff education and minimize costs;

(2) To encourage and assist in the implementation of these policies and procedures through existing committees and other Hospital organizations; and

(3) To inform and educate appropriate personnel and staff about new products or procedures for nutrition support.

j. Pediatric Sedation Committee

The Pediatric Sedation Committee is responsible for oversight of policies and procedures affecting procedural sedation for children. The Committee consists of physicians and nurses from departments and clinical areas where children may undergo procedural sedation provided by non-anesthesiologists. The Committee is chaired by a member of the Active Staff from one such department and may also include a pediatric anesthesiologist and administrative personnel with expertise in patient safety. The size of the Committee shall be determined by the Chief of Staff with the approval of the Executive Committee.

The responsibilities of this Committee are as follows:

(1) To develop and maintain sedation policies and practices applicable to procedural sedation of children.

(2) To develop and maintain training and competency requirements for non-anesthesia personnel who will provide procedural sedation for children.

(3) To perform continuous quality and performance reviews of pediatric sedation practice in the hospitals and clinics.

(4) To address other aspects of quality and patient safety related to airway management and cardiopulmonary support of children who undergo procedures in locations other than the operating rooms.

(5) To report findings and recommendations to the Chair of Anesthesiology for review and potential MSEC consideration.

k. Patient Complaint Monitoring Committee

The Patient Complaint Monitoring Committee consists of members recommended by the clinical Department Chairs and approved by the Medical Staff Executive Committee. The Committee reviews and analyzes information offered by patients and their families about the patient care experience, and at its discretion, using preapproved criteria, provides feedback to individual members of the Medical Staff to improve the quality of patient care and of clinicians' interactions with patients and families.

l. Tissue Committee

The Tissue Committee consists of at least the following: two (2) members from the Department of Pathology and Laboratory Medicine, and one (1) member each from the Departments of Dermatology, Internal Medicine, Obstetrics and Gynecology, Pediatrics, and Surgery. The Director of Surgical Pathology and the President, or his/her designee, shall be ex-officio members. The Committee shall meet at the discretion of the Chair. The responsibilities of the Committee are as follows:

(1) To develop a formal method for communication between the Department of Pathology and Laboratory Medicine service activities and the clinical departments of clinical services;

(2) To develop and/or review all policies and practices regarding the removal and handling of tissue;

(3) To periodically review all normal tissue removed during surgical procedures, including the reporting of results to the appropriate departments;

(4) To identify through data analysis any diagnosis group or groups of diseases or procedures that should be further reviewed under the auspices of the Patient Safety/Quality Improvement Program and to refer such cases to the Quality Council;

(5) To develop operational policies regarding the use of excess tissue in research and/or educational purposes consistent with Hospital policies; and

(6) Through all of the above activities, to improve the quality of care rendered to patients.

m. Transfusion Committee

The Transfusion Committee consists of one representative each from the Departments of Anesthesiology, Dentistry, Internal Medicine, Nursing, Obstetrics and Gynecology, Pediatrics, Surgery, the Blood Bank/Transfusion Medicine Service, and

the President, or his/her designee. The responsibilities of the Committee are as follows:

(1) To periodically review the supply of blood and blood components utilized within the Hospital relative to the sources of blood donors, the adequacy of the supply of blood and blood components, and the related safety factors within that supply;

(2) To review on an ongoing basis the practices and procedures of ordering blood and the utilization of blood by the Medical Staff as reflected by potentially excessive or faulty ordering patterns, single-unit transfusions or unnecessary blood transfusions;

(3) To review on an ongoing basis all serious transfusion reactions as to their causative reasons and to recommend improvements in related procedures and practices; and

(4) To refer to the Quality Council all findings suggesting patient care problems, which are further reviewed by the coordinating committee of the quality improvement program.

Section 4. Special Ad Hoc Committees

Special Ad Hoc Committees may be convened from time to time for the purpose of carrying out specific inquiries or directives. The Chief of Staff, on his/her own initiative or at the direction of the Executive Committee, appoints the membership of such committees and defines the scope and duration of their activities.

Article IV:
Amendments

This Manual may be amended as provided in Article XVI of the Medical Staff Bylaws.