# LeConte Medical Center

Sevierville, Tennessee

# Medical Staff Rules and Regulations

Revised
July 23, 2015

## *Amendment Dates*

Prior Revision Dates are Unknown
December 22, 2008
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# *I. General*

Upon appointment to the Medical Staff at LeConte Medical Center ("LMC or "Hospital") and as often thereafter as necessary, each member shall arrange for coverage by an alternate Medical Staff member for his/her patients in such a member's absence. In the event the member cannot be reached within a reasonable period of time the alternate may be called in his/her place. If the alternate cannot be located, the Chief of Staff shall have the authority to call any member of the Medical Staff to care for the patient should he/she consider it necessary.

# *II Admissions and Discharges*

A. Only members of the Medical Staff may admit a patient to this Hospital. The admitting Staff member shall be considered the attending Staff member. Advanced Practice Professionals may perform the initial evaluation of patients to be admitted. No patient will be admitted without a provisional admission diagnosis. The attending Staff member's name shall appear on the record summary. The attending Staff member is responsible for the care of the patient, unless otherwise documented in the physician's orders (i.e., transfer of service or coverage during the attending physician's absence). The attending Staff member or responsible practice group member will be responsible for completion of the medical record including the diagnosis validation and the discharge summary.

1. Any patient admitted to the Hospital through the Emergency Department (ED) by an ED physician will be admitted to the service of an attending physician for continuity of care at which point Rule II.A. shall apply.

2. Members have the privilege of admitting patients suffering from all types of diseases and illnesses, but may not admit patients for types of care that cannot safely be provided or are not available at the Hospital.

B. Patients admitted to the Hospital shall be the responsibility of the admitting Staff member or another authorized practitioner. Such practitioner shall be responsible for the medical care and treatment, for the completeness and accuracy of the medical record, for necessary special instructtions, and for transmitting reports of condition of the patient to the referring physician and to relatives. Whenever these responsibilities are transferred from one member of the Staff to another, a note to that effect shall be made on the patient's medical record.

C. The admission policy is nondiscriminatory. All patients who require inpatient medical care shall be admitted by members of the attending Staff, and shall be assigned to the services concerned in treatment of the disease that necessitates admission or treatment. Transfer between the various services may be made in accordance with the judgement of the attending physician on service.

D. Members admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients and Hospital personnel from those who are a source

of any danger whatsoever.

1. Patients with a tentative or confirmed diagnosis of a communicable disease will be admitted and placed in accordance with the Hospital infection control policies and procedures.

E. Patients shall be discharged only by order of the attending physician, or the designated responsible physician. The physician shall enter the final diagnosis on the chart, except when the diagnosis is un-clear due to pending pathology specimen or diagnostic study results.

1. When patients leave against medical advice, the policy of "Discharge Against Medical Advice" will be followed.

F. In the event of death of the patient occurring in the Hospital, the attending physician, or a Registered Nurse shall pronounce the patient dead within a reasonable time not to exceed thirty minutes.

1. No autopsy shall be performed without signed, written consent of the proper relative, or other persons authorized by law to order autopsies.

G. Guidelines for Organ/Tissue Donation at LMC are defined to assure that the option of organ/tissue donation is provided to the next-of-kin of all potential donors and that LMC is in compliance with Tennessee State Law 1140 and the Omnibus Act P.L. 99-509.

H. No minimum battery of tests or examinations shall be required for any categories of patients. Individual physicians may establish standard orders for selected patients and/or diagnoses.

## *III. Medical Records and Documentation*

### A. The Medical Record

1. The attending physician shall be responsible for the preparation of a complete medical record for each patient admitted to his/her care.

2. The medical record contains sufficient information to identify the patient and such in information shall be located on each document contained in the medical record.

3. The medical record contains sufficient information to support the diagnosis, justify the treatment, document the course and results accurately, and facilitate continuity of care among health care providers. Each medical record contains at least the following:

a. The patient's name, address, date of birth, and the name of any legally authorized representative;
b. The patient's legal status, for patients receiving mental health services;
c. Emergency care provided to the patient prior to arrival, if any;
d. The record and findings of the patient's assessment;
e. A statement of the conclusions or impressions drawn from the medical history and physical examination;
f. The diagnosis or diagnostic impression;
g. The reason(s) for admission;
h. The goals of treatment and the treatment plan;
i. Evidence of known advance directives;
j. Evidence of informed consent for procedures and treatments for which informed onsent is required by organizational policy;
k. Diagnostic and therapeutic orders, if any;
l. All diagnostic and therapeutic procedures and tests performed and the results of same;
m. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
n. Progress notes made by the medical staff and other authorized individuals which shall include when appropriate;
    i. All reassessments, when necessary;
    ii. Clinical observations;
    iii. The response to care provided;
o. Reports of all consultations provided;
p. Every medication ordered or prescribed for an inpatient;
q. Every dose of medication administered and any adverse drug reaction;
r. Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge;
s. All relevant diagnoses established during the course of care;
t. Any referrals/communications made to external or internal care providers and to community agencies.

4. All patient records remain the property of the Hospital and shall not be removed from the Hospital except by court order, subpoena, or statute.

5. Free access to all medical records of all patients shall be afforded to medical staff members in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients as prescribed under current HIPAA standards.

6. When a patient presents for treatment as an inpatient or an outpatient, all previous medical records are available and assembled upon request for the treating physician(s).

7. The Hospital will follow the legal handbook of the Tennessee Health Information Management Association in determining whether physicians may receive copies of medical records without patient authorization.

8. Clinical Documentation by Qualified Participants in Professional Education Programs:

It is the policy of LeConte Medical Center to permit qualified participants in professional education programs, such as medical students, interns and residents, to participate in training, education and practice opportunities at this facility. Charting guidelines for these participants are as follows:

| | History & Physical Examinations | Progress Notes | Orders | Discharge Summary |
|---|---|---|---|---|
| Medical Students | Documentation only on student documentation form. Student documentation form is not part of the permanent record. | Documentation only on student documentation form. Student documentation form is not part of the permanent record. | Medical students may not write orders. | Documentation only on student documentation form. |
| Interns | May perform with follow-up note from attending physician written within the next 24-hours | May write with the attending to co-sign on the next visit. | May write orders. | May write or dictate with co-signature required. |
| Residents | May perform with follow-up note from attending physician written within the next 24-hours | May write with the attending to co-sign on the next visit. | May write orders. | May write or dictate with co-signature required. |

All entries in the medical record must be signed, dated, and timed.

## B. Content Of The Medical Record

1. All clinical entries in the patient's medical record shall be accurately timed, dated, authenticated, and legible. All entries in the medical record must be legible.

2. A record of each patient's history and physical examination shall be legibly written in the chart or dictated within twenty-four (24) hours of admission.

   a. If a complete history and physical examination has been obtained within thirty (30) days prior to admission, such as in the office of a physician, a durable, legible copy of this report may be used in the patient's medical record provided there is a written or dictated addendum indicating either appropriate changes or a

statement of no change at the time of admission. Such addendum shall be subject to Rule III.B.1.

b. A history shall be deemed complete when it contains documentation of the following when pertinent:
   i. Chief complaint
   ii. Details of the present illness\
   iii. Past medical and surgical history
   iv. Social history
   v. Family history
   vi. Medication history
   vii. Any known patient allergies
   viii. An inventory of disease processes, symptoms, or complaints by body system

c. A physical examination shall include, when pertinent, at least the following:
   i. Head, eyes, ears, nose, and oral examination
   ii. Respiratory examination
   iii. Cardiovascular examination
   iv. Gastrointestinal examination
   v. Genitourinary examination
   vi. Central nervous system examination
   vii. Musculoskeletal examination

d. A statement of conclusions or impressions drawn from the examination shall be included in each history and physical examination.

e. A plan of action for the current treatment encounter shall be included in each history and physical examination.

f. Obstetrical medical records shall include all prenatal information. A durable, legible original or reproduction of the office or clinic prenatal record is acceptable.

g. Physicians are encouraged to document other information that may be pertinent, such as concerning psychosocial needs, informed consent, and advanced directives if these are not previously known or defined by the patient, otherwise see Rule III.B.i and III.3.j.

h. The medical history should be obtained from the patient whenever possible.

3. A member of the medical staff must authenticate the history and physical. When non-physician care providers have been approved for such duties as taking medical histories and documenting physical examinations, such information is to be authenticated by the

physician responsible for the patient. The responsible physician is also responsible for completing any items under Rule III.B.1. which the non-physician care provider has not completed.

4. With the exception of emergencies (here defined as any procedure, which, if delayed, would reasonably be expected to result in loss of life or permanent impairment of the patient), patients shall not be taken to the operating room unless a history and physical examination, or a brief handwritten admission note and evidence that a history and physical has been dictated, appears on the chart.

5. Informed consents are required before medical treatments, diagnostic studies, Investigational drugs, each surgical or invasive procedure, blood transfusions, or administration of anesthesia on all patients except in case of an emergency. Minimally invasive procedures do not require a history and physical. Minimally invasive procedures are defined as all epidural steroid injections or diagnostic injections, nerve root blocks, sympathetic blocks, and IV regional blocks. The patient or his/her legal guardian shall sign informed consents. In the case of emergencies involving a minor or an unconscious patient in which consent cannot be obtained from the parent, guardian, or next of kin, the circumstances shall be fully documented in the patient's medical record. A written permit for sterilization shall be signed by the patient for operative sterilizations for any male or female. Written consent is required from the legal next of kin prior to initiation of an autopsy unless law requires such autopsy.

6. A dictated operative report is required for all invasive procedures performed, inpatient or ambulatory. This report must be dictated within twenty-four (24) hours of the end of the procedure. In addition, a handwritten operative note must be placed in the progress notes prior to admission to the recovery room to provide continuity of care for the staff taking care of that patient. This note should include all of the following:
   a. Preoperative diagnosis
   b. Postoperative diagnosis
   c. Procedure performed
   d. Surgeons
   e. Type of anesthesia used
   f. Estimated blood loss
   g. Complications which occurred during the case
   h. Specimens removed from the patient
   i. Intraoperative findings if not fully explained by the postoperative diagnosis
   j. Patient's status upon admission to the recovery room (stable, critical, extubated, etc.)

7. Anesthesia records must include a pre-anesthetic assessment documented by the Attending physician or anesthetist prior to surgery. The post-anesthetic assessment shall be documented by a physician or anesthetist and must document the presence or absence of anesthesia-related complications and must include the date and time of the visit. The post-anesthesia evaluation must be performed after the patient's completed recovery from the anesthesia and shall take place no later than twenty-four (24) hours following the procedure. If the post-anesthetic visit and record entry by anesthesia personnel are not

feasible because of early patient release from the hospital, the physician who discharges the patient from the hospital is responsible for the post-anesthesia note.

8. A dictated discharge summary is required for all admitted patients. A final progress note may be substituted for the discharge summary in the case of patients who require less than a forty-eight (48) hour period of hospitalization, and in the case of normal newborn infants and uncomplicated vaginal deliveries. The final progress note includes discharge instructions given to the patient or responsible party.

9. A progress note summarizing the patient's course since the last progress note shall be Recorded at the time of observation, sufficient to permit continuity of care and transfer-ability. Progress notes shall be written at least daily on hospitalized patients.

10. Physicians shall authenticate all written entries in the medical record with their written signature within forty eight (48) hours of that entry (verbal or telephone orders, standard admission orders, protocol orders, etc.) Dictated entries may be authenticated by written signature or electronic key. However, if the hospital's read-back and verify process is followed, the verbal orders shall be authenticated according to State Law effective 7/1/11, no later than fourteen (14) days after the date of the verbal order.

11. Diagnostic and therapeutic orders shall be written in ink or typewritten and shall be dated, timed, and signed. All orders shall be written clearly, legibly, and completely. A Registered Nurse (RN) or Licensed Practical Nurse (LPN) shall be authorized to take verbal orders of a general nature. Other persons, such as, but not necessarily limited to a Physical therapist, Occupational therapist, Respiratory therapist, Speech therapist, Pharmacist, Radiology technologist, Ultrasonographer, Nuclear medicine technologist, or Registered Dietician may take only orders limited to their specific license, training, and experience. The ordering practitioner shall authenticate all verbal orders as delineated in item #10 above.

12. The requesting physician(s), the appropriate staff committee, and administration may develop protocols or standing orders, applying to all patients or groups of patients. Once developed, unit-wide or department-wide standing orders shall be brought to a vote by the staff, published by administration, and may not be changed except by the mutual consent of the medical staff and administration, with administration notifying all concerned parties. Standing orders shall be followed insofar as proper treatment of the patient will allow, and when the attending physician does not write specific orders, they shall constitute the orders for treatment. Standing orders shall not replace or cancel specific orders for any patient.

13. When preprinted instructions are given to the patient or responsible party, the record shall indicate such and an example of the instruction sheet in use the time shall be on file in the Medical Record Department.

14. Reports of pathology, clinical laboratory, imaging services, and anesthesia services are completed promptly and are filed in the record within twenty-four (24) hours of

completion or dictation. The final autopsy report shall be completed and filed in the record within sixty (60) days of expiration.

15. A list of acceptable abbreviations and symbols approved by the medical staff shall be maintained with the explanatory legend and is made available to those authorized to make entries in the medical record and those who must interpret records. The official list of approved abbreviations shall be reviewed annually, revised as necessary, and be kept on file in the Administrative Policy and Procedure manual. Each abbreviation and symbol approved must have only one meaning.

16. Physicians will receive written notification each Monday concerning his/her deficient and delinquent medical records. Each physician will have one (1) week to complete all of these records. If it becomes necessary to suspend a physician's privileges, the Chief of Staff will notify him/her in writing, stating that the physician may continue to attend those patients already hospitalized under his/her care, but otherwise will be denied all admitting, consulting, obstetrical, and surgical privileges until the medical record delinquencies and/or deficiencies have been cleared. If after suspension, the delinquent medical records are not completed, within ten (10) days, the physician's appointment to the Medical Staff shall be terminated and the physician shall be notified by the Chief of Staff in writing. Reinstatement to the Medical Staff must be made by new application. Extension of the time limit may be granted due to illness or prolonged absence for the city. This would have to be discussed with the Chief of Staff, in consultation with the leader of Health Information Management.

17. Any physicians with three (3) suspensions will constitute voluntary resignation of his/her Medical Staff membership. Once a physician has lost admitting privileges for a second time, Health Information Management will send a certified letter, signed by the Chief of Staff or his/her designee, reminding him/her that if he/she is suspended a third time, he/she will be referred to the Medical Executive Committee for voluntary resignation of Medical Staff membership. After reapplication and reappointment to the Medical Staff, any subsequent suspension occurring will result in voluntary resignation of Medical Staff membership.

18. No medical record shall be filed until complete, except on order of the Medical Executive Committee. No medical staff member shall be permitted to complete a medical record on a patient unfamiliar to him/her in order to retire a record that was the responsibility of another staff member who is deceased or unavailable permanently or protractedly for other reasons.

## *IV. General Principles Of Medical Care*

**A.** All drugs and medications administered to patients shall be those listed in the latest edition of the "United States Pharmacopoeia", "National Formulary", or "New Nonofficial Drugs" or those approved for marketing by the Food and Drug Administration. Drugs for investigational use will be handled in accordance with principles developed by the American Hospital Association and

the American Society of Hospital Pharmacists. Reports concerning any investigational drug will be submitted as required by the Food and Drug Administration. Investigational drugs need to be approved by the IRB.

**B.** All orders for medications and treatments shall be recorded by the responsible physician, dentist, APP, or consultant and signed. Verbal orders shall be dealt with as in Rule III.B.10 and Rule III.B.11.

**C.** At the time of operation, all previous orders are cancelled.

**D.** Psychiatric and/or mental health consultations and treatment will be requested for all patients who have attempted suicide or have taken a chemical non-alcoholic overdose unless the patient refuses in writing or unless mitigating circumstances are outlined in writing in the chart. Mental health consultations in such situations may be performed by Psychologists, Masters of Social Work, and Psychological Examiners licensed by the Board of Healing Arts of the State of Tennessee and credentialed through the Medical Staff. They may be permitted to exercise privileges only under the direct supervision of physician staff members.

## *V. Surgery*

The following rules governing procedure and conduct in the operating rooms of LeConte Medical Center have been assembled with one prime consideration- the welfare of the surgical patient. All other considerations are secondary.

**A.** Questions as to policies and procedures in the operating rooms at LeConte Medical Center are under jurisdiction of the Surgical Quality Improvement Committee. No change to policies or procedures shall be made without the authority of this committee.

**B.** No operating time or bed space shall be allotted to any physician or dentist except for specific case.

**C.** With the exception of emergencies, all surgical operations must have prior written consent of the patient or his legal representative. Please also see Rule III.B.4.

**D.** The decision as to what constitutes an emergency is to be made by the attending surgeon scheduling the case and the head nurse in charge of the operating room. In case of disagreement between the two, the decision is to be made by the Medical Director of Surgery, or if he/she cannot be reached, the Chief of Staff or his/her designee.

**E.** Emergencies take priority over all other surgeries at all times.

**F.** Operating time may be forfeited when the start of the operation is delayed for more than fifteen (15) minutes by the absence of one or more of the essential members of the operating team. Surgeons are required to call the operating room if they anticipate being fifteen (15) minutes or more late. If the Medical Director of Surgery is not present or available, the operating room supervisor will determine an alternate time or forfeiture.

**G.** Specimens removed during a surgical procedure shall ordinarily be sent to the pathologist for evaluation. The limited categories of specimens that may be exempted include the following: specimens that by nature of condition do not permit fruitful examination, such as cataract, orthopedic appliance, foreign body, intrauterine device, toenails, teeth, or grossly normal placentas.

**H.** The operating surgeon and anesthetist are required to check their patient's identity before Administering anesthesia and starting the operation. The circulating nurse is to confirm the patient's identity as he/she enters the operating room and notify the surgeon.

**I**. No spinal anesthesia may be given unless there is a designated person other than the surgeon to watch the patient's condition. Such person may be anyone authorized by the surgeon and credentialed by the Medical Staff to do so.

**J.** Any patient who has had an operation under a conductive or general anesthesia shall go to the recovery room or to an area where recovery services are available.

**K.** No one is to enter an operating room during surgery without operating suit, cap and mask; or gown, cap, and mask for observers, and conductive shoes or shoe covers.

**L.** Visitors in the operating room are to be kept to a minimum and restricted to those persons whose presence is expressly approved by the patient, operating surgeon, and the acting operating room supervisor. The visitor's presence is for observation purposes only.

**M.** Infringements of these rules are to be reported by the operating room supervisor to the Medical Director of Surgery or to the Chief Administrative Officer. If they cannot handle the infringement, then the matter is to be referred to the Medical Executive Committee.

**N.** It shall be the responsibility of the operating surgeon to have a qualified assistant in attendance during operations, which, in his/her judgement, present unusual hazards to the patient.

**O.** The attending surgeon will be responsible for evaluating the patient as to the patient's need for surgery and anesthesia. Once this evaluation is made and recorded in the medical record, the anesthetist will evaluate the patient and choose the appropriate anesthesia plan-of-care in accordance with the AANA (American Association of Nurse Anesthetists) guidelines published by that organization.

**P.** In the event the operating surgeon is unable to continue with an operative procedure and no physician first assistant is present, a physician of the same specialty as the incapacitated

physician shall be requested to attend the patient. If a suitable replacement of the same specialty is not available, a general surgeon shall be requested to attend the patient. If a general surgeon is unavailable, the physician on duty in the emergency department will be requested to attend the patient and, if necessary, stabilize the patient until relieved by another physician.

## *VI. Emergency Department and Emergency Services*

**A.** The Emergency Department shall be staffed by (a) qualified physician(s) and (b) registered nurse(s) at all times, and such assistants as may be required.

**B.** Each specialty service, (OB, Cardiology, Family Practice, Internal Medicine, Hospitalist, Orthopedics, General Surgery, Urology and Otolaryngology) shall maintain a separate duty roster for emergency care. The rosters must be submitted to the Medical Staff Services Office by the twentieth ($20^{th}$) of the month prior to the scheduled month. If a roster is not submitted by that time, Medical Staff Services will make the roster. Medical Staff Services will distribute these rosters by the twenty fifth ($25^{th}$) of the month prior to the scheduled month.

**C.** It shall be the responsibility of the assigned physician to notify Medical Staff Services of any change from the posted duty roster and the Medical Staff Services Office will change the schedule accordingly and distribute changes to all departments.

**D**. If the assigned physician, while on duty, becomes unable to carry out their on call responsibility, they must immediately notify the Administrator on call and the Chief of Staff.

**E.** If an assigned physician cannot be located, the nurse will act in the following manner:

**1.** Call the alternate physician
**2.** Contact the Medical Director of that particular department.
**3.** Call the Chief of Staff who will either provide or find coverage.
**4.** Call the Administrator on call.

**F.** A copy of the Rules and Regulations concerning the Emergency Department and Emergency Services shall be available in the Emergency Department.

**G**. Emergency Department records must contain sufficient clinical information, treatment data, follow-up instructions, and condition of patient on discharge as to allow easy transferability of the patient from one physician's care to another.

**H.** When called by the ED physician for an admission, it is the responsibility of the on-call physician to admit the patient. If the on-call physician believes the admission is not appropriate, the on-call physician will come to the ED to evaluate the patient within the hour

unless a mutually acceptable alternative to admission is agreed upon by both the ED physician and the on-call physician.

**I.** If a patient's medical condition, as determined by the ED physician necessitates an on-call physician to come to the hospital to evaluate and/or treat the patient for an emergent condition, it is expected that the on-call physician will come to the hospital and evaluate the patient immediately.

## *VII. Suspension Of Admitting Privileges*

A. The member is referred to both the Medical Staff Bylaws and the Rules and Regulations section on Medical Records.

## *VIII. Delineation Of Privileges*

A. The delineation of privileges forms to apply for clinical privileges are filed in Medical Staff Services and updated at each reappointment by the Credentials Committee.

## *IX. Inappropriate Behavior*

A. It is the intent of the Medical Staff to prevent and eliminate inappropriate conduct that may disrupt hospital operations and/or interfere with optimal patient care. Medical Staff members, Medical Associates, and Medical Assistants are expected to refrain from inappropriate behavior. Inappropriate behavior subject to the Rules and Regulations shall mean any one or more of the following:

a. Sexual or other harassment of an individual or individuals that is based on race, color, gender, religion, pregnancy, national origin, age, or disability.

b. Violence (meaning behavior intended to cause harm to either person or property or Behavior bearing a substantial possibility of causing such harm, whether intended or not).

c. Threats of violence.

d. Carrying weapons.

e. Use of alcohol or any illegal drug or inappropriate use of controlled substances while on call or duty.

f. Inappropriate and disrespectful verbalization with respect to individual or individuals.

g. Failure to maintain confidentiality.

**B**. Incidents of inappropriate behavior will be reported to the Chief of Staff confidentially and without further publication or discussion of the report with others, except to the extent necessary to prevent recurrences or to protect the safety of any individual on hospital premises. Instances of violence, threats of violence, carrying weapons, and/or intoxication shall be reported to hospital security as well as the CAO and Chief of Staff. Any complaint of employee harassment must be reported to the Human Resources Department.

**C**. The Chief of Staff will report the instance(s) of inappropriate behavior to the Medical Executive Committee (MEC). After their evaluation, if the MEC determines the reported behavior(s) to be credible, the physician, medical associate, assistant will be notified. It is the responsibility of each committee member to maintain total confidentiality.

**D**. Nothing herein shall prohibit collegial or informal attempts to address inappropriate behavior. The MEC shall have the right to require the reported party to meet with the committee to discuss any aspect of the individual's behavior.

**E.** The MEC shall recommend one of the following courses of action in response to the reported behavior:

1. A letter reminding the physician, medical associate, or medical assistant of his/her responsibilities and the specific behavior(s) and event(s) in question is sent to the physician, medical associate, or medical assistant and a copy placed in his/her quality file.

2. The MEC may decide that a reported behavior is sufficiently egregious to warrant limitation of privileges or precautionary suspension even after a single incident.

3. The MEC may decide that repeated instances of inappropriate behavior should result in limitation or suspension of privileges.

4. Suspension or limitation of privileges shall be reported to the Board in accordance with Medical Staff Bylaws. The Hearing and Appeals Procedure shall apply.

**F.** Documentation of inappropriate behavior shall include:

1. Date and time of behavior
2. If the behavior affected or involved a patient in any way, the name of the patient.
3. The circumstances which precipitated the situation
4. A description of the behavior limited to factual, objective language as much as possible
5. The consequences, if any, of the behavior as it related to patient care or hospital operations
6. Record of any action taken to remedy the situation, including date, time, place, action, and names of those intervening.

**G.** This procedure shall apply only to instances of inappropriate behavior. Concerns related to clinical care of patients are to be referred to the Case Review Committee.

## *X. Enforcement Of The Rules And Regulations*

A. Article X of the Medical Staff Bylaws provides that these Rules and Regulations shall have the same force and effect as the Bylaws.

B. Violation of the Rules and Regulations is subject to the same disciplinary measures described in the Bylaws.

## *XI. Amendment Of The Rules and Regulations*

A. Amendment of the Rules and Regulations shall follow the same procedure described in Article VII of the Medical Staff Bylaws.