

**MEDICAL STAFF**  
**RULES AND REGULATIONS**

St. Mary's Sacred Heart Hospital

The Medical Executive Committee (MEC) shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles contained within these bylaws. Immediately upon adoption or revision, such Rules and Regulations shall be communicated in writing to each member of the Medical Staff and shall become effective upon notification of the Medical Staff. Rules and Regulations adopted or revised by the MEC shall be presented at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. At that meeting the Rules and Regulations shall be ratified by the affirmative vote of a majority of the members of the Active Medical Staff present at the meeting. Any Rules and Regulations that fail to be ratified shall immediately become null and void and may not be implemented in the future without the approval of the Medical Staff. If no quorum is established at the meeting, the Rules and Regulations shall remain in effect pending ratification at a subsequent meeting of the Medical Staff.

*Adopted by the MEC: December 8, 2021*  
*Approved by the Medical Staff: December 31, 2021*  
*Approved by the Board: January 17, 2022*

**Article 1. RULES AND REGULATIONS GOVERNING ST. MARY'S SACRED  
HEART HOSPITAL MEDICAL STAFF**

- 1.01 The attending physician must provide a reason for patient admission.
- 1.02 Standing orders may be formulated by the Medical Staff members, Chief Nursing Officer, and Pharmacy Leadership. There may be changes by the individual physician.
- 1.03 All orders for treatment shall be in writing. The hospital shall appropriately limit the use of verbal/telephone orders. Verbal/telephone orders shall be used only in situations where immediate written or electronic communication is not feasible and the patient's condition is determined to warrant immediate action for the benefit of the patient. Verbal/telephone orders shall be received by an RN, LPN, Medical Technologist, Medical Lab Technician, Radiological Technician, Respiratory Therapist, Physical Therapist, Physical Therapy Assistant, Registered Dietician, Pharmacist, or Pharmacy Intern and signed by the person to whom dictated, followed by the name of the physician. Verbal orders may be issued only by licensed personnel at the request of the attending physician. The individual receiving the verbal/telephone order shall immediately enter the order into the medical record, sign and date the order with the time noted, and, where applicable, enter the dose to be administered. The individual receiving the order shall immediately repeat the order, and 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 "verbal order read back (VORB)" or "telephone order read back (TORB)." Verbal orders will be authenticated according to the State of Georgia regulations.
- 1.04 Patients shall be attended by a physician on a daily basis.
- 1.05 It is the physician's responsibility to communicate to the patient, and as appropriate the patient's family, the expected plan and outcome of any treatment or procedure to be provided. When deviations from the expected outcome occur, it is the physician's responsibility to communicate these to the patient and/or family. Conversations regarding deviations from expected outcome of care provided should be documented appropriately in the patient's medical record.
- 1.06 Patients shall be discharged only on written or verbal orders by the attending physician, except those leaving AMA.
- 1.07 Each member of the Medical Staff is expected to be actively interested in securing autopsies. All autopsies shall be performed by the hospital pathologist or by a physician to whom he or she may delegate the duty. No

autopsy shall be performed without written consent of a relative or legally authorized agent.

1.09 Physician Qualifications for Administering Moderate Sedation

01. Physician's privileging in accordance with medical staff bylaws will include:
  - a. Completing a self-directed learning module, and passing the written exam available via email or hardcopy.
  - b. Current certification in ACLS, PALS or ATLS.
02. At the time of recredentialing, the physician must show proof of the following:
  - a. Current certification in ACLS, PALS, or ATLS.

1.10 Focused Professional Practice Evaluation

01. When clinical privileges are initially-granted, whether at the time of initial appointment, reappointment, or during the term of appointment, Focused Professional Practice Evaluation (FPPE) shall be conducted by an evaluator from the active staff who is appointed by the MEC Chairman. If an evaluator cannot be chosen from the Medical Staff for any reason, including lack of expertise or obvious or perceived conflict of interest, the Chief of Staff shall select an evaluator (outside of the Medical Staff) with expertise in the field or procedure being proctored. In all cases, the approved proctor will be an active member of an accredited hospital. The evaluator will review the provisional staff member's clinical practice and procedural skills and provide a report to the designated peer review committee. Ongoing Professional Practice Evaluation (OPPE) may be conducted thereafter and reported to the MEC at quarterly intervals during the provisional period.
02. FPPE will be conducted immediately upon appointment to the Provisional Staff and will consist of the following:
  - a. Evaluation of documentation performed by the designated evaluator of patient contacts in a retrospective review conducted to assure compliance with Medical Staff Bylaws and Rules and Regulations. The appropriate documentation will be submitted to the designated peer review committee for review and formal recommendation to the MEC. In the event there is an outlier or concern, the MEC may require further evaluation prior to completing the review.
  - b. Evaluation of clinical practice will be performed by the assigned physician reviewer. A retrospective review will be conducted of five patient charts to evaluate the practitioner's knowledge base, utilization of resources, adherence to evidence-based practice, and

appropriate use of consultants. The appropriate documentation will be submitted to the designated peer review committee for review and formal recommendation to the MEC. In the event there is an outlier or concern, the MEC may recommend further evaluation prior to completing the review.

- c. Evaluation of procedural skills will be conducted by the assigned physician reviewer. An intensive review of five charts to include evaluation of complications, procedure time, re-admissions, compliance with the Medical Staff Bylaws and Rules and Regulations, and compliance with the hospital's quality standards will be conducted and submitted to the designated peer review committee. Procedures may be observed and documented on the appropriate form and submitted to the designated peer review committee for review.
- d. Evaluation of outcomes will be performed by the Medical Staff Services quality improvement coordinator to compare length of stay, mortality and complication data during the first six months of Provisional Staff membership. This information will be presented to the designated peer review committee.

#### 1.11 Ongoing Professional Practice Evaluation

- 01. Following completion of the FPPE process, the Quality Oversight Committee will oversee the ongoing review and analysis of data to identify issues in practitioner's professional performance. The QOC shall review the following metrics for each practitioner based on his/her particular privileges:
  - a. **Hospitalist/General Practitioner** – reviewed by Medical Staff Chair or designee
    - 1) Patient Care & Medical Clinical Knowledge
    - 2) Number of admissions (PI)
    - 3) 30-day readmission rate (PI)
    - 4) Mortality rate (PI)
    - 5) Pharmacy Interventions (illegible orders, incomplete orders, prescribing errors) (Pharmacy)
    - 6) Blood transfusion criteria compliance (PI)
    - 7) Practice-Based Learning and Improvements  
Core Measure compliance (PI)
    - 8) System-Based Practice  
History and Physical within 24 hours (PI)

- 9) Interpersonal/Communication Skills and Professionalism
    - a) Communication problems (incident reports)
    - b) Patient/Staff/Peer complaints (incident reports)
  - 10) Behaviors that undermine a culture of safety (incident reports)
  - 11) **FPPE trigger** – Readmission rate/mortality rate outside of peers for 2 consecutive periods (a period is 6 mos.) and/or recommendation by a Medical Staff Committee
- b. **General Surgery** – reviewed by Surgical Case Committee Chair or designee
    - 1) General Practitioner measures
    - 2) Postop infection rate (PI)
    - 3) History and Physical before procedure (PI)
    - 4) Cases referred to Surgical Case Committee with unfavorable review (PI)
    - 5) **FPPE trigger** – Cases with unfavorable review >2 per year and/or recommendation by a Medical Staff Committee
  - c. **OB** – reviewed by OB Committee Chair or designee
    - 1) General Practitioner measures
    - 2) C-section rate (PI)
    - 3) 3rd- or 4th-degree laceration (PI)
    - 4) **FPPE trigger** – 3rd- or 4th-degree lacerations outside of peers for 2 periods
  - d. **OB Surgery** – reviewed by OB Committee Chair or designee
    - 1) Cases referred to Surgical Case Committee with unfavorable review (PI)
    - 2) **FPPE trigger** – Cases with unfavorable review >2 per year and/or recommendation by a Medical Staff Committee
  - e. **Pediatrics** – reviewed by Pediatrics Committee Chair or designee
    - 1) General Practitioner measures
    - 2) Cases referred to Pediatrics committee with unfavorable review (PI)
    - 3) **FPPE trigger** – Cases with unfavorable review >2 per year and/or recommendation by a Medical Staff Committee

- f. **Emergency Department** – reviewed by Critical Care Committee Chair or designee
  - 1) X-ray discrepancies that result in significant change in treatment (ER Manager)
  - 2) 72-hour returns to ED that result in ICU admission (ER Manager)
  - 3) Code Review – ACLS protocol followed (Critical Care Committee)
  - 4) **FPPE trigger**– X-ray discrepancies >5 per 6 months, ACLS protocol not followed >2 per year, 72-hour returns that result in ICU admission >2%, and/or recommendation by a Medical Staff Committee
- g. **Pathology** – reviewed by Surgical Case Chair or designee
  - 1) Review Blood cases quarterly for Blood Utilization
  - 2) **FPPE trigger**– Blood cases not reviewed >6 months (Surgical Case) and/or recommendation by a Medical Staff Committee
- h. **Radiology** – reviewed by Medical Staff Chair or designee
  - 1) Compliance with turnaround times (Prodigy)
  - 2) **FPPE trigger** – Compliance with turnaround times <90% and/or recommendation by a Medical Staff Committee
- i. **Radiology Physician Assistant** – reviewed by Medical Staff Chair or designee
  - 1) Time out completed before procedure (PI)
  - 2) Procedure note completed immediately after procedure (PI)
  - 3) Procedure complications (PI)
  - 4) **FPPE trigger** – Time out completed <90%, complications >3 per year, and/or recommendation by a Medical Staff Committee
- j. **APRN/PA** – reviewed by Medical Staff Chair or designee
  - 1) Patient Care and Medical Clinical Knowledge
  - 2) Pharmacy Interventions (illegible orders, incomplete orders, prescribing errors) (Pharmacy)
  - 3) Blood transfusion criteria compliance (PI)
  - 4) Practice-Based Learning and Improvements  
CE participation
  - 5) System-Based Practice

- History and Physical within 24 hours (PI)
  - 6) Interpersonal/Communication Skills and Professionalism
    - a) Communication problems (incident reports)
    - b) Patient/Staff/Peer complaints (incident reports)
    - c) Behaviors that undermine a culture of safety (incident reports)
  - 7) **FPPE trigger** – History and Physical within 24 hours <90% and/or recommendation by a Medical Staff Committee
  - k. **Anesthesia (CRNA)** – reviewed by Surgical Case Committee Chair or designee
    - 1) Complete pre-anesthesia assessment (PI)
    - 2) Number of control drug discrepancies (Pharmacy)
    - 3) Response time for emergency cases (OR)
    - 4) **FPPE trigger** – Response time to emergency cases >30 minutes >2 per year, complete pre-anesthesia assessment <90% and/or recommendation by a Medical Staff Committee
  - l. **Consultants (other)** – reviewed by Medical Staff Chair or designee
    - 1) Number of Consultations (PI)
    - 2) Communication problems (Incident reports)
    - 3) Patient/Staff/Peer complaints (Incident reports)
    - 4) Behaviors that undermine a culture of safety (Incident reports)
    - 5) **FPPE trigger** – Recommendation by a Medical Staff Committee
02. The QOC shall review these metrics by engaging in the following activities:
- a. Periodic chart review
  - b. Direct observation
  - c. Monitoring and proctoring of diagnostic and treatment techniques
  - d. Interviews of other members of the staff and personnel
03. The findings shall be maintained in the credentialing file for the practitioner. The OPPE shall be continuous, and the Performance Improvement findings shall be reported to the MEC for action, as

applicable. Based upon the review of the findings described above, the QOC may recommend to the MEC one of the following:

- a. The practitioner is performing well or within the desired expectations, and no further action is warranted, or
- b. The practitioner has issues and requires further evaluation or potential proctoring, or
- c. Privileges should be revoked because they are no longer required, or
- d. Privileges should be suspended until further data may be obtained, or
- e. Focused review on a minimum number of patients should be initiated based upon the review findings.

04. The QOC coordinates the following activities:

- a. Monitoring and evaluation of the quality and appropriateness of patient care and the clinical functions, and consideration of findings from ongoing monitoring activities of the Performance Improvement Plan through surgical case review, drug usage evaluation, medical records review, blood usage review, pharmacy and therapeutics review, infection control, and utilization review.
- b. Periodic collection, screening, and evaluation of information about common, important aspects of patient care to identify problems that have an impact on patient care and clinical performance, including collecting data, without limitation, on the following:
  - 1) Operative or other procedures that place patients at risk of disability or death
  - 2) Discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
  - 3) Adverse events related to using moderate or deep sedation or anesthesia
  - 4) Use of blood and blood components
  - 5) Transfusion reactions
  - 6) Results of resuscitation
  - 7) Behavior management and treatment
  - 8) Medication errors
  - 9) Adverse drug reactions
  - 10) Patient perception of the safety and quality of care, treatment, and services



11) Documentation of medical histories and physical examinations

- c. Establishment of objective criteria for screening that reflect current knowledge in clinical experience. Criteria shall be developed and approved by the MEC.
- d. Evaluation of information collected in order to identify important problems in, or opportunities to improve, common patient care and clinical performance; information shall include data from clinical outcomes, Medical Staff opinions, identified needs, perceptions of risk to individuals, suggestions, and reported adverse events.
- e. Documentation of all findings, conclusions, recommendations, actions taken, results of actions taken, and reporting of same to the MEC or the Board
- f. Communication of information among committees when problems or opportunities to improve patient care involve more than one committee
- g. Tracing of the status of identified problems to assure improvements or resolution
- h. Analysis of information to detect trends, patterns of performance, or potential problems that impact more than one committee
- i. Evaluation of the Performance Improvement Plan's objectives, scope, organization, and effectiveness at least annually and revision as necessary
- j. Evaluation of actions taken to improve patient care, implement potential changes to improve performance and confirm that they resulted in improvements, and recommend action if sustained planned improvement is not initially achieved
- k. Evaluation of the identification of Sentinel Events, review of the Root Cause Analysis regarding Sentinel Events, and assistance with implementation of Action Plans to reduce the risk of recurrence of any such Sentinel Event as a "Professional Peer Review Activity," as this term is defined by Georgia law. The QOC shall also identify the system and/or process changes that will reduce the likelihood that a similar Sentinel Event will occur in the future, and assist with implementing and communicating the system or process change to the members of the Medical Staff.
- l. Evaluation of the patient safety data that is reviewed and collected by the hospital and communication of system and process changes to improve patient safety initiatives

- m. Evaluation of all Ongoing Professional Practice Evaluation (OPPE) data and Focused Professional Practice Evaluation (FPPE) data. If additional clinical expertise is needed, the committee may request assistance from any specialist on the medical staff.
  - n. Recommendation to the MEC as described above to facilitate FPPE and OPPE
- 1.12 The Health Information Management Committee (HIMC) shall monitor the legibility of medical records, timeliness and quality of the medical record entries, including history and physical documentation, and timely signature of orders and completion of medical records; the HIMC shall report deficiencies to the QOC for review and action to support medical staff compliance with the applicable laws and these Bylaws. The HIMC shall also require that a history and physical examination of all patients be completed and recorded within 24 hours of admission and prior to the performance of an invasive procedure or surgery that requires anesthesia services, to include:
  - 01. Chief complaint
  - 02. Pertinent past medical history, including family and social history
  - 03. Review of systems
  - 04. History of present illness
  - 05. Comprehensive physical examination for inpatients and physical examination limited as pertinent to the diagnosis for outpatients.
- 1.13 If a history and physical examination has been performed within 30 days before admission or encounter date, a durable, legible copy of this report may be used in the patient's medical records. This must be updated to reflect patient's current condition, including documentation of no changes. The update must be documented, dated, and signed on the history and physical no

longer than 24 hours after registration or inpatient admission and prior to surgery or the outpatient service/procedure.

- 1.14 The attending physician shall be held responsible for the preparation of the medical record of each patient. This record shall include:
  01. Identification data
  02. Chief complaint
  03. Personal history
  04. Family history
  05. History of present illness
  06. Physical examination
  07. Special reports (consultations, etc.)
  08. Clinical laboratory, X-ray, etc.
  09. Provisional diagnosis
  10. Medical or surgical treatment
  11. Pathological findings
  12. Progress notes daily
  13. Condition on discharge
  14. Discharge summary
- 1.15 The surgeon is responsible for providing informed consent, which is that process by which the patient or legally responsible decision-maker is educated concerning the nature of the proposed surgical therapy, including pertinent risks and expected benefits. Signing of the consent form, which constitutes acknowledgement that informed consent has been addressed, may be obtained and witnessed by nursing or other hospital personnel.
- 1.16 All surgical procedures performed must have a postoperative progress note entered into the medical record prior to the patient being discharged from the surgical unit. The progress note must contain specified information in

- accordance with recognized standards. The formal operative note must be completed within 10 days following the surgical procedures(s).
- 1.17 Tissue and specimens removed during surgical procedures must be submitted for pathological evaluation unless they are exempted by the Pathology Policy and Procedures Manual.
  - 1.18 Any foreign body requested by a law enforcement agency for forensic purposes shall be transmitted to same by appropriate protocol.
  - 1.19 Cancellation of Orders Prior to Surgery: All orders *except* DNR orders will be discontinued at time of surgical intervention. DNR orders may or may not be modified by the attending physician or as directed by the patient or the legal decision-maker at that time. In the event of unexpected anesthesia-related complications (e.g., hypotension or hypertension, ventricular fibrillation, etc.) usual and appropriate anesthetic practices will be considered likewise appropriate and indicated, regardless of DNR status, at the discretion of the attending physician. This may include (but is not limited to) mechanical ventilation when there is reasonable expectation for future discontinuation; cardiac electroshock; inotropic, chronotropic, and other cardiac medication; vasopressors and vasodilators; and other interventions which are not considered “heroic” in usual circumstances, including judicious use of closed, or even open, cardiac massage and blood products.
  - 1.20 All records are property of St. Mary’s Sacred Heart Hospital and shall not be removed from the hospital except upon receipt of a subpoena duces tecum.
  - 1.21 Scheduled cases of elective surgery will begin at 8:00 a.m. (Endoscopies may begin at 7:00 a.m.) This means patient on the table and anesthesia ready and surgeon in operating room at 8:00 a.m. Exceptions to this may be made by special arrangements between the surgeon and OR supervisor as long as there is no interference with posted subsequent surgical cases.
  - 1.22 Each member of the Medical Staff shall name another member of the Medical Staff who may be called to attend patients in his/her absence. In case of failure to name such associate, the President or Chief of Staff shall have authority to call any member of the Staff, should he or she consider it necessary.
  - 1.23 Disaster assignment: In case of disaster or when multiple and undetermined numbers of victims enter the emergency area, a “Triage” routine shall be followed. The patients must be sorted out, identified, and classified immediately upon arrival. For treatment or disposition, priorities of seriousness must be used. The patients will be tagged according to the disaster plan. Either the Chief of Staff or the first physician on the scene shall have the

authority to assume high command and shall order the disposition of the victims as is practical for the immediate situation to maintain order.

- 1.24 Charts shall be completed by the physician within 10 days after the chart is completed by consultants, utilization review, etc. In all cases charts shall be completed within 30 days from discharge. After Article 6.03, Section 03 procedures have been undertaken, if not completed, the following action will be taken:
01. The PRESIDENT will refuse to admit to the hospital any patient of the delinquent physician.
  02. No elective surgery on new patients will be performed by the delinquent physician.
  03. No elective lab tests or X-rays on new patients will be performed on the delinquent physician's orders.
  04. The use of the Emergency Room for treatment will not be allowed, and all emergencies will be referred to the physician on call in the Emergency Room.
  05. The delinquent physician may attend only those patients who were admitted prior to loss of staff privileges, and this may be done in the usual and customary manner of the attending physician.
  06. If more than three periods of delinquency occur in a 12-month period and if these periods exceed a total of 30 days of loss of staff privileges, the MEC and the Board will be called into session, and the physician will be granted a hearing as to causes. If no satisfactory explanation of the repeated periods of delinquency can be rendered, then the physician will be removed from the Medical Staff for 60 days and will be allowed to make a new application for staff privileges at that time. The new application will be handled like all new applications.

## **Article 2. RULES AND REGULATIONS GOVERNING PHYSICIAN ASSISTANTS**

### 2.01 Definitions:

01. "Physician Assistant" (PA) means a person approved by and holding a valid permit or certificate issued by the Georgia Composite State Board of Medical Examiners as a Physician Assistant who has applied for and obtained current privileges as an Allied Health Professional to assist his/her Supervising Physician (hereinafter defined) in the delivery of hospital-based care.
02. "Supervising Physician" means a physician member of the Active or Courtesy category of the Medical Staff who has received approval from the Georgia Composite State Board of Medical Examiners to utilize the Physician Assistant, who shall be responsible at all times for the activities of the Physician Assistant, and who shall be approved by the MEC and the Board to utilize and supervise the Physician Assistant in the hospital. As used herein, the term "Supervising Physician" shall include an Alternate Physician (hereinafter defined) when such Alternate Physician is acting as a Supervising Physician, unless the context clearly requires otherwise.
03. "Alternate Physician" means a physician member of the Active or Courtesy category of the Medical Staff who is taking call for the Supervising Physician and who has received approval from the Georgia Composite State Board of Medical Examiners to act as a supervising physician for the Physician Assistant when his/her regular Supervising Physician is unavailable.
04. "Medical Staff Rules" mean the Rules and Regulations Governing the Medical Staff of St. Mary's Sacred Heart Hospital, including the Medical Staff Bylaws.

2.02 The job description of the Physician Assistant shall be available at all times to the hospital.

2.03 In the hospital a Physician Assistant shall at all times wear identification which shall include the PA's name and the words "Physician Assistant." A Physician Assistant shall introduce him- or herself by his/her correct title and shall never at any time imply that he or she is a physician.

2.04 No Physician Assistant shall have privileges, prerogatives, or permission to enter into patient care activities of any type except as specifically provided in these Rules and Regulations Governing Physician Assistants. All privileges,

prerogatives, and permissions relating to patient care activities in the hospital shall be vested only in the Supervising Physician.

- 2.05 No Physician Assistant shall enter into patient care activities of any type or assist the Supervising Physician, whether or not in the physical presence and under the direct supervision of the Supervising Physician, except as specifically approved to do by those privileges granted to the Physician Assistant and those privileges granted to the Supervising Physician pursuant to the Medical Staff Rules.
- 2.06 No Physician Assistant shall have privileges with respect to patient care activities of any patient of the hospital unless that patient is the patient of the Supervising Physician.
- 2.07 Privileges held by a Physician Assistant may not exceed those held by the Supervising Physician and shall automatically and immediately be reduced or terminated at the same time the privileges of the Supervising Physician are reduced or terminated. The privileges of a Physician Assistant shall stand automatically and immediately terminated at the time of termination of the employment of a Physician Assistant with his/her Supervising Physician or upon expiration or termination of the permit or certificate issued to the Physician Assistant by the Georgia Composite State Board of Medical Examiners. It shall be the duty of the Physician Assistant and the Supervising Physician to notify in writing the PRESIDENT of the hospital immediately upon the occurrence of any event specified herein.
- 2.08 These Rules and Regulations Governing Physician Assistants may be amended at any time. The Supervising Physician must ensure that the Physician Assistant will abide by any change that is made in the Rules and Regulations Governing Physician Assistants at the time such change is approved.
- 2.09 The Supervising Physician must always be in telephone contact with his/her Physician Assistant and be available at all times to provide supervision. In the event the Supervising Physician is out of town or is unable to provide the supervision required by these Rules and Regulations Governing Physician Assistants and the Medical Staff Rules, such supervision must be provided by an Alternate Physician, but such alternate supervision shall not relieve the Supervising Physician of responsibility for the activities of the Physician Assistant.
- 2.10 Should a patient of the Supervising Physician indicate that he or she would like to see the Supervising Physician, the Physician Assistant shall promptly

convey this desire to the Supervising Physician, and the Supervising Physician will make every effort to see the patient on that day.

2.11 Consistent with the Medical Staff Rules, these Rules and Regulations Governing Physician Assistants, and the Physician Assistant's job description and privileges granted, the Physician Assistant may perform the following duties and shall be subject to the following limitation:

01. Assist in preparing a history and physical at the time of the admission of a patient.
02. Make rounds on patients of the Supervising Physician. The Physician Assistant may make entries in the progress notes, but must report to the Supervising Physician regarding the patient contact on the same day the Physician Assistant makes rounds. The progress notes of the Physician Assistant shall be countersigned by the Supervising Physician within 30 days following discharge of the patient.
03. Prepare discharge summaries for the Supervising Physician. The Supervising Physician shall retain full responsibility for all the discharge summaries of his/her patients. The Supervising Physician shall review and countersign all discharge summaries prepared by the Physician Assistant within 30 days following discharge of the patient.



### **Article 3. RULES AND REGULATIONS GOVERNING NURSE PRACTITIONERS**

#### 3.01 Definitions:

01. "Nurse Practitioner" means a person holding the following:
  - a. A current RN license issued by the Georgia Board of Nursing
  - b. A nurse practitioner certificate (advanced nursing practice certificate) issued by a national certifying agency approved by the Georgia Board of Nursing
  - c. An approval from the Georgia Board of Nursing to practice as a nurse practitioner,

Who has applied for and obtained current Medical Staff privileges as an Allied Health Professional to assist his/her Collaborating Physician (hereinafter defined) in the delivery of hospital-based care.

02. "Collaborating Physician" means a physician member of the Active or Courtesy category of the Medical Staff who has submitted practice protocols that reflect accepted standards of nursing practice, which include provisions for case management, including diagnosis, treatment, and appropriate record keeping by the Nurse Practitioner.
03. "Alternate Physician" means a physician member of the Active or Courtesy category of the Medical Staff who has agreed to act on behalf of the regular Collaborating Physician if that physician is unavailable.
04. "Medical Staff Rules" means the Rules and Regulations Governing the Medical Staff of St. Mary's Sacred Heart Hospital and includes the Medical Staff Bylaws.

3.02 The "practice protocols" referred to in Paragraph 02 above shall be available at all times in the hospital. These protocols must adhere to the guidelines published by the Georgia Board of Nursing, the Georgia Registered Nurse Practice Act, and OCGA.

3.03 While in the hospital, a Nurse Practitioner shall at all times wear identification which shall include the Nurse Practitioner's name and the words "Nurse Practitioner." A Nurse Practitioner shall introduce him- or herself by his/her correct title and shall never at any time imply that he or she is a physician.

3.04 No Nurse Practitioner shall have permission to enter patient care activities of any type except as specifically provided in these Rules and Regulations

Governing Nurse Practitioners. All permissions relating to patient care activities in the hospital shall be vested only in the Collaborating Physician.

- 3.05 No Nurse Practitioner shall enter into patient care activities of any type or assist the Collaborating Physician, whether or not in the physical presence and under the direct supervision of the Collaborating Physician, except as specifically approved to do so by the protocols under which the Nurse Practitioner works and those privileges granted to the Collaborating Physician pursuant to the Medical Staff Rules.
- 3.06 The protocols under which care is provided by the Nurse Practitioner may not exceed the privileges held by the Collaborating Physician and shall automatically and immediately be reduced or terminated at the same time as the privileges of the Collaborating Physician are reduced or terminated. The protocols under which the Nurse Practitioner works shall stand automatically and immediately terminated at the time of termination of the employment of the Nurse Practitioner with his/her Collaborating Physician or upon expiration or termination of the permit or certificate issued to the Nurse Practitioner by the Georgia Board of Nursing. It shall be the duty of the Nurse Practitioner and of the Collaborating Physician to notify in writing the PRESIDENT of the hospital immediately upon the occurrence of any event specified herein.
- 3.07 These Rules and Regulations Governing Nurse Practitioners may be amended at any time in accordance with the Medical Staff Bylaws. The Collaborating Physician must ensure that the Nurse Practitioner will abide by any change that is made in these Rules and Regulations Governing Nurse Practitioners at the time such change is approved.
- 3.08 The Collaborating Physician must be available at all times to provide supervision.
- 3.09 Should a patient of the Collaborating Physician indicate that he or she would like to see the Collaborating Physician, the Nurse Practitioner shall promptly convey this desire to the Collaborating Physician, and the Collaborating Physician will make every effort to see the patient on that day.
- 3.10 Consistent with the Medical Staff Rules, these Rules and Regulations Governing Nurse Practitioners, and the Nurse Practitioner's job description

and protocols granted, the Nurse Practitioner may perform the following duties and shall be subject to the following limitations:

01. Those clinical privileges that are granted to all professional nurses
02. Providing direct care to a selected patient population through the following activities:
  - a. Comprehensive and episodic health assessments by taking histories, performing physical examinations, and ongoing data collection
  - b. Participating in the rounds of the Collaborating Physician
  - c. Performance of approved diagnostic and therapeutic procedures
  - d. Coordination of all aspects of patient care and discharge/follow-up plans
03. Patient and family education and counseling
04. Coordination of referrals to other in-house and outside health care providers
05. Functioning as a resource to health care personnel and participating in their educational programs
06. Writing orders to the extent of the privileges granted. All orders must contain the date and time written and the signature of the nurse practitioner. The Collaborating Physician shall countersign all orders no later than the following day.
07. The Collaborating Physician shall review all progress notes, lab reports, and imaging data at least every 48 hours, and after reviewing, the Collaborating Physician should indicate the completed review by entering the date and time reviewed and his/her signature.
08. Preparing discharge summaries; however, the Collaborating Physician shall retain full responsibility for all the discharge summaries of his/her patients.

**Article 4. RULES AND REGULATIONS GOVERNING MEDICAL SCREENING EXAMINATIONS AND THE DUTIES OF EMERGENCY ROOM PHYSICIANS AND ON-CALL PHYSICIANS**

Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition.

Qualified medical personnel who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:

Emergency Department:

- Members of the Medical Staff with clinical privileges in Emergency Medicine;
- other Active Staff members;
- resident physicians; and
- appropriately credentialed allied health professionals.

Labor and Delivery:

- members of the Medical Staff with OB/GYN privileges;
- Certified Nurse Midwives with OB privileges; and
- Registered Nurses who have achieved competency in Labor and Delivery and who have validated skills to provide fetal monitoring and labor assessment. The medical screening examination may be performed by a qualified obstetrical nurse in consultation with the Obstetrician for patients presenting to the Emergency Room for a pregnancy-related complaint if the obstetrical patient is  $\geq 20$  weeks gestation. Examples of pregnancy-related complaints include but are not limited to: cramping, contractions, pressure, leaking/rupture of membranes. The qualified obstetrical nurse is a professional registered nurse who has met criteria to perform a medical screening exam, as evidenced by completion of the nursing unit competency skills for performance. The OB nurse will call report to the responsible Obstetrician on all obstetrical evaluations. The Obstetrician is responsible for determining the appropriate plan of care and disposition of the patient.

4.01 Definitions: An “Emergency Medical Condition” is defined as follows:

01. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in
  - a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
  - b. Serious impairment to bodily functions; or
  - c. Serious dysfunction of any bodily organ; or

02. With respect to a pregnant woman who is having contractions, an emergency means:
  - a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - b. That transfer may pose a threat to the health or safety of the woman or the unborn child.
  
- 4.02 If an emergency medical condition exists, it will be the responsibility of the hospital to provide treatment to the patient to remove the emergency medical condition, or if St. Mary's Sacred Heart Hospital does not have the capabilities to provide the treatment necessary to remove the emergency medical condition, to provide stabilizing treatment followed by an appropriate transfer of the patient to another facility. Stabilizing treatment is described as follows:
  01. To provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or to occur during the transfer, or
  02. With respect to a pregnant woman having contractions, stabilizing treatment means caring for the woman until she has delivered the child and the placenta.
  
- 4.03 The staff of St. Mary's Sacred Heart Hospital will not delay examination and/or treatment in order to inquire about insurance or payment status.
  
- 4.04 In order to carry out this policy, the Emergency Department shall be staffed with sufficient personnel (including physicians and support personnel). A method of providing backup physicians will be established by the MEC and will include an on-call roster of physicians who are available to provide evaluation and/or treatment necessary to stabilize patients in the emergency room presenting with an emergency medical condition. An on-call roster will be available for each of the following medical or surgical specialties: Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Surgery, and Orthopedics.
  
- 4.05 When there is one physician in a specialty, he or she should be required to take 10 days of call per month, including one weekend during the 10 days. When there are two physicians in a specialty, both should be required to take 10 days each, including two weekends between them. When there are three physicians in a specialty, they should provide 100% coverage for the month, including all weekends. A physician who has Emeritus, Honorary, Consulting or Courtesy

Medical Staff Privileges may elect not to be on the Emergency Room rotation call.

01. The PRESIDENT's office shall coordinate with the Executive Committee to publish a monthly duty roster and circulate it to each physician as well as to the appropriate departments.
02. This shall be made available to the patient who presents himself to the Emergency Room and who does not have a private physician.

4.06 After performing the medical screening examination, if the emergency room (ER) physician determines a patient requires the services of a physician on one of the above on-call rosters, the following procedures will be followed:

01. **If the patient has a local primary care physician**, the ER physician (or his/her designee) will proceed as follows:
  - a. Contact the patient's primary care physician by telephone or pager.
  - b. If the primary care physician does not respond within 30 minutes, the ER physician will proceed as if the patient does not have a local primary care physician as described in Paragraph 03 below.
02. After consultation with the primary care physician, the ER physician (or designee) will proceed as follows:
  - a. If necessary, contact the physician from the appropriate on-call roster by telephone or pager.
  - b. If the on-call physician does not respond within 15 minutes, contact the Medical Director of Emergency Services (a.k.a. ER Director) and the hospital PRESIDENT.
  - c. If the ER Director does not respond within 30 minutes, contact the Chief of Staff.
  - d. In all instances where the on-call physician fails to respond, proceed with making an appropriate transfer of the patient.
03. **If the patient does not have a local primary care physician**, the ER physician (or his/her designee) will proceed as follows:
  - a. Contact the physician from the appropriate on-call roster by telephone or pager.
  - b. If the on-call physician does not respond within 30 minutes, contact the Director of Emergency Services (a.k.a. ER Director) and the hospital PRESIDENT.
  - c. If the ER Director does not respond within 30 minutes, contact the Chief of Staff.

- d. In all instances where the on-call physician fails to respond, proceed with making an appropriate transfer of the patient.
- 4.07 After performing the medical screening examination, if the emergency room (ER) physician determines a patient requires the services of a specialist who practices at TCRMC on a part-time basis – i.e., the specialist is not on one of the above on-call rosters – the following procedure will be followed:
01. **If the patient has a local primary care physician**, the ER physician (or his/her designee) will proceed as follows:
    - a. Contact the patient's primary care physician by telephone or pager.
    - b. If the primary care physician does not respond within 30 minutes, the ER physician will proceed as if the patient does not have a local primary care physician as described in Paragraph 03 below.
  02. After consulting with the primary care physician, the ER physician will proceed as follows:
    - a. Use his/her medical judgment to determine which is in the patient's best interest: to attempt to contact one of the part-time specialists, or to arrange for an immediate transfer of the patient to another facility.
    - b. If the decision is made to consult one of the part-time specialists, attempt to contact the part-time specialist by telephone or pager.
    - c. If the part-time specialist does not respond within 15 minutes, use medical judgment to determine if an attempt should be made to contact another part-time specialist (if more than one part time specialist is on staff).
    - d. If the second part-time specialist does not respond within 30 minutes, or if the decision is made not to contact the second part-time specialist, proceed with making an appropriate transfer of the patient.
  03. **If the patient does not have a local primary care physician**, the ER physician (or his/her designee) will proceed as follows:
    - a. Use his/her medical judgment to determine which is in the patient's best interest: to attempt to contact one of the part-time specialists, or to arrange for an immediate transfer of the patient to another facility.
    - b. If the decision is made to consult with one of the part-time specialists, attempt to contact the part-time specialist by telephone or pager.
    - c. If the part-time specialist does not respond within 30 minutes, use medical judgment to determine if an attempt should be made to

contact another part-time specialist (if more than one part time specialist is on staff).

- d. If the second part-time specialist does not respond within 30 minutes, or if the decision is made not to contact the second part-time specialist, proceed with making an appropriate transfer of the patient.

4.08 The patient will be transferred to another facility under one of the following conditions:

01. The individual (or a legally responsible person acting on the individual's behalf) requests the transfer after being informed of the hospital's obligations under EMTALA and of the risk of transfer. The request must be in writing, indicate the reasons for the request, and indicate that he or she is aware of the risks and benefits of the transfer; or
02. The ER physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual – or, in the case of a woman in labor, to the woman or the unborn child – from being transferred. The certification must contain a summary of the risks and benefits upon which it is based.

4.09 The patient will not be transferred, even if the physician determines that a transfer is necessary, unless all of the following conditions are met:

01. Stabilizing treatment has been provided within the hospital's capacity to minimize the risk to the health of the patient or the unborn child.
02. The receiving facility has available space and qualified personnel to treat the condition.
03. The receiving facility has agreed to accept the transfer and to provide appropriate treatment.

If the above requirements for an appropriate transfer cannot be met, the patient will not be transferred and the staff will continue to provide treatment within its capabilities.

4.10 Upon transfer of the patient, the physician is responsible for forwarding the following information to the receiving hospital:

01. All medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or



telephone reports of the studies, treatment provided, and results of any tests

02. The informed written consent or certification (or copy thereof)
  03. The name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment
  04. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer
- 4.11 The on-call physician who failed to contact the hospital's emergency room within the time prescribed above will be reported to the MEC for investigation and appropriate action. The Chief of Staff will convene a special meeting of the MEC to consider appropriate corrective action as provided in ARTICLE 5 of the St. Mary's Sacred Heart Hospital Medical Staff Bylaws.

## **Article 5. RULES AND REGULATIONS ON PHYSICIAN HEALTH/IMPAIRMENT**

- 5.01 The goals of all actions taken by individuals following procedures outlined in this section shall be to:
01. Protect the well-being of the patient(s).
  02. Handle all proceedings in a fair and respectful manner with respect to the physician's interests.
  03. Manage matters of individual physician health in a separate process from the medical staff disciplinary function.
- 5.02 The medical staff will provide education about physician health; address prevention of physical, psychiatric, or emotional illness; and facilitate confidential diagnosis, treatment, and rehabilitation of physicians who suffer from a potentially impairing condition.
- 5.03 The medical staff encourages self-referral by the physician and referral by other organization staff of the affected physician to appropriate professional resources (internal or external) for diagnosis and treatment of a condition or concern. The medical staff will maintain the confidentiality of the physician seeking referral or referred for assistance except as limited by law or ethical obligation, or when the safety of the patient is threatened.
- 5.04 As soon as an impaired physician is identified, the Chief of Staff will appoint three physicians from the MEC to be responsible for the monitoring of the affected physician and the safety of patients until the rehabilitation or any disciplinary process is complete.
- 5.05 Any accusation of impairment that warrants emergent suspension of privileges or investigation of merit must be formally documented, with a designated accuser and dates, time, and specific events supporting the accusation. Such accusations will not be the result of accumulated gossip.
- 5.06 An investigation will follow any formal accusation. The individual making the complaint about the physician must be willing to have his/her name known, to be interviewed by investigators, and to submit a written document at some point in the future containing specific details about the accusation.
- 5.07 The formal complaint may come from any hospital or medical staff member and be made to anyone in a position of authority in the hospital, including Nursing, Administration, or the Medical Staff leadership.
- 5.08 Due to the nature of the situation, the initial complaint may be verbal. Therefore, the person to whom the complaint is registered will inform the individual making the complaint that a written report will be required and subsequent testimony is likely at some point in the future. If the individual

making the complaint expresses unwillingness to provide testimony or a written statement, no further investigation will be pursued.

- 5.09 The Chief of Staff will be informed immediately by the person in authority who received the complaint. If the accused physician in question is the Chief of Staff, the Vice Chief of Staff will be notified.
- 5.10 Once a formal complaint has been filed with an administrative hospital staff member, the appropriate individuals in the hospital chain of command will be consulted and informed, and the PRESIDENT will be consulted and notified.
- 5.11 Should numerous verbal accusations be made by hospital staff who express unwillingness to make a formal complaint, the Chief of Staff shall file a formal complaint against the physician when the complaints become so numerous as to strongly imply dangerous behavior. This complaint shall be referred to as an officer-initiated complaint.
- 5.12 A formal complaint will be investigated immediately in the following manner:
  01. If the situation is urgent, meaning that the accused physician is rendering direct patient care at the time of the alleged impairment, the Chief of Staff or a designated physician will directly observe the physician in question and the care that is being provided.
  02. If there is no problem, then no further actions are warranted. It is important, however, for the Chief of Staff to document this impression.
  03. If there is a real problem, immediate temporary suspension of all staff privileges of the physician will be effected, and the Chief of Staff will arrange provision of care for the physician's patients.
  04. The Chief of Staff will compassionately inform the physician of his/her decision in a manner that will not be embarrassing to the physician or hospital staff members that may be in the immediate area.
  05. When warranted, the Chief of Staff will offer a blood or urine test to the accused physician.
  06. All actions taken by the Chief of Staff will be documented at the earliest convenience of the Chief of Staff.
- 5.13 Within one working day of completing the initial investigation, the Chief of Staff shall designate a committee of three physicians for the purpose of investigating the formal accusation and rendering a decision of merit or lack of merit to the Executive Committee on the subject of the accusation.
  01. The committee shall meet within three working days of their designation by the Chief of Staff. The investigation shall not be delayed in order to

allow the Executive Committee to act on reinstatement of privileges of the accused physician.

02. The committee shall designate a chairman if it wishes, but the input of each member of the committee will have equal merit.
  03. The accused physician will be informed of the names of the members of the committee. The physician may dismiss one of the named members if he or she wishes, replacing that person with a staff physician of his/her choosing. The named staff physician will then function as a full committee member with full voting privileges for the duration of the investigation.
  04. The committee shall call for interviews of all individuals involved and of anyone the committee feels would have information useful to the committee, including the accused.
  05. The committee shall make no demands of the accused physician other than requesting answers to the questions asked. If the accused physician wishes his/her attorney to be present, the attorney will be clearly informed that this is an investigation of an accusation and not a formal hearing, and is for the purpose of establishing the merit or lack thereof of the accusation against his/her client.
  06. After gathering all the information, the committee shall determine by vote whether, in the opinion of the committee, the accusation has merit or does not have merit. Specific notation must be made as to the vote or the committee member's name by the accused physician.
  07. The decision will be rendered to the MEC with presentation of the supporting evidence. Specific reference will be made as to the vote of the physician named by the accused physician.
  08. The MEC shall ascertain that the investigation was conducted by the committee to the point that, in the opinion of the Executive Committee, a correct decision was reached. The Executive Committee shall dismiss the committee after receiving the report.
  09. This initial investigation shall not take longer than 30 days.
- 5.14 The MEC will consider the accusation and its merit, or lack thereof, and decide upon the disposition it feels appropriate. Should any action be recommended as outlined in Article 6 of the Medical Staff By-Laws, procedural rules for conducting a hearing as outlined in Article 7, Section 7.03 and subsequent sections will be followed.
01. If the physician is found innocent, then no record of the events will be placed in the physician's files, and no transfer of this information made to any requesting agent.

02. If the physician is found guilty and his/her privileges are permanently terminated or reduced or practice is altered, records are to be placed in the physician's permanent files, and transfer of records to requesting agents is appropriate.
03. Records of all proceedings shall be kept in the confidential files of the Medical Staff as long as it is felt appropriate and, in case of litigation by the accused physician, regardless of the disposition.