**JOINT MEDICAL STAFF**

**RULES & REGULATIONS**

**AND**

**DEPARTMENTAL RULES**

**ST. JOSEPH’S HOSPITAL, INC.**

**AND**

**CANDLER HOSPITAL, INC.**

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# PREAMBLE

St. Joseph’s Hospital, Inc. and Candler Hospital, Inc. are parties to a Joint Operating Agreement under which the two Hospitals operate with a common management team and their governing boards report to a common parent organization, St. Joseph’s/Candler Health System, Inc. The Hospitals each maintain a separate corporate existence and have separate Medical Staffs. Because St. Joseph’s Hospital and Candler Hospital, while separate legal entities, are operated together under a Joint Operating Agreement, joint departments and joint committees are performing many of the functions of their respective Medical Staffs. These Joint Rules and Regulations are intended to authorize the St. Joseph’s Hospital Medical Staff and the Candler Hospital Medical Staff to work in cooperation and coordination with the other as appropriate to achieve efficiencies and enhance the performance of the work done by each organized Medical Staff. **DEFINITIONS**

The following definitions shall apply to terms used in this policy:

1. “Attending practitioner” and “Attending Staff member” mean the Medical Staff member or credentialed practitioner who has primary responsibility for the patient’s care and the completion of the patient’s medical record in a timely manner in accordance with these Rules and Regulations.
2. "Board" or "Boards" mean the Boards of Trustees of Saint Joseph's Hospital, Inc. and/or Candler Hospital, Inc., as applicable to the context and facts, who have the overall responsibility for the conduct of the Hospitals;
3. “Candler,” “Candler Hospital,” “Candler Medical Staff” or the abbreviation “CH” means Candler Hospital, Inc. or its Medical Staff, as the context implies
4. "Chairperson" of a Medical Staff department means the person elected or appointed to serve as "Chairperson" of the department.
5. "Dentist" means both a fully licensed doctor of dental surgery and doctor of dental medicine;
6. "Hospital" or "Hospitals" means both Saint Joseph's Hospital, Inc. and Candler Hospital, Inc., unless one of them is specifically designated or unless another hospital is specifically named;
7. “Licensed independent practitioner” means physicians and any other individual permitted by law and by a Hospital to provide care and services without direction or supervision within the scope of the individual’s license and consistent with individually granted privileges.
8. "MEC" means the Executive Committee of the Medical Staff at either or both Hospitals unless specifically written "Executive Committee of the Board";
9. “Medical Assistant” means licensed or certified healthcare professionals who are approved by one or both Boards to provide clinical services with a physician supervisor in one or both Hospitals and who have been granted authority to provide clinical services within an approved scope of practice.
10. "Medical Staff" means all physicians, dentists, and licensed independent practitioners who are given privileges to treat patients at either or both Hospitals, as applicable to the situation, and specifically includes the Medical Staff of Saint Joseph's Hospital and/or the Medical Staff of Candler Hospital, as the circumstances indicate;
11. "Member" means those physicians, dentists, and other licensed independent practitioners who have been granted Medical Staff appointment and/or clinical privileges by a Hospital Board to practice at its Facility.
12. “Optometrist” means a doctor of optometry.
13. "Physicians" means both doctors of medicine ("MD's") and doctors of osteopathy ("DO's");
14. "Podiatrist" means a doctor of podiatric medicine;
15. “Psychologist” means a licensed psychologist;
16. "President of the Hospital" or "President of a Hospital" means the individual appointed by the Boards to act on their behalf in the overall administration of the Hospitals and in granting Medical Staff membership and privileges, or the designee of that person;
17. "President" of a Hospital's Medical Staff means the person elected to serve as President of the Medical Staff;
18. “SJ/CHS” means St. Joseph’s/Candler Health System, Inc.
19. “St. Joseph’s,” “St. Joseph’s Hospital,” “St. Joseph’s Medical Staff” or the abbreviation “SJ” means Saint Joseph’s Hospital, Inc. or its Medical Staff, as the context implies.
20. “Staff” means members of the Medical Staff of either or both Hospitals, as the context implies;
21. Words used in this policy shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this policy.

# PART ONE: ADMISSION OF PATIENTS

## 1.1 ADMITTING PREROGATIVES

1.1.1 GENERALLY: Only a member in good standing of the Active or Associate, category of the Medical Staff holding clinical privileges to admit patients, may admit patients to a Hospital, subject to the official admitting policies of the Hospital as may be in effect from time to time. Designated representatives of the President of the Hospital with his or her approval submit names of members not in good standing to the Admitting Offices.

1.1.2 LIMITATIONS FOR ORAL SURGEONS AND DENTISTS: An oral surgeon

or a dentist member of the Medical Staff with clinical privileges to admit patients may admit patients to a Hospital on his or her own initiative. Under the conditions specified in the Medical Staff Bylaws, an oral surgeon may perform all or part of the admission medical history and physical examination on his or her patient. Otherwise, all oral surgery and dental patients must receive the same basic medical appraisal as patients admitted for other services, including the performance and recording of the findings in the medical record by a physician member of the Medical Staff of an admission medical history and physical examination and an evaluation of the overall medical risk and effect of any planned operation or procedure on the patient's health.

1.1.3 CO-ADMIT PRIVILEGES FOR PODIATRISTS**:** A Podiatrist may co-admit

patients to a Hospital if the Board approves the Podiatrist for that level of privilege and the patient requires an overnight stay. Any limitations on the Podiatrist’s co-admit privileges approved by the Board shall apply. When a Podiatrist co-admits a patient, there shall at all times be a physician member of the Medical Staff with admitting privileges who is the co-admitter and who accepts responsibility for the patient's medical care during the admission. The physician who co-admits with the Podiatrist must give any orders outside the scope of the Podiatrist’s delineated privileges.

## 1.2 ADMISSION INFORMATION AND ORDER

Except in an emergency, a patient will not be admitted to a Hospital until the practitioner requesting admission provides a provisional diagnosis or a valid reason and order for admission stating the unit to which the patient is to be admitted, i.e., inpatient, observation, a critical care unit, etc. The admitting practitioner is also responsible for documenting the following information concerning a patient to be admitted: Any source of communicable or significant infection; behavioral characteristics that may disturb or endanger others; need for protecting the patient from self-harm.

# PART TWO: ATTENDANCE OF PATIENTS

## 2.1 GENERAL

Each patient will be attended by a member of the Medical Staff who has appropriate clinical privileges to treat the patient's problem. When any patient is under the care of two or more members of the Staff, the name of each Staff member and their role as attending or consulting practitioner must be entered officially on the Hospital records. Unless superseded by Departmental policy, a practitioner is obligated to arrange appropriate follow-up care for the patient.

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## 2.2 CHARITY PATIENTS

Members of the Active Staff and Associate Staff who are applicants for the Active Staff will be assigned, commensurate with their delineated clinical privileges, to attend charity patients according to the on-call schedule for the service to which the patient is admitted.

## 2.3 ALL PATIENTS

Every Hospital patient shall be seen by an attending or covering physician every day and such visit documented in the progress notes except in non-acute settings (i.e., rehabilitation unit, skilled nursing unit, etc.), where the patient shall be seen as required by the unit policy or more often if required by the patient’s condition. If a consult is ordered, the consulting physician shall visit the patient in a timely manner and as often as deemed medically necessary in the judgment of the physicians providing care.

## 2.4 EMERGENCY DEPARTMENT PATIENTS

2.4.1 ADMISSION ORDERS: Admission orders will be given at the time the admission decision is made. If the admitting physician chooses to evaluate the patient in the ED prior to writing orders, they must be available to do so within 30 minutes. If the admitting physician (or their representative) does not arrive within the 30-minute time frame, they will be called back to provide immediate admission orders for the patient. The above time frame may be extended on a case by case basis provided that the admitting physician has explained the reason for the delay, and provided their best estimate of when they will be available to see the patient in the ED.

2.4.2 EVALUATING PRIVATE PATIENTS IN THE EMERGENCY DEPARTMENT (WITHOUT INVOLVING THE ED PHYSICIAN): If a staff physician would like to see a patient in the ED without involving the ED physician, they must be available to evaluate the patient within 30 minutes of the patient’s arrival. The physician must provide the nurse with a way to reach them quickly should there be any questions about the patients care. The evaluating physician will be responsible for the timely interpretation of test results, and will provide disposition instructions for the patient. Under no circumstances may a patient be evaluated in the ED without receiving a medical screening exam. If at any time during the ED stay the nurse feels the patient is unstable or needs immediate attention they will involve the ED physician in the patients care.

## 2.5 ON-CALL EMERGENCY DEPARTMENT RESPONSIBILITIES

* + 1. The Hospital(s) is/are responsible for maintaining an on-call schedule for Emergency Department and unassigned patient care. It is the Department Chairpersons responsibility to determine the call schedules for the departments and specialists as appropriate to provide continuous coverage. The schedules shall include the name and contact information of each physician in the department who is required to fulfill on-call duties. (Physician group names are not acceptable for identifying the on-call physician.) On-call rotation schedules shall be maintained in the Emergency Department(s). Any changes to the schedules are made through the Department Chairperson, reported to the Medical Staff office for updating of the schedule and distribution to the Emergency Departments.
		2. The on-call schedules may be general (e.g., medicine or surgery) or by specialty (general surgery, orthopedic surgery, plastic surgery), as determined by the Medical Staff(s) and Hospital(s) leadership and implemented by the relevant Department Chairperson(s). The Medical Executive Committee shall review the on-call schedule and make recommendations to the CEO and/or Board when formal changes are to be made or legal and/or operational issues arise.
		3. Staff members with 30 years of service may, on application to the Department Chairperson, be exempt from Emergency service.
		4. Since Active and Associate Medical Staff members are required to have staff membership at both Hospitals, some Staff members whose practice is at one Hospital more than another may make application to the Department Chairperson(s) to take Emergency call at the Hospital of his/her primary practice. The Department Chairperson for each Hospital are encouraged to work together to assign the physician to the primary practice Hospital without compromising Emergency Department on-call coverage. If an exemption to call has been granted for any reason, the Medical Staff Leadership and the Board shall have the prerogative to withdraw the exemption based on patient care need and the burden on the remaining physicians.
		5. The physician is responsible for call coverage in their specialty as per their core privileges. If the physician does not feel competent to provide call in an area of their core privileges, it is the physician’s responsibility to provide alternate coverage or make appropriate arrangements through their specific department.
		6. Members of the Medical Staff will not be permitted to relinquish specific clinical privileges for the purpose of avoiding on-call responsibility.
		7. When the Emergency Department contacts an on-call physician, the on-call physician must respond within 30 minutes. The Emergency Department physician, in consultation with the on-call physician, shall determine whether the patient’s condition requires the on-call physician to see the patient immediately. The determination of the Emergency Department physician shall be the controlling in this regard.
		8. A refusal or failure to timely respond shall be reported immediately to the Department Chairperson and, the Vice president of Medical Affairs, who shall review the matter and determine how to address the matter based on the circumstances.
		9. When a physician is on-call for Emergency Department and elects to schedule surgery or other time-consuming procedure or in the case of simultaneous on-call, it is the expectation that the physician will have planned back-up coverage should the need arise.
		10. If you are on call for unassigned patients and are called to the ED to see a patient, your or your covering physician are obligated to come to the ED to evaluate the patient and managed that episode of illness or injury regardless of the patient’s insurance coverage or ability to pay.
		11. If you are on call for unassigned patients and such a patient presents to the ED, is initially treated there, and is referred to the “on-call physician” for follow-up, you or your covering physician are obligated to see that patient and manage that episode of illness or injury regardless of the patient’s insurance coverage or ability to pay.
		12. If you are on call for unassigned patients and another physician admits a patient and consults you for an urgent problem, you are obligated to manage the episode of illness or injury that prompted the consult regardless of the patient’s insurance coverage or ability to pay.

# PART THREE: GENERAL RESPONSIBILITY FOR CARE

## 3.1 GENERALLY

A member of the Staff shall be responsible for the care and treatment of each patient in a Hospital, for the prompt completeness and accuracy of those portions of the medical record for which he is responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner, if any, and to relatives of the patient. Primary responsibility for these matters belongs to the admitting practitioner except when transfer of responsibility is affected pursuant to Section 3.2.

## 3.2 TRANSFER OF RESPONSIBILITY

When primary responsibility for a patient's care is transferred from the admitting practitioner to another Staff member, an order transferring care must be recorded and a note covering the reason for transfer of responsibility. There must be an appropriate exchange of clinical information that is needed to effectively manage patient care (progress reports, dictated reports, etc. will provide this information) and an opportunity to ask and respond to questions and the acceptance of the same must be simultaneously documented in the progress notes. Without this order and note, responsibility for completing the record remains with the admitting practitioner.

## 3.3 ALTERNATE COVERAGE

Each practitioner must assure timely, adequate professional care for his or her patients in a Hospital by being available or designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at the Hospital to care for the patient. There must be an exchange of appropriate clinical information that is needed to effectively manage patient care with an opportunity to ask and respond to questions (for example: dictated reports, progress notes, and contact information). It is the responsibility of the practitioner to confirm that the person who is covering for him/her has clinical privileges that are the equivalent of or higher than his/her own; provided that if the practitioner is a sole practitioner; and there are three (3) or less practitioners in the community credentialed in the same specialty; and the practitioner is primarily a consulting physician provider then the alternative coverage may be provided by a physician who has the general knowledge or ability to provide general care for the proper patient treatment and procedures. Failure of an Attending or Consulting practitioner to meet these requirements may result in loss of Staff membership or such other disciplinary action as the MEC or Board deems appropriate. Each practitioner who will be out of town or unavailable in case of emergency must designate another practitioner to assume responsibility for the care of his/her patients during such absence. This may be done through communication with his/her answering service or any other way that assures appropriate care for his/her patients and rapid contact for hospital staff attempting to reach the practitioner. In the absence of such designation, the President of the Hospital, President of the Medical Staff or applicable Department or Section Chairperson has the authority to call any member of the Staff qualified to care for the patient. Whenever in these Rules an action is required of a practitioner, the person who has been designated to act for him or her in connection with the patient’s care may perform it.

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## 3.4 ORAL SURGEONS, DENTISTS, PODIATRISTS, PSYCHOLOGISTS, OPTOMETRISTS AND MEDICAL ASSISTANTS

3.4.1 Oral surgeons, dentists, Podiatrists, Psychologists, Optometrists and Medical Assistants may treat patients within the scope of their clinical privileges or scope of services and under the conditions provided in the Medical Staff Bylaws. Each Oral Surgeon, Dentist, Podiatrist, Psychologist, Optometrist and Medical Assistant credentialed to do so, is responsible for documenting in the medical record, in timely fashion, a complete and accurate description of the services he or she provides to the patient in accordance with these rules.

More specifically, oral surgeons and dentists are responsible for the following:

* + - 1. A detailed dental history and description of the dental problem documenting the necessity for hospitalization and for any surgery;
			2. A detailed description of the examination of the oral cavity;
			3. A complete operative report, naming the surgeon or dentist performing the procedure and the assistant, if any, and describing the findings, technique, specimens removed and post-operative diagnosis;
			4. Progress notes as are pertinent to the dental condition;
			5. Pertinent instructions relative to the dental condition for the patient and/or significant other at the time of discharge; and
			6. Clinical resume or final summary note.

3.4.2 An oral surgeon, who has been granted the privilege to perform the admission medical history and physical examination on his or her patients who have no medical problems, is also responsible in these instances for the complete medical history and physical examination as required under these Rules. Otherwise, the physician has responsibility for the medical history and physical examination and for the supervision of the patient's general health status, including admission and discharge orders and completion of progress notes relating to the medical status of the patient.

3.4.3 Medical histories, physical examinations, admission work-up results, consultations and discharge summaries written/dictated by a Physician Assistant or Nurse Practitioner shall be signed by the supervising or responsible physician within twenty-four (24) hours following completion. Physician Assistants and Nurse Practitioners are allowed to perform consultations with the consulted physician required to see the patient, approve and countersign the consult note within 24 hours of the request. Physician Assistants and Nurse Practitioners may be allowed to make rounds independent of a supervising or responsible physician or to write progress notes but the patient shall be seen by the attending physician or his/her physician designee within the same day. The requirement of an attending physician or his/her physician designee to see the patient within the same day shall not apply to the date of discharge provided that the patient has been evaluated by the attending physician or his/her physician designee for appropriateness of discharge. Should any Hospital employee who is licensed or certified by the State have any question regarding the clinical competence or authority of the Physician Assistant or Nurse Practitioner either to act or to issue instructions outside the physical presence of the supervising physician in a particular instance, such Hospital employee has the right to require that the supervising physician validate, either at the time or later, the instructions of the Physician Assistant or Nurse Practitioner. Any act or instruction of the Physician Assistant or Nurse Practitioner shall be delayed until such time as the Hospital employee can be certain that the act is clearly within the scope of practice of the Physician Assistant or Nurse Practitioner as permitted by the Board. At all times, the supervising physician will remain responsible for all acts of the Physician Assistant or Nurse Practitioner.

## 3.5 PROCEDURE FOR RESOLVING IMMEDIATE QUESTIONS OF CARE

If a healthcare professional employed by a Hospital has any reason to doubt or question the care provided to any patient, or believes that appropriate consultation is needed and has not been obtained, the employee shall call this to the attention of his or her supervisor who, in turn, shall bring the matter to the attention of the Chairperson of the Department in which the member of the Medical Staff has clinical privileges. Where circumstances justify such action, the Chairperson may request a consultation or take other appropriate action.

## 3.6 AUTHENTICATION

All practitioners who have been granted clinical privileges to make entries in a patient’s medical record must authenticate his or her entry with signature, date and time.

# PART FOUR: TRANSFER OF PATIENTS

## 4.1 ALL TRANSFERS

To ensure continuity of care among settings, organizations and providers, appropriate patient information must be communicated whenever patients are transferred. In addition to any information required by hospital policy, the following information must be shared with other providers assuming responsibility for the patient’s care:

* + 1. the reason for the transfer;
		2. the patient’s physical and psychosocial status;
		3. a summary of care provided and progress toward goals; and
		4. community resources or referrals provided to the patient.

## 4.2 INTERNAL TRANSFER

* + 1. Transfer of a patient from one unit of a Hospital to another (such as between an intensive care unit and an inpatient patient room) shall be accomplished according to the documentation requirements in these Rules, the policies and priorities set forth in the policies of the Hospital and any appropriate departmental policies.
		2. Transfers between Hospital inpatient units and separately licensed facilities that provide a lower level of care (such as Subacute Units, Skilled Nursing Facilities, or Rehabilitation Units), are discharges even if the Hospital and the separately licensed facility are in the same building. The documentation requirements of these Rules applicable to discharges shall apply each time a patient moves from one facility to a separately licensed facility that provides a different level of care so there will be documentation supporting the medical necessity of the change in the level of care.
		3. If a patient is traveling between the two Hospitals for a test or procedure with the intent to return to the originating Hospital, there is neither a transfer nor a discharge.
		4. Transfers of patients between St. Joseph’s Hospital and Candler Hospital when the patient is not expected to return after a test or procedure (or does not return because of an unanticipated event) must be documented as transfers to another hospital.
		5. When lack of bed availability requires patients to be transferred between St. Joseph’s Hospital and Candler Hospital during times of high census, the Hospitals shall make a good faith effort to keep patients at the Hospital where their Attending Physician has privileges or concentrates his/her practice.

## 4.3 TRANSFER TO ANOTHER FACILITY

4.3.1 GENERAL REQUIREMENTS: A patient shall be transferred to another medical care facility only upon the order of the Attending Staff member, only after arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to insure continuity of care must accompany the patient. All Hospital policies relating to transfer for patients must be followed.

4.3.2 SPECIAL CIRCUMSTANCES: See appropriate policies of the Hospital and any appropriate departmental policies.

# PART FIVE: DISCHARGE OF PATIENT

## 5.1 REQUIRED ORDER

A patient may be discharged only on the order of the Attending practitioner. The attending practitioner is responsible for documenting the discharge diagnosis in the discharge progress note at the time the discharge order is written. The Attending practitioner shall dictate the discharge summary, see that the record is complete and if all reports are in, sign the record.

## 5.2 TIME OF DISCHARGE

Every effort shall be made to discharge patients as soon as they no longer need hospitalization. The Attending practitioner shall use his/her best effort to discharge patients by 11 A.M. on the day of discharge.

## 5.3 SPECIAL CIRCUMSTANCES

The process to be followed in handling the situation of a patient or legal guardian demanding discharge against the advice of the Attending practitioner is set forth in the policies of the Hospital and any appropriate departmental policies, including specifically Nursing Administration policies.

# PART SIX: MEDICAL RECORDS

## 6.1 ORDERS - GENERAL

All orders for treatment or diagnostic tests must be documented clearly, legibly and completely and dated, timed and authenticated by the practitioner responsible for them. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the hospital staff. The use of "renew", "repeat", and "continue" orders are not acceptable except as included in properly approved standing orders as described below. Orders for diagnostic tests that necessitate the administration of test substances or medications will be considered to include the order for this administration.

## 6.2 STANDING ORDERS/ORDER SETS/PROTOCOLS

6.2.1 Standing Orders/Order Sets/Protocols are orders developed by physicians and other clinical staff to standardize and optimize care in accordance with current clinical guidelines and standards of practice. These standing orders/order sets/protocols play a role in reducing medication errors and promoting optimal treatments for patients with certain conditions.

6.2.2 The use of standing orders/order sets/protocols must be documented as an order in the patient’s medical record and dated, timed and authenticated by the practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely, and necessary care or other patient safety advances.

6.2.3 It is the expectation that standing orders/order sets/protocols, where appropriate, will be used by all medical staff members.

6.2.4 The policy of the Hospitals developed by the Hospitals and the Medical Staff(s) for development, approval, and implementation shall be followed with respect to Standing Orders/Order Sets/Protocols.

## TELEPHONE ORDERS

* + 1. Telephone orders shall be used only in situations where immediate or electronic communication is not feasible and the patient’s condition is determined to warrant immediate action for the benefit of the patient.
		2. Telephone orders shall be received by an appropriately licensed or otherwise qualified individual as determined by the medical staff in accordance with state law.
		3. The individual receiving the order shall immediately read back the order and the prescribing physician or other authorized practitioner shall verify that the read back order is correct. The individual receiving the order shall document, in the patient’s medical record, that the order was “read back and verified.” (This may be indicated by using lower case letters “r/v”.)
		4. Where the procedures outlined in paragraph 6.3.3 above are followed, the hospital shall require all verbal/telephone orders be dated, timed and authenticated no later than thirty (30) days after the patient’s discharge.

## 6.4 INTENTIONALLY OMITTED

## 6.5 AUTOMATIC CANCELLATION OF ORDERS

6.5.1 MEDICATION ORDERS-DURATION: All dated, timed and authenticated orders for medications should specify the administration times, the interval between doses, and the length of duration for administration. If no duration is stated, it will be assumed that the medication(s) is/are to continue for the length of stay of the patient.

6.5.2 MEDICATION ORDERS-AUTOMATIC CANCELLATION: All orders for medications will be automatically stopped as set forth in the current Medication-Automatic Stop Order policy of the Hospitals.

6.5.3 ORDERS FOR PATIENTS IN INTENSIVE CARE UNITS: For patients being transferred to or from intensive care units, all current physician's orders will be rewritten and dated, timed and authenticated, unless the patient was admitted or transferred within the last twenty-four (24) hours or unless the physician has written transfer orders.

## 6.6 SPECIAL ORDERS

6.6.1 PATIENT’S OWN DRUGS AND SELF-ADMINISTRATION: The administration and/or storage of a patient’s own medications shall be governed by the current Home Medication Order Clarification & Storage policy of the Hospitals*.* Self-administration of medications by a patient will be governed by the Medication Administration policy of the Hospitals.

6.6.2 DO NOT RESUSCITATE (DNR) ORDERS: Orders for Do Not Resuscitate/Allow Natural Death shall be governed by the current Do Not Resuscitate/Allow Natural Death (DNR/AND)policy of the Hospitals.

6.6.3 RESTRAINT ORDERS: Orders for restraints shall be governed by the current Restraint Policy of the Hospitals which applies to all Medical Staff members, others who have clinical privileges or are permitted to practice within the scope of their job descriptions and hospital staff.

## 6.7 FORMULARY

 6.7.1 Any drug or medication that has been approved and released by the Food and Drug Administration (“FDA”) may be used in patient care in the Hospital unless restricted by the MECs and the Boards. However, only drugs and medications that have been reviewed and approved for inclusion in the Hospital Formulary by the Pharmacy and Therapeutics Committee will be routinely available. Medications brought into a hospital by a member of the Medical Staff may be used for patient care only when these medications are controlled through the Pharmacy. Unless an exception is otherwise agreed upon by the Pharmacy, medications that are compounded outside of the hospital may not be used for patients treated in SJ/CHS facilities. The Institutional Review Board must review and approve the use of any drug study/investigational drug or medication. Medications not approved by the FDA must be approved by the Pharmacy and Therapeutics Committee before inclusion on the Hospital Formulary. In the case of equivalent drugs made by reputable pharmaceutical manufacturers, if the bio-availability and efficacy of such drugs has been established, substitution by the Pharmacy under the general direction of the Pharmacy and Therapeutics Committee is allowed. If the practitioner does not want a substitution, he or she must signify "No Substitution" on each order where there is possibility of substitution of an equivalent drug.

6.7.2 The Staff shall be notified of any new equivalent drug(s) approved for substitution and a list of all equivalent drugs approved for substitution will be made available electronically on the hospital formulary.

## 6.8 REVIEW OF ORDERS

Hyperalimentation protocols will be approved by the Pharmacy and Therapeutics Committee.

## 6.9 ORDERS FOR OUTPATIENT PROCEDURES:

* + 1. In order to properly establish “medical necessity” for outpatient services and referred specimens, the practitioner must document a diagnosis, condition, symptom, injury or other reason for the encounter or visit which is primarily responsible for the services provided. The clinical reason should be based on specific symptoms of a diagnosis or condition that will support the test or service. The terms “rule out,” “suspected,” “questionable,” “probable” and “working diagnosis” should not be used as a clinical reason for ordering an outpatient test or service. Instead, state the symptoms or condition that demonstrate medical necessity of the test or service.
		2. The practitioner who is responsible for ordering the test or service must properly date, time and authenticate each order.
		3. All orders for outpatient services will be filed as part of the patient’s medical record.

## 6.10 TISSUE EXAMINATION AND REPORTS

 6.10.1 Any such cases and pathology slides which are going to be utilized to support major cancer surgery must have the pertinent previous pathology report in the medical record prior to surgery. When the pathologic specimen was neither read at Candler Hospital or St. Joseph’s Hospital by a hospital-based pathologist nor obtained directly by the surgeon who will perform the cancer surgery, then it must be reviewed by a hospital-based pathologist prior to surgery.

 6.10.2 Except as provided below, all specimens removed during a procedure shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the pathologist, who shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the pre-operative and post-operative diagnoses. An authenticated report of the pathologist's examination shall be made a part of the medical record.

 6.10.3 Exceptions to sending specimens removed during a surgical procedure to the laboratory shall be made only when the quality of care is not compromised by the exception, when another suitable means of verification of the removal is routinely explored, and when there is an authenticated operative or other official report that documents the removal. The categories of specimens that are exempted according to these principles are:

* + - 1. Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure.
			2. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.
			3. Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary.
			4. Foreign bodies, e.g., bullets, that for legal reasons are given directly in the chain of custody to law enforcement representatives.
			5. Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible post-operatively, e.g., the foreskin from the circumcision of a newborn infant.
			6. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics.
			7. Teeth, provided the number, including fragments, is recorded in the medical record.
			8. Others as may be enumerated in the current list of exempted specimens approved by the MECs and the Boards.

## 6.11 MEDICAL RECORDS - GENERAL

* + 1. The Attending practitioner shall be responsible for the preparation of a timely, complete and legible medical record for each patient under his or her care. This responsibility cannot be delegated. The contents of the record shall be pertinent and current.
		2. Opinions requiring medical judgment should be written or authenticated only by medical staff members.
		3. All entries in the medical record are dated, timed and authenticated by the person making the entry. The duty to authenticate an entry in a medical record cannot be delegated to another practitioner.
		4. In accordance with federal law and regulation, the use of any device for authentication other than handwritten signature, computerized security and authentication code (e-signature) is not permitted.
		5. Non-standard abbreviations may not be used for documentation in the medical record. If an unknown abbreviation is found in the record, the author will be queried as to the meaning of the term. Standard abbreviations that have commonly understood meaning may be found in publications such as *Stedman’s Medical Dictionary and/or Dorland’s Medical Abbreviations*, *W. B. Saunders Company*, copies of which are available in the Health Information Management Department offices.
		6. No original medical records, or microfilm of original records of any type (including but not limited to paper charts and any portion thereof, pathology samples or slides (unless found by a pathologist to be surplus duplicates) and any other original information or data may be removed from a Hospital's jurisdiction and safekeeping other than those records or items that:
			1. are subject to a court order specifically requiring removal of the original medical record;
			2. are tissue blocks that are sent out for consultation with appropriate tracking, upon the approval of the Director of Pathology;
			3. are for purpose of microfilm reproduction;
			4. are diagnostic imaging film removed in accordance with Hospital policy; or
			5. are sent to a contracted offsite storage facility.

Unauthorized disclosure of protected health information and/or removal of medical records from a Hospital is grounds for suspension of the practitioner for a period to be determined by the MEC.

## 6.12 MEDICAL RECORD CONTENT

The Content of Medical Records shall be governed by current policy of the Hospitals.

6.12.1 General Statements

* + - 1. Only healthcare professionals with clinical privileges or job descriptions approved by the Board and authorized Hospital employees shall be responsible for documenting in the medical record.
			2. An adequate medical record is maintained for each individual who is evaluated or treated.
			3. The content of the medical record is sufficiently detailed to enable:
* Practitioners to provide continuing care to the patient
* Determine a patient’s condition at a specific time
* Review diagnostic and therapeutic procedures performed
* Determine patient’s response to treatment.
	+ - 1. All entries are dated, timed and authenticated by the recording/ordering practitioner. Medical histories, physical examinations, work-up results, consultations and discharge summaries written/dictated by Physician Assistants or Nurse Practitioners shall be signed by the supervising or responsible physician within twenty-four (24) hours following completion.

* + - 1. Documentation required prior to invasive and/or high-risk procedures: (i.e. open-heart surgery, hip surgery)
* Patient’s History and Physical, and a preoperative diagnosis
* Diagnostic data indicating medical necessity
* Risk and benefits of procedures
* Need to administer blood or blood components
* Pre-anesthesia or pre-sedation assessment, for any patient for whom moderate or deep sedation or anesthesia is contemplated

- Including determination of candidacy of anesthesia or sedation

- for any moderate sedation patient the ASA classification and physical exam of the airway, heart, lungs, and level of consciousness is to be documented by the physician

- patient’s re-evaluation immediately prior to procedure.

6.12.2 Admission Note, shall contain:

* Diagnosis / Reason for visit
* Admission / Treatment plan
* Patient status (inpatient or observation).
	+ 1. Complete History and Physical shall be required for high risk invasive procedures, and inpatient admissions and further shall be:
			1. Recorded and included in the medical record within 24 hours after admission and prior to performance of surgery or invasive procedure, except in emergent situations. See Emergency Section.
			2. Completed by qualified and credentialed practitioner upon admission.
			3. A complete, legible office or prior hospitalization History and Physical by any physician may be used if completed within thirty (30) days prior to admission (office notes are not acceptable). An update must be entered into the record within 24 hours after admission or prior to surgery. The update to the H&P must contain the following elements:
* Documentation that the H&P was reviewed; and
* Documentation that the patient was examined; and
* A statement the “no change” has occurred in the patient’s condition since the H&P was completed; OR
* Documentation of any changes in the patient’s condition since the H& P was completed.
	+ - 1. Acceptable methods for updating a History and Physical include:
* A written update on the original History and Physical;
* A complete “History and Physical Update” form; and/or
* An admission note that contains the required elements.
	+ - 1. In an emergency, a physician progress note prior to induction of anesthesia or sedation details the patient’s condition until a formal history and physical or an acceptable H&P update can be documented. The progress note may reference findings in the records from transferring facilities. The transferring facilities History and Physical, if used, must then be updated within 24 hours after admission or a complete H&P must be dictated and placed on the patient chart within 24 hours after admission.
			2. A consult note with timely updates may be used as a History and Physical if that consultation note contains all of the necessary elements of a History and Physical.
			3. Dentists, oral surgeons and podiatrists are responsible for documenting their part of the patients’ history and physical examination and associated risks. The patient’s general medical condition is the responsibility of the attending physician.
* A complete history and physical examination shall be recorded on the patient’s chart and dated, timed and authenticated within twenty-four (24) hours following admission. This report shall reflect a comprehensive, current, physical assessment by a doctor of medicine or osteopathy or an appropriate allied health professional (Medical Assistant) who has been granted privileges or given permission by the Hospitals to perform histories or physicals. If an allied health professional (Medical Assistant) completes the history and physical examination, a doctor of medicine or osteopathy shall authenticate the history and physical examination, taking responsibility for the record being accurate and complete. If the patient is admitted solely for oral maxillofacial surgery, the oral maxillofacial surgeon may complete the history and physical exam. If the patient comes to the hospital solely for outpatient podiatry surgery, the podiatrist may complete and update the history and physical exam.
	+ - 1. Completed within twenty-four (24) hours of admission/registration.
			2. Must contain the following items:
* Medical History

- Date of Admission

- Chief complaint & Reason for admission

* May refer to information in the health records received from the transferring facility so that severity of illness and relevant medical conditions are incorporated into the medical record

- Details of present illness

* Onset
* Duration
* Course

- Relevant past, social, and family histories (age appropriate)

* Summary of psychosocial needs (age appropriate)
* A review of systems
* Physical examination findings, current and complete
* Impressions drawn from physical examination
* Diagnosis or diagnostic impression
* Planned course of action for episode of care and goals of treatment plan.
	+ 1. Diagnostic and Therapeutic Orders shall be:
			1. Telephone orders of authorized individuals are accepted and transcribed as provided according to Verbal Order Rule.
			2. Diagnosis justifying medical necessity shall be documented
			3. Included in the patient’s medical record
			4. Dated and timed Authenticated by the ordering practitioner (within forty-eight (48) hours if verbal)

* + 1. Progress Notes, shall be:

6.12.6.1 Recorded at time of observation

6.12.6.2 Documented at least daily by a physician or a Nurse Practitioner or Physician Assistant in acute settings and as frequently as required by unit policy in non-acute settings

* + - 1. Dated and timed
			2. Authenticated by author
			3. Provide specific, objective information sufficient to permit continuity of care and transferability of patient that reflects:
* changes in patient condition
* results of treatment
* revisions to treatment plan
* clinical observations
* conclusions at termination of stay.
	+ 1. Consultation report shall contain:
* Date of consult
* Reason for consult
* Assessment of consultant
* Findings and recommendations of consultant
	+ 1. Results of tests and procedures
			1. When a full Operative/Procedure report cannot be entered immediately into the patient’s medical record, a Post Procedure Progress Note may be documented in the medical record immediately following the procedure. The Post Procedure Progress Note shall include:
* Name of primary surgeon and surgical assistants
* Procedure(s) performed
* Description of each procedure finding
* Estimated blood loss
* Specimens removed
* Postoperative diagnosis
	+ - 1. Operative/Invasive/High Risk Procedure Reports
* Dictated or hand-written in entirety immediately following procedure
* Contains:

- Date and times of operation

- Name(s) of surgeon(s), surgical assistants

- Preoperative diagnosis

- Postoperative diagnosis

- Description of techniques, findings, and any specimens and/or tissues removed or altered

- Type of anesthesia

- Complications, if any

- Estimated blood loss

- Prosthetic device, grafts, tissues, transplant or devices implanted, if any

- Condition of patient

* Included in medical record as soon as possible.
	+ 1. Discharge Summary shall be:
			1. Documented and authenticated in medical record within thirty (30) days of discharge
			2. Final discharge progress note may be substituted for discharge summary for patients with:
* Problems of minor nature that require hospitalization of less than 48-hour period
* Normal newborn infants
* Uncomplicated obstetric deliveries, vaginal or cesarean section
* Progress note must contain

- Patient’s condition on discharge

- Discharge instructions

- Follow-up care required.

* + - 1. Dictated discharge summary shall include
* Reason for hospitalization
* Significant findings
* Procedures and treatments rendered
* Condition on discharge
* Relevant final diagnoses
* Conclusions from hospitalizations
* Instructions to patient and family regarding

- Limitations on activities

- Medications

- Diet

- Follow-up.

* + - 1. All cases of patient death require a full discharge summary.
		1. Autopsy Report
			1. When performed, anatomical diagnoses are recorded within three (3) days.
			2. Protocol is made part of record within 60 days unless special studies are established by medical staff.
		2. Emergency and ambulatory medical records shall include:
* care rendered prior to treatment
* summary of psychosocial needs (age appropriate)
* pertinent history of illness/injury
* physical findings
* conclusions at termination of evaluation/treatment
* final disposition
* patient’s condition on discharge or transfer
* instructions for care.
	+ 1. Obstetrical records
			1. Must include:
* complete prenatal history current to within thirty (30) days of admissions and entered into patient’s medical record prior to admission

- on medical record prior to surgery

- interval admission note including pertinent additions to history and subsequent changes in physical findings since last practitioner office visit

- a complete history and physical is required if the prenatal record is not on the patient’s record on admission and before surgery.

* + - 1. Obstetric surgical patients must have completed obstetrical admission record prior to surgery.
		1. Advance Directives: Prior to obtaining documentation of the actual advance directive that the patient has previously completed, the substance of the directive is to be documented in the patient’s medical record.

##  6.13 MEDICAL RECORD COMPLETION TIME REQUIREMENTS AND ENFORCEMENT POLICIES

6.13.1 DELINQUENT MEDICAL RECORD CRITERIA: Medical records must be completed after discharge to comply with regulatory standards. History & Physical reports, and Operative/Surgical Procedure Reports must be completed within required time limits. The remainder of the record should be completed within 21 days of discharge. The entire medical record is complete when all required contents are in the chart and authenticated. Failure to complete medical records in accordance with these Rules and Regulations shall result in the disciplinary action as defined in Paragraph 6.13.2.

* + 1. MONITORING, NOTICE AND DISCIPLINARY ACTIONS FOR DELINQUENT MEDICAL RECORDS
			1. Monitoring of timeliness of medical record completion will be conducted daily on all charts, Monday through Friday, excluding legal holidays.
			2. The History & Physical must be completed within 24 hours after admission, but prior to surgery. Any update to the History & Physical must be documented within 24 hours after admission, but prior to surgery. History & Physicals are monitored daily and the physician will be informed of the record’s delinquent status.
			3. An Operative/Procedure Note must be written or dictated and authenticated by the surgeon immediately following surgery and prior to transfer to the next level of care. If an Operative/Procedure Note is not completed with the required timeframe, the physician will be informed of the record’s delinquent status.
			4. The physician will receive weekly faxed notification of all incomplete and delinquent records. Staff physicians have access to the current list of incomplete records in Meditech.
			5. All charts must be completed, including authentication, within 21 days of discharge.
			6. Records are considered delinquent at 21 days and must be completed within 9 days. Records requiring dictation should be dictated and authenticated within the 21-day timeframe. Failure to complete delinquent records including dictation and authentication within nine (9) days of notification will be deemed as a voluntary limited relinquishment of clinical privileges. The voluntary limited relinquishment of clinical privileges will remain in effect until all delinquent records are completed.
			7. The Medical Affairs office will notify the physician by telephone of his/her voluntary limited relinquishment of clinical privileges. The Vice President of Medical Affairs shall also send a notice requiring the recipient’s signature, to the practitioner. A copy of the letter will be mailed to the Department Chair of the practitioner and to the Medical Staff Office for their Credentials file.
			8. Physicians who are under voluntary limited relinquishment of clinical privileges for delinquent records will not be allowed:
* to admit any new patients;
* to schedule, perform, or assist in any surgeries or procedures.
	+ - 1. Physicians who are under voluntary limited relinquishment of clinical privileges for delinquent records will be allowed to continue to follow currently registered patients;
			2. Physicians with delinquent records for any reason may only be granted an extension by the Vice President of Medical Affairs or Director of Health Information Management or his/her designee. If the voluntary limited relinquishment of privileges had occurred through an inadvertent error by the Health Information Management Department, the Director of Health Information Management or his/her designee may reinstate the suspended practitioner after verification of the error has been made.
			3. Physicians who are under voluntary limited relinquishment of clinical privileges for delinquent records will be required to find a replacement to take emergency department call.
			4. A physician who is under voluntary limited relinquishment clinical privileges for delinquent medical records 6 or more times within one year (rolling 12 months) shall have voluntarily resigned from the Medical Staff. For each thirty (30) day period that the physician does not respond to a notice of suspension, an additional suspension will occur each month until a total of six (6) suspensions have been accrued and the physician shall have voluntarily resigned from the Medical Staff.
			5. Any physician who has resigned from the Medical Staff pursuant to this Rule shall be ineligible to reapply for Staff membership and clinical privileges until all of his/her medical records are complete and three months have passed since the effective date of resignation stated in the notice sent by the Vice President of Medical Affairs.
			6. Upon loss of Staff membership and clinical privileges under this Rule, the physician must designate another Medical Staff member with similar privileges to whom his or her patients applying for emergency care may be referred. Upon presentation of patients for care, the patient or his/her representative shall be informed of the inability of the resigned physician to treat the patient at this Hospital and shall be offered the options of choosing either the designated alternative Medical Staff member, another member of the Medical Staff of the patient’s choice, or the Medical Staff member on call for that service at that time. Should a physician resign under this Rule during the period of his/her service on Emergency Room rotation, said physician shall designate, subject to approval by the Chairperson of the Department, another Medical Staff member to serve in his or her stead.

## 6.14 ACCESS TO RECORDS

Access to medical records is governed by the current Health Information Management; Release of Health Information; Confidentiality Breach; Disclosing PHI for Research Release; Faxing of Protected Information; and Medical Record – Minimum Necessary Accesspolicies of the Hospitals.

# PART SEVEN: INFORMED CONSENTS

## 7.1 GENERAL

Each patient's medical record must contain evidence of the patient's general informed consent for treatment during hospitalization. Consent must be obtained in accordance with the current Consent - General Treatment/Treatment Authorization/Financial Agreementpolicy of the Hospitals.

## 7.2 ADDITIONAL INFORMED CONSENT REQUIRED

7.2.1 WHEN REQUIRED: Informed consent shall be obtained in accordance with the current Consent – Informed Consent for Medical/Surgical Procedurespolicy of the Hospitals, and is required for, but is not limited to, any surgical procedure, amniocentesis, any diagnostic procedure utilizing intravenous or intraductal injection or contrast material, chemotherapy or radiation therapy.

7.2.2 DOCUMENTATION REQUIRED: Informed consent must be documented in the patient's medical record or on an approved form appended to such record. Required content of the consent is defined in and must be obtained in accordance with the current Consent - General Treatment/Treatment Authorization/Financial Agreement and Consent – Informed Consent for Medical/Surgical Procedurespolicies of the Hospitals.

7.2.3 SIGNATURES: Informed consent must be signed by the patient (or on the patient's behalf by the patient's authorized representative). The patient's signature must be witnessed by a legally competent third party.

7.2.4 EMERGENCIES: If circumstances arise where it is deemed medically advisable to proceed with procedure or treatment specified in subsection 7.2.1 without first obtaining the patient's consent, such circumstances must be explained in the patient's medical record by the responsible physician. Where possible, two physicians shall document the medical advisability of proceeding without consent.

# PART EIGHT: CONSULTATION

## 8.1 REQUIRED CONSULTATIONS

Unless the Attending practitioner has been granted the requisite clinical privileges in the area of the patient's illness, consultation with a qualified physician is required in the following cases:

* + 1. Problems of critical illness in which any significant questions exist of appropriate procedure or therapy;
		2. Cases of difficult or equivocal diagnosis or therapy;
		3. Cases where the patient is not a good risk for operation or treatment;
		4. Unusually complicated situations where specific skills of other Staff members may be needed;
		5. When requested by the patient or his or her family; and
		6. A patient's personal practitioner, if a member in good standing of the Medical Staff, may act as consultant on that patient, regardless of other required qualifications.

Consultations for patients in a special services unit are sought and provided as required by the specific policies for that unit.

## 8.2 RESPONSIBILITY FOR CALLING CONSULTANT

8.2.1 The Attending Staff member is responsible for calling a consultation from a qualified Staff member when the best interests of his or her patient require it and when required by these rules or other policies of the Staff, any of its clinical units, or the Hospital.

8.2.2 When there are indications that the best interests of a patient will be served, the Chairperson of the Department or physician director of the clinical unit in which the patient is under care, or the President of the Medical Staff, may direct that a consultation be held and, if necessary, arrange for such consultation. In such instances, if the Attending Staff member disagrees with the necessity for consultation, the matter shall be brought immediately to the President of the Medical Staff for decision and direction.

## 8.3 QUALIFICATIONS OF CONSULTANT

Any qualified Staff member may be called as a consultant regardless of his or her Staff category assignment. A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or sub-specialty board or by a suitable degree of demonstrated competence based on equivalent training and extensive experience. In either case, a consultant must have demonstrated the skill and judgment requisite to evaluating and treating the patient's condition or problem and must have been granted the requisite privileges to do so. If a consultation is requested from a physician who is part of a group of physicians, any one of the members of the group qualified to provide the consultation may respond, unless the request clearly states that specific physician is to provide the consultation. An advanced practice professional (PA, NP) can perform a consultation with the consulted physician required to see the patient, approve and countersign the consult note within 24 hours of the request.

## TIMELINESS OF RESPONSE TO CONSULTATION REQUEST

8.4.1 The consulted physician (or his/her covering physician) is required to see the patient within 24 hours for non-urgent consultation requests unless other arrangements are made with the consulting physician. Physician to physician contact is requisite for urgent consultation requests. Failure to see the patient in a timely manner shall be reported to the Department Chair, Joint Credentials Committee, and the Medical Executive Committee. Continued failure to see the patient in question, or repeat failures to see consults within the specified timeframes may result in disciplinary action.

8.4.2 Physicians may opt not to accept a new referral for consultation if they are not on ED unassigned call. Notification of such refusal must occur through physician-to-physician communication with the referring physician, and not through nursing or other hospital staff. The referring physician may then consult another physician of choice, or consult the Emergency on-call physician. Notification of such consultation must occur through physician-to-physician communication, and not through nursing or other hospital staff.

## DOCUMENTATION

When requesting consultation, the Attending practitioner may indicate in writing on the consultation record the reason for requesting consultation and the extent of the involvement in the care of the patient expected from the consultant, e.g. "for consultation only," "for consultation and orders," "for consultation, orders and follow-up." The consultant must make and sign a report of his or her findings, opinions and recommendations that reflects an actual examination of the patient and the medical record. Such report shall become part of the patient's medical record.

# PART NINE: SPECIAL SERVICES UNITS AND PROGRAMS

## 9.1 DESIGNATION

Special services, units and programs may be designated by the Hospital(s) from time to time and at the time and are posted in the Medical Staff Office at each Hospital and on the Internet and Intranet websites of SJ/CHS.

## 9.2 POLICIES

Appropriate officers, committees and departments of the Medical Staff will develop, in coordination with applicable Hospital departments, specific policies for the special services units and programs, covering, when applicable, such subjects as the responsibility for care of patients in the unit/program, criteria for patient admission to the unit/program, admission/discharge/transfer protocols, direction/organization of the unit/program, special record-keeping requirements, etc. The policies of the various units and programs will be coordinated by the appropriate Hospital and Medical Staff departments and are subject to the approval of the MEC and the President of the Hospital.

# PART TEN: GENERAL RULES REGARDING EMERGENCY SERVICES

## 10.1 POLICY DEVELOPMENT

General emergency services are provided by physicians under contract with the Hospital who are members of the Medical Staff and the Joint Emergency Department. This care shall be provided in accordance with the Emergency Department policies. Policy and procedure manuals for the Joint Emergency Department physicians shall be developed in conjunction with the Emergency Department Head Nurse. These policies shall be developed by the Staff and the various clinical units and are subject to the approval of the MEC and the President of the Hospital.

# PART ELEVEN: INFECTION CONTROL

## 11.1 POLICY AND PROCEDURES

A comprehensive and multifocal infection control program has been adopted in order that better and safer hospital facilities may be provided for patients and personnel. Procedural guidelines are established in the Hospital’s Infection Control Policy utilizing standards of The Joint Commission and the Centers for Disease Control in Atlanta. The Medical Staff Infection Control Committee oversees this process. (See the policies of the Hospitals including specifically the Infection Control Manual, and the Medical Staff Joint Organization and Functions Manual.).

# PART TWELVE: HOSPITAL DEATHS AND AUTOPSIES

## 12.1 HOSPITAL DEATHS

In the event of the death of a patient in the Hospital, the deceased shall be pronounced (dead) by the attending physician or his or her designee physician within a reasonable period of time. The attending physician is responsible for completion of the Death Certificate.

## 12.2 AUTOPSIES

Autopsies will be considered in accordance with the requirements set forth in the current Autopsy Criteriapolicy of the Hospitals.

# PART THIRTEEN: INTENTIONALLY OMITTED

# PART FOURTEEN: CANDLER DEPARTMENT OF ANESTHESIOLOGY RULES

## 14.1 NAME

The name of this organization shall be the Department of Anesthesiology of the Medical Staff of Candler Hospital.

## 14.2 MEMBERSHIP

The Department shall be composed of those members of the Medical Staff who satisfy the qualifications for Staff membership set forth in the Medical Staff Bylaws and who have been granted clinical privileges in Anesthesiology through the established credentialing process.

## 14.3 DEPARTMENT SPECIFIC RULES

14.3.1 PRE AND POST-ANESTHESIA OR SEDATION: The pre-anesthesia or sedation evaluation of the patient by an anesthesiologist with appropriate documentation of pertinent information as required by applicable operating room policies shall be done prior to surgery. At least one post-anesthesia or post-sedation note describing the presence or absence of anesthesia-related or sedation-related complications shall be recorded, if possible, on all patients by an anesthesiologist or his or her qualified designee. Reference is made to the Patient Care Policies covering the operating room, recovery room, and day surgery program for additional anesthesia-related and sedation-related rules.

14.3.2 COVERAGE RULES:

 14.3.2.1 Surgical Anesthesia or Sedation: Members of the Department of Anesthesiology with Privileges in surgical anesthesia will be responsible for providing emergency coverage for the operating room.

 14.3.2.2 Sub-specialty Anesthesia: Members of the Department of Anesthesiology with Privileges in a sub-specialty area of anesthesia will be responsible for providing emergency coverage in that sub-specialty area only and will be exempt from emergency coverage of the operating room for surgical anesthesia as long as his or her practice is limited to his or her sub-specialty area.

# PART FIFTEEN: JOINT DEPARTMENT OF CARDIOVASCULAR SERVICES RULES

## 15.1 NAME

The name of this organization shall be the Department of Cardiovascular Services of St. Joseph’s and Candler Hospitals.

## 15.2 MEMBERSHIP

The Department shall be composed of those members of the St. Joseph’s and Candler Medical Staffs who satisfy the qualifications for Staff membership set forth in the Medical Staff Bylaws and who have been granted clinical privileges in Cardiology and Cardiothoracic through the established credentialing process.

## 15.3 DEPARTMENT SPECIFIC RULES

15.3.1 Each member of the Department must fulfill the basic obligations of Staff membership set forth in the Medical Staff Bylaws and the specific obligations that attach to his or her category of Staff membership as set forth in Article II of said Bylaws. In addition, Active and Associate Staff members of the Department may be assigned by the Department Chair, on a rotational basis, to emergency unassigned call coverage for cardiology and cardiovascular services. The Department Chair may assign Adjunctive staff emergency call coverage, as necessary, to meet the needs of the Hospitals.

15.3.2 Only those members who are Active members of the Staff may vote on matters presented to the Department. When decisions are required to be made that effect persons with one type of privileges (section) and not all the department members, it is the discretion of the individual members attending to vote or abstain on the issue.

# PART SIXTEEN: JOINT DEPARTMENT OF EMERGENCY MEDICINE RULES

## 16.1 NAME

The name of this organization shall be the Joint Department of Emergency Medicine. It is a department of the Medical Staffs for St. Joseph’s and Candler Hospital.

## 16.2. MEMBERSHIP

The Department shall be composed of those members of the Medical Staff who satisfy the qualifications for Staff membership set forth in the Medical Staff Bylaws and who have been granted clinical privileges in Emergency Medicine through the established credentialing process.

## 16.3 DEPARTMENT SPECIFIC RULES

16.3.1 Patients requiring specialized care in critical care areas will be transferred from the Emergency Department as soon as deemed practical by the Emergency Department physician or the private attending.

16.3.2 EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA): The following individuals will be considered “Qualified Medical Personnel” as such term is used in the EMTALA to provide a “Medical Screening Examination” in the ED: (1) physicians for all level of care, (2) nurse practitioners, and (3) physician assistants for Level 1 and 2 patients.

# PART SEVENTEEN: CANDLER DEPARTMENT OF FAMILY PRACTICE RULES

## 17.1 NAME

The name of this organization shall be the Department of Family Practice of the Medical Staff of Candler Hospital.

## 17.2 MEMBERSHIP

The Department shall be composed of those members of the Medical Staff who satisfy the qualifications for Staff membership set forth in the Medical Staff Bylaws and who have been granted clinical privileges in Family Practice through the established credentialing process.

## 17.3 DEPARTMENT SPECIFIC RULES

Each member of the Department must fulfill the basic obligations of Staff membership set forth in the Medical Staff Bylaws and the specific obligations that attach to his or her category of Staff membership as set forth in Article II of said Bylaws. In addition, Active and Associate Staff members of the Department may be assigned, on a monthly rotational basis, to the on-call list for the Emergency Department coverage. They may be required to see, treat and/or admit patients referred to them by the Emergency Department physicians during their month of rotation. They must follow the patient being referred to them for that period of illness in the Hospital or make arrangements for referral of these patients.

# PART EIGHTEEN: CANDLER DEPARTMENT OF MEDICINE RULES

## 18.1 NAME

The name of this organization shall be the Department of Medicine of the Medical Staff of Candler Hospital.

## 18.2 MEMBERSHIP

The Department shall be composed of those members of the Medical Staff who satisfy the qualifications for Staff membership set forth in the Medical Staff Bylaws and who have been granted clinical privileges in Internal Medicine, Dermatology, Neurology, Nephrology, Oncology/Hematology, Pulmonology, Allergy/Immunology, Endocrinology, Infectious Diseases, Rheumatology or Psychiatry through the established credentialing process.

## 18.3 DEPARTMENT SPECIFIC RULES

The Department Chairperson will appoint the following standing committees: Mortality and Morbidity and Ad Hoc Committees as needed. Each member of the Department must fulfill the basic obligations of Staff membership set forth in the Medical Staff Bylaws and the specific obligations that attach to his or her category of Staff membership as set forth in Article II of said Bylaws. In addition, Active and Associate Staff members of the Department may be assigned, on a rotational basis, for Emergency Department coverage of Internal Medicine, Dermatology, Neurology, Psychiatry and Nephrology.

# PART NINETEEN: JOINT DEPARTMENT OF OB/GYN RULES

## 19.1 NAME

The name of this organization shall be the Department of Obstetrics and Gynecology (OB/GYN). It is a department of the Medical Staff at Candler Hospital. Its services have been consolidated at Candler Hospital. Only emergency and consulting services are provided at St. Joseph’s Hospital, where its service falls under the Department of Surgery. For purposes of credentialing at St. Joseph’s Hospital, the applications for appointment and reappointment will be reviewed by the Chairperson of the Department of Surgery or his/her designee, who may be the Chairperson of the Joint Department of OB/GYN.

## 19.2 MEMBERSHIP

The Department shall be composed of those members of the Medical Staff who satisfy the qualifications for Staff membership set forth in the Medical Staff Bylaws and who have been granted primary clinical privileges in Obstetrics and Gynecology through the established credentialing process.

## 19.3 DEPARTMENT SPECIFIC RULES

* + 1. The medical care evaluation activity of the Department shall include review of primary C-sections, maternal deaths and cases referred by other applicable authorities of the Medical Staff and Hospital.
		2. All patients presenting to the Birthplace at Telfair shall be given an appropriate Medical Screening Examination to determine whether or not an “Emergency medical Condition” exists as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For this purpose, the physicians and Hospital staff shall comply with the Hospital’s policies pertaining to COBRA and EMTALA as they may change from time to time. The following individuals will be considered “Qualified Medical Personnel” as such term is used in EMTALA to provide a “Medical Screening Examination” at the Birthplace at Telfair: (1) Physicians (2) registered nurses, (2) clinical nurse specialists, and (3) nurse practitioners.
		3. C-SECTIONS: Certified physician extenders may assist in major OB and GYN procedures. The physician extenders must meet all of the credentialing requirements through the Medical Staff Office at SJC. Elective C-Sections for singletons prior to 39 weeks EGA and prior to 38 weeks EGA for twins will not be posted.
		4. VBACs – For patients seeking vaginal birth after previous cesarean delivery, appropriate facilities and personnel, including obstetric anesthesia and nursing personnel are immediately available to perform emergency cesarean delivery when conducting a trial of labor for women with a prior uterine scar.
		5. Each member of the Department must fulfill the basic obligations of Staff membership set forth in the Medical Staff Bylaws and the specific obligations that attach to his or her category of Staff membership as set forth in Article II of said Bylaws. In addition, Active and Associate Staff members of the Department may be assigned on a monthly rotation basis, to the service list for Emergency Department coverage for obstetrical, gynecological problems. The physician who is on call will be the backup for seeing new consults at Candler or St. Joseph’s Hospitals.
		6. When an OB and a GYN only MD are sharing ED call:
			1. Any questionable ectopic pregnancy and any patient with a gestation of 11.6 weeks or less (defined by LMP or sonogram), the on call GYN physician should be called.
			2. Any patients with hyperemesis or a gestational age of 12 weeks for more, the on-call OB physician should be called.

# PART TWENTY: CANDLER DEPARTMENT OF OPHTHALMOLOGY AND OTORHINOLARYNGOLOGY RULES

## 20.1 NAME

The name of this organization shall be the Department of Ophthalmology and Otorhinolaryngology of the Medical Staff of Candler Hospital.

## 20.2 MEMBERSHIP

The Department shall be composed of those members of the Medical Staff who satisfy the qualifications for Staff membership set forth in the Medical Staff Bylaws and who have been granted primary clinical privileges in Ophthalmology and/or Otorhinolaryngology through the established credentialing process.

## 20.3 DEPARTMENT SPECIFIC RULES

* + 1. All elective surgery performed during the Associate Staff period may be required to have a mandatory second opinion provided at no charge to the patient. Second opinions will be assigned on a rotational basis by the Chairperson of the Department or his or her designee and shall be performed by an Active Staff member of the Department who is neither a practice associate of the Associate Staff member nor the assistant surgeon on that case. Should there be a difference of opinion as to the necessity for the surgery, then a third opinion will be obtained in the same manner. If the second and third opinions both agree that the contemplated elective surgery is unwarranted, then it will not be allowed to be performed at the Hospital.
		2. Each member of the Department must fulfill the basic obligations of Staff membership set forth in the Medical Staff Bylaws and the specific obligations that attach to his or her category of Staff membership as set forth in Article II of said Bylaws. In addition, Active and Associate Staff members of the Department may be assigned, on a monthly rotational basis, Emergency Department coverage of Ophthalmology and Otorhinolaryngology.
		3. Staff members with 30 years of service may, on application to the Department Chairperson, be exempt from Emergency service.

# PART TWENTY-ONE: JOINT DEPARTMENT OF PATHOLOGY RULES

**21.1 NAME**

The name of this organization shall be the Joint Pathology Department. It is a department of the Medical Staff at Candler Hospital and its service falls under the Department of Surgery at St. Joseph’s Hospital. For purposes of credentialing at St. Joseph’s Hospital, the applications for appointment and reappointment will be reviewed by the Chairperson of the Department of Surgery or his/her designee, who may be the Chairperson of the Joint Pathology Department.

## 21.2 MEMBERSHIP

The Department shall be composed of those members of the Medical Staff who satisfy the qualifications for Staff membership set forth in the Medical Staff Bylaws and who have been granted clinical privileges in Pathology through the established credentialing process.

## 21.3 DEPARTMENT SPECIFIC RULES

Active and Associate Staff members of the Department shall be assigned on a rotation basis to provide for service twenty-four (24) hours daily.

# PART TWENTY-TWO: JOINT DEPARTMENT OF PEDIATRICS

## 22.1 NAME

The name of this organization shall be the Department of Pediatrics. It is a department of the Medical Staff at Candler Hospital. Its services have been consolidated at Candler Hospital. Only emergency and consulting services are provided at St. Joseph’s Hospital, where its service falls under the Department of Medicine. For purposes of credentialing at St. Joseph’s Hospital, the applications for appointment and reappointment will be reviewed by the Chairperson of the Department of Medicine or his/her designee, who may be the Chairperson of the Joint Department of Pediatrics.

## 22.2 MEMBERSHIP

The Department shall be composed of those members of the Medical Staff who satisfy the qualifications for Staff membership set forth in the Medical Staff Bylaws and who have been granted primary clinical privileges in Pediatrics through the established credentialing process.

## 22.3 DEPARTMENT SPECIFIC RULES

* + 1. The department shall review all fetal mortalities and other quality or process improvement matters referred to it by any department or committee of the Medical Staff.
		2. Each member of the Department must fulfill the basic obligations of Staff membership set forth in the Medical Staff Bylaws and the specific obligations that attach to his or her category of Staff membership as set forth in Article II of said Bylaws. In addition, Active and Associate Staff members of the Department may be assigned, on a monthly rotational basis, to the service list for Emergency Department coverage of pediatric problems.
		3. The ED Unassigned Call list for pediatric services will be used to provide coverage for emergency pediatric patients who present to the Emergency Department at St. Joseph’s/ or Candler Hospitals as well as provide coverage for any unassigned newborn admissions to St. Joseph’s or Candler Hospitals.

# PART TWENTY-THREE: JOINT DEPARTMENT OF IMAGING RULES

## 23.1 NAME

The name of this organization shall be the Department of Imaging of St. Joseph’s/Candler Health System, Inc.

## 23.2 MEMBERSHIP

The Department shall be composed of those members of the St. Joseph’s and Candler Medical Staffs who satisfy the qualifications for staff membership as set forth in the Medical Staff Bylaws and who have been granted clinical privileges in Radiology through the established credentialing process.

## 23.3 DEPARTMENT SPECIFIC RULES

Active and Associate Staff members of the Department may be assigned on a rotation basis to provide for service twenty-four (24) hours daily.

# PART TWENTY-FOUR: CANDLER DEPARTMENT OF SURGERY RULES

## 24.1 NAME

The name of this organization shall be the Department of Surgery of the Medical Staff of Candler Hospital.

## 24.2 MEMBERSHIP

The Department shall be composed of those members of the Medical Staff who satisfy the qualifications for Staff membership set forth in the Medical Staff Bylaws and who have been granted Privileges in General Surgery, Dentistry, Oral Surgery, Orthopedic Surgery, Plastic Surgery, Podiatric Surgery or Urology through the established credentialing processes. A Family Practice physician whose primary interest and practice is surgery may also be granted membership in the Department.

## 24.3 DEPARTMENT SPECIFIC RULES

Active and Associate members of the Department may be assigned by the Department Chairperson, on a monthly rotational basis, on the service list to provide coverage to the Emergency Department. New physicians approved for General Surgery privileges will be added to the General Surgery ED Unassigned Call schedule, when the schedule is revised for the next year and effective in January. The only exception is if they are filling in for or taking the place of another physician in their group. The new medical staff member may take call with and for his group members until added to the call schedule in January. If a physician leaves a group, the other group members are expected to cover the vacated call days until the schedule is revised and active the next January.

# PART TWENTY-FIVE: ST. JOSEPH’S DEPARTMENT OF MEDICINE RULES

## 25.1 NAME

The name of this organization shall be the Department of Medicine of the Medical Staff of St. Joseph’s Hospital.

## 25.2 MEMBERSHIP

The Department shall be composed of those members of the Medical Staff who satisfy the qualifications for membership set forth in the Medical Staff Bylaws and who have been appointed to the Department with privileges in Internal Medicine, Family Practice, Neurology, Pulmonology, Gastroenterology, Dermatology, Emergency Medicine, Nephrology, Allergy/Immunology, Hematology/Oncology, Endocrinology, Infectious Diseases, Pediatrics or Rheumatology, through the established credentialing processes. Only those members of the Department who are Active members of the Staff may vote on matters presented to the Department for Action.

**PART TWENTY-SIX: ST. JOSEPH’S DEPARTMENT OF SURGERY**

## 26.1 NAME

The name of this organization shall be the Department of Surgery of the Medical Staff of St. Joseph’s Hospital.

## 26.2 MEMBERSHIP

The Department shall be composed of those members of the Medical Staff who satisfy the qualifications for membership set forth in the Medical Staff Bylaws and who have been appointed to the Department with privileges in General Surgery, Orthopedic Surgery, Ophthalmologic Surgery, Otolaryngologic Surgery, Urologic Surgery, Plastic Surgery, Podiatric Surgery, Anesthesiology, Obstetrics and Gynecological Surgery, Dentistry and Oral Surgery. Only those members of the Department who are Active members of the Staff may vote on matters presented to the Department for Action.

**26.3 DEPARTMENT SPECIFIC RULES**

New physicians approved for General Surgery privileges will be added to the General Surgery ED Unassigned Call schedule, when the schedule is revised for the next year and effective in January. The only exception is if they are filling in for or taking the place of another physician in their group. The new medical staff member may take call with and for his group members until added to the call schedule in January. If a physician leaves a group, the other group members are expected to cover the vacated call days until the schedule is revised and active the next January.

# PART TWENTY-SEVEN: JOINT DEPARTMENT OF NEUROSURGICAL SERVICES RULES

## 27.1 NAME

The name of this organization shall be the Joint Department of Neurosurgical Services of St. Joseph’s and Candler Hospitals.

## 27.2 MEMBERSHIP

The Department shall be composed of those members of the St. Joseph’s and Candler Medical Staffs who satisfy the qualification for Staff membership set forth in the Medical Staff Bylaws and who have been granted clinical privileges in Neurosurgery through the established credentialing process.

## 27.3. DEPARTMENT SPECIFIC RULES

Each member of the Department must fulfill the basic obligations of Staff membership set forth in the Medical Staff Bylaws and the specific obligations that attach to his or her category of Staff membership as set forth in Article II of said Bylaws. In addition, Active and Associate Staff members of the Department may be assigned by the Department Chair, on a rotational basis, to emergency unassigned call coverage for neurosurgical services. The Department Chair may assign Adjunctive staff emergency call coverage, as necessary, to meet the needs of the Hospitals. Only those members who are Active members of the Staff may vote on matters presented to the Department.

# PART TWENTY-EIGHT: AMENDMENT

## 28.1 RULES APPLICABLE AT BOTH HOSPITALS

* + 1. The provisions of these Rules that are applicable at both Hospitals may be amended upon approval of both MECs by a majority vote of the members present and voting at any meeting of the MECs where a quorum exists provided that the proposed amendment has been communicated to the Medical Staff for review and comment at least 14 days prior to the MEC vote No such amendment shall be effective unless and until it has been approved by both MECs and by both Boards.
		2. The MEC(s) shall have the power to adopt such urgent amendments to the Rules & Regulations which are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within 60 days of adoption by the MEC. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the MEC. Immediately upon adoption, such amendments shall be sent to the President of the Hospital and posted on the Medical Staff bulletin board for fourteen (14) days.

## RULES APPLICABLE AT ST. JOSEPH’S HOSPITAL ONLY

The provisions of these rules that are applicable at St. Joseph’s Hospital only may be amended by a majority vote of the members of the St. Joseph’s MEC present and voting at any meeting of that committee where a quorum exists provided that the proposed amendment has been communicated to the Medical Staff for review and comment at least 14 days prior to the MEC vote. No such amendment shall be effective unless and until it has been approved by the St. Joseph’s Board.

## 28.3 RULES APPLICABLE AT CANDLER HOSPITAL ONLY

The provisions of these Rules that are applicable at Candler Hospital only may be amended by a majority vote of the members of the Candler MEC present and voting at any meeting of that committee where a quorum exists provided that the proposed amendment has been communicated to the Medical Staff for review and comment at least 14 days prior to the MEC vote. No such amendment shall be effective unless and until it has been approved by the Candler Board.

# PART TWENTY-NINE: ADOPTION

These Rules are adopted and made effective upon approval by both Hospital MECs and Boards, superseding and replacing any and all other Medical Staff rules or policies pertaining to the subject matter hereof, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges at a Hospital shall be taken under and pursuant to the requirements of these Rules.

***Date Approved by St. Joseph’s MEC: 12/14/2020***

***Date Approved by St. Joseph’s Board (Consent in Lieu): 12/15/2020***

***Date Approved by Candler MEC: 12/14/2020***

***Date Approved by Candler Board (Consent in Lieu): 12/15/2020***