SOUTH GEORGIA MEDICAL CENTER

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 and such signatures shall be dated.

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. Qualification. In addition to the requirements defined by the Medical Staff Bylaws, in order to qualify to be a member of the Medical Staff, the Practitioner must comply with the immunization guidelines. 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 questionnaire must be completed and if there is clinical concern then a repeat TST, QuantiFERON, 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.

2. EMERGENCY SERVICES

2.1. The Emergency Department shall be operated under the governance of the Governing Body and the Medical Director of the Emergency Department. The policies and procedures governing medical care provided in the emergency service or department shall be established by and are a continuing responsibility of the medical staff. The Emergency Department policies shall be subject to the approval of the Medical Executive Committee and the Governing Body.

2.2 The Medical Staff through each Department shall establish a list of individual providers that are members of the Hospital's active medical staff to provide emergency back-up call coverage for the unassigned patients that present to the Emergency Department or on the Hospital's campus seeking emergency care. Each Department Chairman shall provide the on-call list for unassigned call coverage to the Hospital in advance which shall be maintained in the Emergency Department.

Each patient that presents to the Emergency Department or on the Hospital campus seeking emergency care, attached (private) or unattached, will be evaluated by an Emergency Services Physician. The Emergency Department physician shall determine if the physician scheduled to be on call for unassigned patients or the treating provider for attached patients is needed to assist with the emergency medical screening, provide stabilizing treatment or provide care, the physician shall report on-site to the Hospital in accordance with the Emergency Department physician's direction and the Medical Staff policies or procedures. Patient's private physician shall maintain call coverage back-up for his/her patient in the Emergency Department in the event the Physician is not available to respond to call for attached patients or in the event Physician is scheduled to provide call for unassigned patients.

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. A licensed physician shall be available to cover basic emergency room services on-site twenty-four hours a day seven day a week.

Any unassigned 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.

In order to ensure 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. The attending private physician can elect to have the Emergency Medicine physician treat his/her private patients in the Emergency Medicine Service as necessary and if the treatment exceeds the scope of Emergency Medicine physician's scope, the physician shall be required to report on site to the hospital as directed by the Emergency Department physician.

2.3. An appropriate medical record shall be kept for every patient receiving emergency service. An emergency medical record shall include all assessment and treatment information about the patient from the time of presentation until the time of discharge or transfer. 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.

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

2.5. The Medical Staff designates and authorizes the following professionals to be the Qualified Medical Personnel ("QMP") 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

2.6. Protocols. The Emergency Department Medical Director shall develop protocols consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with obstetrical emergencies, complications, and immediate post-delivery care. The protocols addressing obstetrical emergencies, complications and immediate post-delivery care shall be developed in coordination with the Department leadership for the obstetrical and gynecology service line. The protocols will be subject to the review and approval of the Medical Executive Committee and the Governing Body.

2.7 Training. The medical staff members and the allied health professional staff providing services in the emergency department shall receive training on the Emergency Medical Treatment and Labor Act (EMTALA) annually. In addition, the Hospital shall utilize its quality assurance and performance improvement program to identify training needs and any additions, revisions, or updates to training topics on an ongoing basis for the medical staff and personnel. Training documentation and evidence of the education shall be maintained in the medical staff office files or the personnel files for employed providers, as applicable.

2.8. The Emergency Department physician shall provide direction to the EMS personnel and respond to requests from EMS personnel.

2.9 Procedures performed in the Emergency Room are usually of a minor diagnostic or therapeutic nature. Procedures which require general anesthesia are permitted only for short term minor cases and are scheduled only after mutual agreement among the charge nurse, staff physician, and anesthesiologist.

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. All entries in the patient's medical records shall be accurate and legible and shall contain sufficient information to support the diagnosis and to describe the treatment provided and the patient's progress and response to medications and treatments. Inpatient records shall also contain sufficient information to justify admission and continued hospitalization. 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. Upon completion, medical records for inpatients and outpatients shall contain, at minimum, the documents as specified below. Records for patients at the hospital for other specialized services, such as emergency services or surgical services, shall contain such additional documentation as required for those services.

(a) **Inpatient Records.** Medical records for inpatients shall contain at least the following:

1. A unique identifying number and a patient identification form, which includes the following when available: name, address, date of birth, sex, and person to be notified in an emergency;
2. The date and time of the patient's admission;
3. The admitting diagnosis and clinical symptoms;
4. The name of the attending physician;
5. Any patient allergies;
6. Documentation regarding advanced directives;
7. The report from the history and physical examination;
8. The report of the nursing assessment performed after admission;
9. Laboratory, radiological, electrocardiogram, and other diagnostic assessment data or reports as indicated;
10. Reports from any consultations;
11. The patient's plan of care;
12. Physician's orders or orders from another practitioner authorized by law to give medical or treatment orders;
13. Progress notes from staff members involved in the patient's care, which describe the patient's response to medications, treatment, procedures, anesthesia, and surgeries;
14. Data, or summary data where appropriate, from routine or special monitoring;
15. Medication, anesthesia, surgical, and treatment records;

16. Documentation that the patient has been offered the opportunity to consent to procedures for which consent is required by law;

17. Date and time of discharge;

18. Description of condition, final diagnosis, and disposition on discharge or transfer;

19. Discharge summary with a summary of the hospitalization and results of treatment; and

20. If applicable, the report of autopsy results.

(b) **Outpatient Records.** Medical reports for outpatients shall contain at least the following:

1. A unique identifying number and a patient identification form, which includes the following if available: name, address, date of birth, sex, and person to be notified in an emergency;

2. Diagnosis of the patient's condition;

3. The name of the physician ordering treatment or procedures;

4. Patient allergies;

5. Physician's orders or orders from another practitioner authorized by law to give medical or treatment orders as applicable;

6. Documentation that the patient has been offered the opportunity to consent to procedures for which consent is required by law;

7. Reports from any diagnostic testing; and

8. Sufficient information to justify any treatment or procedure provided, report of outcomes of treatment or procedures, and, as appropriate, progress notes and the disposition of the patient after treatment.

4.3 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.

4.4. 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 significant 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, previous records within the time frame for retention as required by state law, 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. Practitioner shall obtain informed consent for any person who undergoes any surgical procedure under general anesthesia, spinal anesthesia, or major regional anesthesia or any person who undergoes an amniocentesis diagnostic procedure or a diagnostic procedure which involves the intravenous or intraductal injection of a contrast material must consent to such procedure and shall be informed in general terms of the following:

(1) A diagnosis of the patient's condition requiring such proposed surgical or diagnostic procedure;

(2) The nature and purpose of such proposed surgical or diagnostic procedure;

(3) The material risks generally recognized and accepted by reasonably prudent physicians of infection, allergic reaction, severe loss of blood, loss or loss of function of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, disfiguring scar, brain damage, cardiac arrest, or death involved in such proposed surgical or diagnostic procedure which, if disclosed to a reasonably prudent person in the patient's position, could reasonably be expected to cause such prudent person to decline such proposed surgical or diagnostic procedure on the basis of the material risk of injury that could result from such proposed surgical or diagnostic procedure;

(4) The likelihood of success of such proposed surgical or diagnostic procedure;

(5) The practical alternatives to such proposed surgical or diagnostic procedure which are generally recognized and accepted by reasonably prudent physicians; and

(6) The prognosis of the patient's condition if such proposed surgical or diagnostic procedure is rejected.

It shall be the responsibility of the responsible Physician to ensure that the information required above is disclosed and that the consent provided for in this section is obtained. The information provided for in this section may be disclosed through the use of video tapes, audio tapes, pamphlets, booklets, or other means of communication or through conversations with nurses, physician assistants, trained

counselors, patient educators, or other similar persons known by the responsible physician to be knowledgeable and capable of communicating such information; provided, however, that for the purposes of this section only, if any employee of a hospital or ambulatory surgical treatment center participates in any such conversations at the request of the responsible physician, such employee shall be considered for such purposes to be solely the agent of the responsible 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 and shall authenticate 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 switchboard/emergency department call coordinator 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.

1. A history and physical examination shall be completed within the first twenty-four (24) hours after admission. A history and physical examination completed by either the admitting Practitioner or the Allied Health Professional operating under the direction of the physician as authorized by law no more than thirty (30) days prior to the admission may be accepted but must be updated to reflect the patient's condition at the time of admission. Where the patient is admitted solely for oromaxillofacial surgery, such history and physical may be completed by the oromaxillofacial surgeon.

(b) **Patient's Plan of Care.**

1. On admission, the plan of care shall be initiated by the admitting Practitioner for each patient to meet the needs identified by the initial assessments. The initial plan of care shall be placed in the patient's record within twelve (12) hours of admission.

2. As the patient's treatment progresses, the plan of care shall be updated by the Practitioner to reflect any changes necessary to address new or changing needs.

(c) **Reassessments of the Patient's Condition.** Reassessment of the patient's condition shall be performed periodically at appropriate intervals and defined in hospital policy. In addition, reassessments shall occur at least as follows:

1. During and following an invasive procedure;

2. Following a change in the patient's condition or level of care;

3. During and following the administration of blood and blood products;

4. Following any adverse drug reaction or allergic reaction; and

5. During and following any use of physical restraints or seclusion.

(d) **Other Treatment Requirements.**

1. All patients shall be given the opportunity to participate, or have a designated representative participate, in decisions regarding their care.

2. Patients shall be provided treatment free from physical restraints or involuntary seclusion, unless utilized solely for protection during brief transport to a specified destination or authorized by a physician's order, for a limited period of time, to protect the patient or others from injury. Policies and procedures shall be in place to require that a patient's physical comfort and safety needs are addressed during any period of required physical restraint or confinement. A positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize during medical, dental, diagnostic, or surgical procedures is not considered a restraint.

3. Patients shall receive care in a manner free from all forms of abuse or neglect.

4. Patients shall receive treatment in an environment that respects their personal privacy, both of their physical person and their treatment information.

5. Practitioners providing direct care to the patient identify themselves to the patient by name and title or function.

6. ORDERS

6.1. Orders shall only be given by Medical Staff members or by PAs and NPs who have been credentialed by the Medical Staff.

6.2 All clinical entries in the patient's medical record shall be legible, complete, accurately timed and dated and authenticated by signature or electronic format. Orders which are illegible or not understood by the nurse should be clarified by contacting the ordering Physician.

6.3. All previous medication orders are reviewed when patients go to a procedural area. When a medication order is unclear for any reason, the clinician will contact the prescriber for clarification prior to medication administration.

6.4. Protocols shall be formulated by joint action of the Medical Staff and Hospital Governing Body and may be changed only in the same manner. These 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. Protocols shall be reviewed annually and revised when appropriate.

6.5. 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. Entries in the medical record by an Allied Health Professional shall include the name of his or her supervising or delegating physician or sponsor.

6.6 Telephone or verbal orders may be taken by appropriate licensed medical care providers. Verbal orders (face to face communication of orders) may only be used infrequently and must not be a common practice. The use of verbal orders should be limited to those situations in which it is impossible or impractical for the prescriber to write the order or enter it into a computer. Verbal orders are not to be used for the convenience of the ordering practitioner (physician, PA, NP or RN).

a. The individual receiving the order shall immediately write the order and then read back the order and the name of the ordering physician. The prescribing physician or other authorized practitioner shall verify that the repeated order is correct. The individual receiving the order shall document, in the patient's medical record, that the order was "read back and verified" (RAV). (Example: T.O. RAV/John Smith, M.D./Mary Smith, RN)

b. Telephone and verbal orders transcribed and verified by the repeated and verified procedure (RAV), with the exception of the admission status order, shall be authenticated by the prescribing physician or by another physician

who is responsible for the care of the patient within thirty (30) days after the patient's discharge. If the patient stay was less than forty-eight hours then the orders, with the exception of the admission status order, must be authenticated within thirty days of discharge, whether or not a "repeat and verify" protocol was used. Authentication of telephone and verbal orders must be dated and timed.

6.7 All admission and discharge orders shall be co-signed by the sponsoring or delegating 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
SGMC Health Medical Staff
December 16, 2025

Elizabeth Flail, DO, Chief of Staff

Approved by
South Georgia Medical Center Inc., d/b/a SGMC Health
December 17, 2025

By: Sam Allen, Chairman