SGMC LANIER CAMPUS

MEDICAL STAFF

RULES AND REGULATIONS

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DEFINITIONS

Rules which require a physician to "sign" a medical record, means that the physician must manually or electronically sign or authenticate the record.

Unless otherwise defined in a specific Medical Staff Rule or Regulation, all capitalized terms shall have the meaning defined in the Medical Staff Bylaws.

RULES AND REGULATIONS

1. APPOINTMENT & PRIVILEGING

1.1. In order to comply with guidelines for TB Screening and Compliance Monitoring for Medical Staff Members, Limited License Professionals, and Allied Health Professionals, all Medical Staff Members, Limited License Professionals and Allied Health Professionals shall, in accordance with the Centers for Disease Prevention and Infection Control (CDC), undergo clinical TB screening and provide results of a Quantiferon Gold TB blood test or Tuberculin Skin Test (TST) test. Annually thereafter a TB screening must be completed and if there is clinical concern then a repeat TST or Chest X-Ray may be warranted.

. Results of TB screenings performed by outside health care providers are submitted to the Medical Staff Office. All TB screening results are then forwarded to the Medical Executive Committee. Medical Staff Members who fail to provide results of an annual TB screening by the due date, and remain delinquent for sixty (60) days thereafter, will be deemed to have automatically relinquished admitting privileges for elective admissions until completion of the annual TB screening. Limited License Professionals and Allied Health Professionals who fail to provide results of an annual TB screening by the due date, and remain delinquent for sixty (60) days thereafter, will lose all Clinical Privileges or Clinical Functions until the annual TB screening is completed.

If any Medical Staff Member, Limited License Professional or Allied Health Professional who has previously tested positive for TB becomes symptomatic, such person must immediately submit to a chest x-ray and self-report the occurrence of symptoms.

Any initial applicant for Clinical Privileges or Clinical Functions who has previously tested positive for TB must submit to a baseline chest x-ray.

1.2. Acceptable excuses for missing meetings include: 1) sickness – of magnitude unable to attend patients; 2) out of town; 3) another medical commitment, and 4) acute or chronic disability.

2. EMERGENCY SERVICES

2.1. The Medical Staff shall provide emergency back-up call coverage for the Emergency Department. The Chief of Staff shall insure a schedule of such emergency back-up call is furnished to Hospital Administration.

Every patient, attached (private) or unattached, will be evaluated by an Emergency Department Physician or Allied Health Professional and managed by him or her until disposition is made. In the event the patient's private physician has made arrangements to meet his/her patient in the Emergency Department and intends to assume care of the patient, the Emergency Department Physician or Allied Health Professional will continue management of the patient until the private physician arrives.

The Emergency Department Physician or Allied Health Professional who contacts a Medical Staff Member to request the Staff Member to assess and/or admit a patient who presents to the Emergency Department should document the following in the patient's medical record: (1) the date and time the Emergency Department Physician or Allied Health Professional contacted the Staff Member; and (2) the level of criticality or acuity of the patient; and (3) the time frame within which the Staff Member should present to the Emergency Department.

Patients who present to the Emergency Department will be seen and evaluated by an Emergency Department Physician or Allied Health Professional who will be responsible for disposition of the patient. In the event that the Emergency Department Physician or Allied Health Professional determines that the patient needs further evaluation or treatment or admission to the Hospital, the Emergency Department Physician or Allied Health Professional will contact a Medical Staff Member as follows:

a. Any unattached patient (a patient with no private attending physician) may select any Physician with appropriate Hospital Clinical Privileges to attend him or her. When no such selection is made or when the Physician selected is not available or does not elect to attend to the patient, a member of the Medical Staff on emergency back-up call for the appropriate specialty will be responsible for disposition of the patient. Additionally, when appropriate, a hospitalist may be called for admissions for unattached patients and patients whose attending physician has delegated his/her Hospital admissions to the Hospitalist Service.

b. If the patient has a relationship with a physician with appropriate Hospital Clinical Privileges, such Physician or his/her covering physician is responsible for presenting to the Emergency Department if requested to do so and is responsible for disposition of the patient.

In order to insure the continuity of care of emergency patients who are treated in the Emergency Department and then admitted to the Hospital, such patients remain the responsibility of the Emergency Department Physician or Allied

Health Professional until the patient is physically moved from the Emergency Department to a Hospital room.

2.2. An appropriate medical record shall be kept for every patient receiving emergency services. This emergency services record shall be incorporated into the patient's SGMC record and shall include:

a. Adequate patient identification;
b. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
c. Pertinent history of the injury or illness, including details relative to first aid or emergency care given the patient prior to his arrival at the Hospital;
d. Description of significant clinical, laboratory and roentgenologic findings;
e. Diagnosis;
f. Tests and other assessment procedures conducted;
g. Treatment given;
h. Condition of the patient on discharge or transfer;
i. Final disposition, including instructions given to the patient and/or his/her family, relative to necessary follow-up care;
j. When appropriate, an indication that the patient left against medical advice; and
k. A copy of any information made available to any practitioner or medical facility providing follow-up care.

2.3. Each emergency patient's medical record shall be signed by the Practitioner in attendance, who is responsible for its clinical accuracy.

2.4. The Medical Staff designates and authorizes the following professionals to perform medical screening examinations to determine whether an emergency medical condition is present:

a. All Physicians with appropriate privileges; and
b. Physicians Assistants and Registered Nurse Practitioners who have appropriately designated Clinical Functions under the supervision of the responsible physician,

3.1. ADMISSION

3.1. The Hospital accepts patients presenting themselves for care without regard to age, race, creed, ethnicity, diagnosis, religion, culture, national origin, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

3.2. A patient may be admitted to the Hospital only by a Physician who has been granted admitting privileges pursuant to the Medical Staff Bylaws. All Practitioners shall be governed by the official policies of the Hospital.

3.3. Except in an emergency, no patient shall be admitted to the Hospital until provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible, but within twenty-four (24) hours.

4. DOCUMENTATION/MEDICAL RECORDS

4.1. The attending Practitioner is required to document the need for continued hospitalization after specific periods of stay in accordance with the Hospital's Utilization Plan.

4.2. Patients shall be discharged only on a written order of the attending Practitioner. Should a patient leave the Hospital against the advice of the attending Practitioner or without proper discharge, the "Against Medical Advice" form shall be signed and completed.

4.3. The attending Practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification, date, time, complaint, personal history, family history, history of present illness, physical examination, clinical symptoms, special reports such as consultations, monitoring activities, clinical laboratory and radiology services and others, results of prescribed tests, allergies, adverse drug reactions, information on hospital-acquired infections, information regarding advance directives, information concerning emergency medical care received prior to hospital arrival, provisional diagnosis, medical or surgical treatment, operative report, anesthesia evaluation reports, pathological findings, progress notes, plan of care, treatment goals, orders, medication records, documentation of patient consent, final diagnosis, condition on discharge or transfer, summary or discharge note, clinical resume and autopsy report when performed.

4.4. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems shall be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

4.5. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. Authentication means to establish authorship by written signature.

4.6. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the record room and nursing stations.

4.7. Except in an emergency in compliance with Hospital policy, the responsible physician will insure informed consent is obtained and documented for the following: surgical or invasive procedures performed under general, spinal, or major regional anesthesia, or procedural sedation, amniocentesis, diagnostic procedures or a diagnostic procedure which involves intra-arterial, intravenous or intraductal injection of a contrast material, or blood transfusion or blood product infusion.

Other providers may assist with the informed consent process. Employees of the Hospital who participate in the communication process, at the direction of the physician, are considered agents of the physician.

4.8. The designation of one principal diagnosis and applicable procedure and any appropriate secondary diagnosis shall be recorded in full without the use of symbols or abbreviations at the time of discharge of all patients. This designation shall be dated, timed and signed with a legible first initial and full last name of/by the responsible Practitioner. The designation of principal diagnosis shall be "the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital." The definition of secondary diagnosis shall be "other conditions which have an impact on the length of the hospital stay or hospital complications."

In order to expedite the completion of the medical record the designation of the principal and secondary diagnosis shall be recorded at the time of discharge in one of the following manners:

a. Diagnoses dictated as a component of the discharge summary;
b. Diagnoses dictated separately from summary material;
c. Diagnoses written in the body of the chart in the form of a progress note; and
d. Diagnoses written on the DRG form included in the record.

4.9. A discharge summary shall be written or dictated for all patients admitted as inpatients to this hospital. The content of the medical record shall include the diagnosis, condition at discharge, discharge instructions, and required follow-up care and shall be sufficient to accurately reflect the patient's stay in the Hospital. All summaries and/or progress notes shall be authenticated (signed) by the responsible Practitioner.

4.10. The patient's medical record shall be completed as soon as possible after discharge and the completed medical record shall comply with the pertinent provisions of these Medical Staff Rules and Regulations. Failure to do so will be handled in accordance with the Medical Staff Bylaws.

4.11. Non-physicians who have been granted Hospital Clinical –Privileges or Clinical Functions must complete those portions of the medical records written by them in accordance with the time limitations imposed upon Medical Staff Members.

4.12. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Administrator. In case of the readmission of a patient, all previous records shall be available for the use of the attending Practitioner. This shall apply whether the patient is attended by the same Practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the Practitioner for a period to be determined by the Executive Committee of the Medical Staff.

5. CARE

5.1. A Physician member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Staff Member, a note covering the transfer of the responsibility shall be entered on an order sheet or progress note.

5.2. Each Practitioner must assure timely, adequate, professional care for his/her patients in the Hospital by being available or having available through his/her office an eligible alternate Practitioner with whom prior arrangements have been made and who has at least similar Clinical Privileges at the Hospital. Failure of an attending Practitioner to meet these requirements may result in loss of Clinical Privileges or Clinical Functions, as applicable. A Practitioner who will be unavailable for the care of his/her patients will notify the Hospital Administration and the PBX operator of the name of the Practitioner or Practitioners who will be responsible for his/her patients and specify the beginning and ending times.

5.3. The Admitting Physician is the Attending Physician. The Attending Physician can be changed only by the Attending Physician with the consent of the Physician who will become the Attending Physician.

6. ORDERS

6.1. The Practitioner's orders should be written clearly, legibly, and completely. Orders which are illegible or not understood by the nurse should be clarified by contacting the ordering Physician.

6.2. Pre-printed orders and protocols shall be formulated by joint action of the Medical Staff and the Administrator of the Hospital and may be changed only in the same manner. These pre-printed orders and protocols shall be followed insofar as proper treatment of the patient will allow, and shall constitute the orders for treatment until specific orders are written and signed by the attending Physician. Pre-printed orders and protocols shall be reviewed annually and revised when appropriate.

6.3. A Practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record and shall be dated, timed and signed by the Practitioner.

6.4. Outpatient, non-invasive tests, including laboratory tests, radiographic studies and EKG's may be requested by a licensed Allied Health Professional working within the scope of practice authorized by the State Board, Hospital Medical Staff Bylaws, Rules and Regulations and Policies, an approved job description and delegated duties, under the supervision of a Supervising Physician, provided the request is signed by the Allied Health Professional, and the results are reported to the Licensed Supervising Physician. Requests for outpatient or inpatient invasive tests require the countersignature of the Supervising Physician.

7. CONSULTATION

7.1. Any qualified Practitioner with Clinical Privileges at the Hospital can be called for consultation within his/her area of expertise.

7.2. Except in an emergency, consultation is required in the following situations:

a. Where there is doubt as to the choice of therapeutic measures to be utilized;

b. In unusually complicated situations where specific skills or other practitioners may be needed; and

c. When requested by the patient or his/her family.

7.3 Request for consultation shall be made by the patient's primary Attending Medical Staff Member to the Consultant in order to make clear the history, needs and the desired extent of participation in the care of the patient by the Consultant. An order shall be entered on the Physician Orders giving the name of the Consultant. Contact with the Consultant is the duty of the primary Attending Medical Staff Member. Unless otherwise agreed upon in writing by the attending Physician and Consultant, the Attending Physician should be contacted initially in the event of patient's needs or change of condition.

7.4. If an on-call Physician receives a request for a consultation, such on-call Physician shall complete the consultation within twenty-four (24) hours from the time he/she was contacted by the referring Physician, i.e., even if the on-call Physician cannot complete the consultation during his/her call shift, he/she is obligated to complete the consultation within the twenty-four (24) hour time period described above. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

8. DRUGS

8.1. Control of drugs brought into the Hospital by patients shall be set forth by the Pharmacy and Therapeutics Committee.

8.2 At time of discharge from the Hospital, materials and drugs will not be ordered to be sent home with the patient other than remaining materials and drugs already purchased by or for the patient, unless arranged otherwise through the discharge planning process of the Hospital.

9. DEATH OF A PATIENT

9.1. In the event of a Hospital death, the deceased shall be pronounced dead and shall be released in compliance with then current State statutes.

9.2. It shall be the duty of all staff members to secure meaningful autopsies whenever appropriate. In addition to autopsies required by law, the Medical Staff shall order an autopsy to be performed when an autopsy is appropriate. The Medical Staff shall annually approve circumstances under which an autopsy is appropriate.

10. EDUCATION

10.1. Individual Medical Staff Members participate in the education of patients and families with regard to individual patients' specific health care needs through the admission and discharge planning process. The Medical Staff participates in the education of patients and families on a community level through the activities of the Departments of the Medical Staff and Medical Staff and hospital committees such as the Bioethics Committee, the Infection Control Committee, and the Oncology Committee, and by participation in community educational events such as community lectures and health fairs.

(Signatures Appear on Following Page)

Adopted by the
SGMC Lanier Campus Medical Staff
2 - 4, 2021

Bruce Herrington, MD Chief of Staff

Approved by
The Hospital Authority of Valdosta and
Lowndes County, Georgia
February 18, 2021

By: Sam Allen
Sam Allen, Chairman