SOUTH GEORGIA MEDICAL CENTER

MEDICAL STAFF

RULES AND REGULATIONS

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SOUTH GEORGIA MEDICAL CENTER
MEDICAL STAFF RULES & 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 & MEMBERSHIP

1.1. In order to comply with guidelines for TB Screening and Compliance Monitoring for SGMC 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). 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 Medicine Service. The Chief of each service shall insure a schedule of such emergency back-up call is furnished to the Emergency Medicine Service via the PBX Switchboard Operator.

Every patient, attached (private) or unattached, will be evaluated by an Emergency Services Physician 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 Services Physician will continue management of the patient until the private physician arrives.

The Emergency Medicine Physician 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 Medicine Physician 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.

Any unattached patient (a patient with no private attending physician) admitted to the Emergency Medicine Service will be seen and evaluated by the Emergency Medicine Physician who will be responsible for disposition of the patient. An Emergency Medicine patient admitted to the Hospital is the responsibility of the admitting (attending) Physician from the time the Physician accepts the patient for admission to the Hospital.

An unattached patient may select any Practitioner in the applicable department or service to attend him or her. When no such selection is made or when a selection is not accepted by the Physician selected, a member of the Medical Staff on emergency back-up call for the appropriate service will be responsible for disposition of the patient.

In order to insure the continuity of care of emergency patients treated in the Emergency Medicine Service, it is the responsibility of the backup physician on call at the time that the disposition of the unattached patient is made to provide continuing care until the patient's emergency illness has been treated and resolved.

Emergency Services personnel are to notify the attending private physician or his/her on-call designated physician, of all attached patients unless notified otherwise by the attending private physician. The attending private physician can elect to have the Emergency Medicine physician treat his/her private patients in the Emergency Medicine Service as necessary.

2.2. An appropriate medical record shall be kept for every patient receiving emergency service. 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;
b. Physicians Assistants, Registered Nurse Practitioners, and Nurse Midwives who have appropriately designated clinical functions under the supervision of the responsible physician;
c. Registered Nurses in the Labor and Delivery area who have appropriate training and authorization; and
d. Registered Nurses in Youthcare who have appropriate training and authorization.

2.5. The following will set forth conditions under which the simple curettage may be performed in the Emergency Room:

a. When a patient presents herself at the Emergency Room with an incomplete or inevitable abortion, after consultation, and after the appropriate signatures on an operative permit a simple curettage may be performed in the Emergency Room.
b. When a prolonged or complicated procedure is anticipated, the patient must be admitted to the Hospital and the procedure must be performed in the Operating Room.

2.6. Pre-hospital medical screening exams can be performed by appropriately qualified EMS personnel.

3. 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 SGMC.

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 or portion of the electronic medical record shall be signed and/or 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. An operative note must be written in the progress notes immediately and postoperatively signed by the physician and made a part of the current medical record. The operative note should include a short summary of the procedure including the outcome and any complications and significant blood loss.

Operative reports shall be dictated within twenty-four (24) hours of completion of surgery for outpatients as well as inpatients. Operative reports must contain at least the following information:

- Name of primary surgeon and assistants
- Type of anesthesia administered
- Findings
- Technical procedures used
- Specimens removed or altered
- Preoperative and postoperative diagnosis
- Name and hospital identification number of the patient

- Date and times of the surgery
- Name and description of the specific surgical procedure
- Complications, if any
- Description of surgical tasks conducted by those other than the primary Practitioner
- Estimated blood loss (if applicable to the procedure)

4.6. The current obstetrical record shall include the following information relating to the mother:

- A complete prenatal record;
- Condition upon admission of the mother and fetus;
- Labor and membrane status;
- Presence of bleeding, if any;
- Fetal activity level;
- Time and content of mother's most recent ingested meal; and
- Labor and postpartum care notes.

The prenatal record may be a legible copy of the attending Practitioner's office record transferred to the Hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

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

4.8. 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.

4.9. 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.

4.10. A discharge summary shall be written or dictated on medical records of all patients admitted as inpatients to the Hospital except for normal obstetrical deliveries, normal newborn infants and for patients hospitalized less than 48 hours having problems and/or procedures of a minor nature declared by the attending Practitioner, defined by the Medical Executive Committee as "non-life threatening." For these exceptions, a final summation-type progress note, written or dictated, shall be sufficient. In all instances, 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 justify the diagnosis and warrant the treatment and results. All summaries and/or progress notes shall be authenticated (signed) by the responsible Practitioner.

4.11. The anesthesiologist shall maintain a complete anesthesia record to include evidence of preanesthetic evaluation and postanesthetic follow-up on the patient's condition.

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.

4.13. 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.

4.14. 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 *Article XI, Section D. 4.* of the Medical Staff Bylaws.

4.15. 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. Employees of the Hospital who participate in the communication process, at the direction of the physician, are considered agents of the physician.

4.16. Except in severe emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled. In any emergency the Practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

4.17. A written, signed, informed surgical consent shall be obtained prior to an operative procedure except in an emergency. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.

4.18. Nuclear Medicine Diagnostic and Therapeutic Services shall be performed only upon the written request of a physician. The patient's medical record shall contain reports of nuclear medicine interpretations, consultations, and therapy. It is desirable that the patient's medical record show the identity, date, time and amount of radiopharmaceutical used, as well as any specific preparation of the patient. Records to be maintained should include at least the following information:

a. Dates, times, amount and methods of receipt and disposal.
b. Supplier and lot number and, where applicable, the date, amount, and the identity of any recipient.

Instrument Log Books shall be maintained and should include at least the following:

a. Calibration records of equipment and monitors showing dates, times, name of technologist, and sources of reference standards.
b. Maintenance and repair records showing dates and sources of service.

Records shall be maintained and show the radiation exposure of each Nuclear Medicine employee.

4.19. Non-physician members of the Medical Staff who have been granted privileges in the Hospital must complete those portions of the medical records written by them in accordance with the time limitations imposed upon Medical Staff Members.

4.20. Medical Staff Members may dictate History & Physicals, Discharge Summaries, OP Notes, Progress Notes and Procedure Notes.

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 the Order section of the patient's medical record.

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. A Practitioner who will be unavailable for the care of his/her patients will notify the Hospital 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. Patients are admitted to designated specialty units/departments whenever possible. The Medical Staff participates in establishing these areas of specialty and their locations, and approves policies governing patient placement.

It is understood that when deviations are made from assigned areas, the Nursing Supervisor will correct these assignments at the earliest possible moment, in keeping with the transfer priorities. All areas may accept observation patients in the designated specialty areas.

5.4. If during the course of a medical history and physical examination, an oral surgeon suspects or discovers a medical condition or risk which falls outside the area of expertise of the oral surgeon, he or she shall ask a Physician member of the Medical Staff to examine and assess the patient, in order to determine whether the patient may undergo the proposed procedure.

When there is significant medical abnormality, the final decision must be a joint responsibility of the oral surgeon and the Physician. The oral surgeon is responsible for that part of the history and physical examination related to oral surgery. The designated Physician member shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of oral surgery patients.

5.5. Patients shall be discharged from post-anesthesia areas by a Physician or in accordance with established discharge criteria.

An Anesthesiologist with Clinical Privileges to administer anesthesia in the Hospital or a Certified Registered Nurse Anesthetist or Physician's Assistant Anesthetist with Clinical Functions to administer anesthesia in the Hospital,

functioning under the direction and supervision of an Anesthesiologist shall complete a post-anesthesia evaluation in compliance with applicable Hospital policies for each patient receiving anesthesia prior to the patient's discharge from the Hospital, but in no event later than forty-eight (48) hours after surgery.

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. All previous medication orders are reviewed when patients go to a procedural area.

6.3. 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.

6.4. 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. When the patient is not a good risk for operation or treatment;

b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;

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

d. In unusually complicated situations where specific skills or other practitioners may be needed.

e. In instances in which the patient exhibits severe psychiatric symptoms; and,

f. 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. When operative procedures are involved the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

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. A method of control of use of dangerous and toxic drugs shall be developed by the Medical Staff through its Pharmacy and Therapeutics Committee. In accordance with this rule, the following drugs shall be controlled as noted below:

Narcotics
Antibiotics*

*Except antitubercular drugs.

Unless a definite time or dosage limit is specified by the Physician, the medications in these two categories will be discontinued after ten (10) days. The medication will be continued until 8:00 a.m. on the eighth day until the Physician can be notified. The Physician will not be called during the night for reorder if the expiration time occurs then. Impending stop orders will be called to the Physician's attention in the electronic medical record and if applicable, by a label on the front cover of the chart stating **"RE-ORDER DRUGS,"** and an orange colored sheet at the front of the Physician's orders listing the drugs needing a reorder. Antibiotic utilization will be managed according to Department of Pharmacy policy and procedure (RxPP 02.01).

8.3. 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. LABORATORY SERVICES

9.1. All human tissues and foreign bodies removed at an operation shall be sent to the Hospital's pathologist, who shall make such examination as he may consider necessary to arrive at a pathological diagnosis. His authenticated report shall be made a part of the patient's medical record. Any exceptions or revisions to this rule shall be made only with the approval of the Executive Committee, who shall follow the standard requirements of The Joint Commission for Pathology and Medical Laboratory Services. The Executive Committee in consultation with the pathologist shall list these exceptions in writing and make them available to the staff. This list shall be updated from time to time when necessary. Refer to HPP#30 for complete list.

All tissues and foreign bodies that are exempted from examination will be documented by the operating surgeon as a part of the patient's surgical record.

In the event of a foreign body needed for evidence in a criminal case, this may be submitted to the proper authorities after all identification, documentation and authorization signed by the patient (or by the patient's parents or guardian ad litem in the case of a minor) authorizing the release to a named police officer. If the patient (or the patient's parents or guardian) refuses to sign the authorization, the foreign body shall be produced only in response to a grand jury subpoena, a trial jury subpoena, or an appropriate court order.

9.2. Pathology and Medical Laboratory Service

The limited categories of specimens that may be exempted from the requirements to be examined by a pathologist include, but need not be limited to, the following:

Specimens that by their nature or condition do not permit productive examination, such as a cataract, orthopedic appliance, foreign body, or portion of the rib removed only to enhance operative exposure;

Therapeutic radioactive sources, the removal of which is guided by radiation safety monitoring requirements;

Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;

Foreign bodies (e.g. bullets) that, for legal reasons, are given directly in the chain of custody to law enforcement representatives;

Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible post-operatively, such as a foreskin from the circumcision of a newborn infant;

Placentas that are grossly normal and have been removed in the course of operation and non-operative obstetrics;

Teeth, provided the anatomic name and anatomic number of each tooth, is recorded in the medical record;

Ophthalmology specimens: cataract, trabecular meshwork, hordeolum foreign body, iridectomy, vitrectomy, skin from blepharoplasty or eyelid repair (entropion, ectropion, etc.), pinguecula;

Nucleus pulposus (disc material), cartilage, ligament and bone removed during the course of spinal procedures;

Podiatric hardware, oral surgical prosthetic implants, vascular prosthetic implants (example: Lifeport), plastic surgical reconstructive and cosmetic implants, other artificial prosthetic implants.

Bone or bone debris removed for placement of joint arthroplasty, for which examination for medical or legal reasons is not deemed necessary by treating physician.

10. DEATH

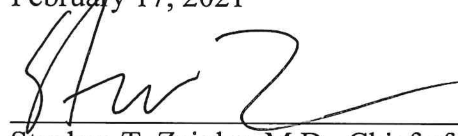
10.1. In the event of a Hospital death, the deceased shall be pronounced dead and shall be released in compliance with then current State statutes.

10.2. It shall be the duty of all staff members to secure meaningful autopsies whenever appropriate. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the Hospital pathologist, or by a Practitioner delegated this responsibility. Provisional anatomic diagnosis shall be recorded on the medical record within seventy-two (72) hours and the complete protocol should be made a part of the record within one (1) month.

11. EDUCATION

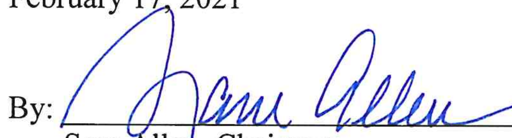
11.1. Individual Medical Staff Members participate in the education of patients and families with regard to individual patients' specific health care needs through the admission and discharge planning process. The Medical Staff participates in the education of patients and families on a community level 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.

Adopted by the
South Georgia Medical Center Medical Staff
February 17, 2021



Stephen T. Zeigler, M.D., Chief of Staff

Approved by
The Hospital Authority of Valdosta and
Lowndes County, Georgia
February 17, 2021

By: 

Sam Allen, Chairman