SUTTER MEDICAL CENTER OF SANTA ROSA

MEDICAL STAFF RULES AND REGULATIONS

EFFECTIVE DATE: December 2009

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I. ADMISSIONS

A. Who May Admit Patients
Patients shall be admitted only upon the order and under the care of a member of the Medical Staff of the Hospital who is lawfully authorized to diagnose, prescribe, treat patients, and been granted admitting privileges.

B. Medical Staff Responsibilities
1. The member of the medical staff who admits the patient shall establish the patient's condition and provisional diagnosis at time of admission.

2. Precautions: The attending physician, at admission, shall inform the admitting staff and nursing staff if he/she suspects that the patient may be a danger to self or to others or has an infectious or contagious disease or condition. He/she shall recommend appropriate and approved precautionary measures to protect the patient and the staff, and shall note in the patient's record both the reason(s) for his/her suspicions, and the precautions to be taken.

C. Emergency Admissions
1. Except in an emergency, no patient shall be admitted to the hospital until a 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 (refer to Section V.A).

D. Patients admitted to the adult intensive care units shall be seen by the attending physician or designee within two (2) hours of admission. Patients not seen by the attending practitioner within two (2) hours of admission shall be seen by the Critical Care Intensivist on call.

E. The attending practitioner shall see the patient as soon as possible, but in no case shall this be longer than twenty-four (24) hours after admission for medical/surgical. The attending practitioner shall be responsible for directing and supervising the patient's overall medical care. Transmitting information regarding the patient's status to the patient, the referring practitioner if any, and to the patient's family shall be the responsibility of the attending practitioner.

II. AUTOPSY

A. The attending practitioner should attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. The mechanism for documenting permission to perform an autopsy must be defined (refer to Hospital Consent Policy).

B. An autopsy may be performed only with a written consent, signed in accordance with State law. Autopsy is recommended and/or required by State law when the following circumstances exist:

1. All deaths in which the cause of death is not known with certainty on clinical grounds.
2. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
3. Deaths resulting from high-risk infectious and contagious diseases.
4. Obstetric deaths.
5. Perinatal and pediatric deaths.
6. Deaths at any age in which it is believed that an autopsy would disclose a known or suspected illness that also may have a bearing on survivors or recipients of transplant organs.
7. Deaths known or suspected to have resulted from environmental or occupational hazards.

C. Death Certificates – The attending physician or other physician last in attendance is responsible for signing the death certificate or ensuring its completion.

D. Notifying the Next of Kin – The attending physician or his/her representative is responsible for notifying the next of kin.

E. Disposition of Remains and Contributions of Anatomical Gifts – The patient's remains shall be disposed of in accordance with the instructions of the patient, the patient's legal representative, or his or her next of kin.

   If the patient or his/her family indicates that the patient has or will contribute anatomical gifts, such consent shall be secured in accordance with the law. The patient's attending physician shall comply with the Hospital protocol for identifying potential organ and tissue donors.

F. Coroner's Cases

   It is the physician's responsibility to assure immediate notification of the Coroner's Office for deaths which occur under any of the following circumstances:

1. Unnatural Deaths
   a. Homicides, known or suspected
   b. Child deaths (under age of one year)
   c. Suicides (known or suspected)
2. Accidental Deaths
   a. Auto accidents, drowning, fire, gunshot, stabbing
   b. Falls, cutting, starvation, exposure, acute alcoholism
   c. Drug addiction, strangulation, hanging, aspiration
   d. Poisoning (food, chemical, drug, therapeutic agents)
   e. Related to or following known or suspicious criminal act
   f. Accidental or suspected deaths that occur in the ER

g. Related to or following known or suspected self-induced or criminal abortion
h. Associated with known or alleged rape or crime against nature
i. Occupational accident

3. Other Reportable Deaths
   a. Following an accident or injury (primary or contributory – occurring immediately or at some remote time)
   b. Occupational diseases or occupational hazards
   c. Reportable diseases and conditions (See Infection Control Policies)
   d. All deaths in operating rooms
   e. Physician unable to state cause of death
   f. No attending physician
   g. Medical attendance less than 24 hours
   h. When the deceased has not been attended by a physician in the last 20 days prior to death
   i. All deaths where a patient has not fully recovered from anesthetic, whether in surgery, recovery room or elsewhere
   j. All deaths in which the patient is comatose throughout the period of physician's attendance, whether at home or hospital
   k. In prison or while under sentence
   l. All solitary deaths (unattended by physician or other person in the period preceding death)
   m. Where the suspected cause of death is Sudden Infant Death Syndrome
   n. All deaths of State Hospital patients
   o. All stillborn births, of criminal nature, no prenatal care, caused by accident, drug or abuse, or illegal abortion
   p. All Deaths where the supervisor is unsure if the coroner's review is required
   q. Deaths where next of kin needs to be contacted to provide information about patient
   r. If family needs to be notified
   s. Cases from other facilities, if nothing can be done
   t. If evidence may be destroyed
   u. If question that delay may hamper ability to determine cause
   v. If cause of death is undetermined, hold blood draws and toxicology results for Coroner
   w. Indigent patient with no funds for burial
   x. Deceased with no relative, No family

G. Fetal Death

No autopsy is required if an infant is a stillborn and is less than twenty (20) weeks gestation.

H. Consent for Autopsy

An autopsy may be performed only with a written consent, signed in accordance with State law for those deaths not referred to the Coroner. Refer to most recent California Hospital Association Consent Manual.

I. Physician Notification

When a private physician's patient has an autopsy, that physician will be notified of the performance of the autopsy and the results.

J. Coroner's Report

The report will be filed and become a permanent part of the patient's medical record.

K. Pronouncement of Death

It shall be the responsibility of the attending practitioner to pronounce the patient dead. The attending practitioner's designee or the emergency room physician, in the event of the practitioner's unavailability, may pronounce death.

III. CONSENTS

A. General – Refer to California Hospital Association (CHA) Consent Manual and Hospital policy.

B. Informed Consent

It is the treating physician's responsibility to obtain and document in either progress notes or dictation informed consent. See Hospital policy on Informed Consent and CHA.

1. All physicians performing important parts of the case;
2. Any potential conflicting interest the physician may have (such as research or financial interests).

C. Autopsy – Refer to Rules and Regulations Section II

D. Blood Transfusion

Whenever there is a reasonable possibility that a blood transfusion will be recommended, it is the responsibility of the physician to provide the patient with the Department of Health Services mandated (*Paul Gann Blood Safety Act*) patient brochure on blood transfusions. There shall be documentation in the patient medical record that the brochure was provided and consent was obtained.

E. Breast Cancer Treatment

1. Documentation - The law specifically states that, prior to performance of a biopsy, the physician must note in the patient's medical record that he or she has given the patient the written summary and the brochure entitled "A Woman's Guide to Breast Cancer Diagnosis and Treatment".

2. Role of Physician – The physician may use written materials or audio or video cassettes to provide information to the patient, it is recommend that they physician always give a personal explanation of the procedure.

3. Written Consent – the patient may attest with the following: By my signature below, I acknowledge that the physician named above has given me the breast cancer treatment brochure.

F. Prostate Cancer Treatment

The law provides that DHS must approve, and the Medical Board of California (MBC) must make available, a written summary of the advantages, disadvantages, risks and descriptions of procedures with regard to medically efficacious alternative methods of treatment of prostate cancer. Physicians are "urged" to make it available to patients when appropriate.

IV. DISCHARGE OF PATIENTS

A. Required Order

It shall be the responsibility of the attending practitioner or designee to discharge his or her patients from the Hospital.

Patients shall be discharged only on the direct order of the attending practitioner or designee. The order will be timed, dated, and signed by an attending practitioner. Patients shall be seen by the attending practitioner or designee on the day of discharge.

B. Discharge Summary

For all patients hospitalized more than 48 hours, a concise discharge summary providing information to other caregivers and facilitating continuity of care shall state the reason for hospitalization and procedures performed and care, treatment, and services provided. The summary shall also briefly recapitulate the significant findings and events of the patient's hospitalization, condition on discharge, recommendations and arrangements for future care, and instructions to the patient and family, as appropriate.

Discharge instructions shall include recommendations for diet, activity, medications and follow-up.

C. Against Medical Advice (AMA)

Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record by the attending practitioner.

D. Transfers to Other Facilities

1. No patient shall be transferred or discharged for the purpose of effecting a transfer from a hospital to another health facility unless:

   a. Arrangements have been made in advance for admission to such health facility.

   b. A determination has been made by the patient's physician that such a transfer or discharge would not create a medical hazard to the patient.

   c. The patient or the person legally responsible for the patient has been notified, or attempts have been made over the 24-hour period prior to the patient's transfer and the legally responsible person cannot be reached.

2. A discharge/transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility. The discharge/transfer summary shall include essential information relative to the patient's diagnosis, hospital course, medications, treatments, dietary requirement, rehabilitation potential, known allergies and treatment plan and shall be signed by an attending practitioner and/or designee.

V. GENERAL CONDUCT OF CARE

a. Attendance of Patients

The patient shall be visited at least daily during the hospitalization and progress notes shall be written reflecting the patient's condition. The progress notes shall give a chronological picture of the patient's progress, and be sufficient to permit continuity of care and/or transferability.

A. Transfer of Responsibility

Whenever the patient care responsibilities are transferred to another Staff member, an order covering the transfer of responsibilities shall be entered on the order sheet in the medical record. It shall state the date and time responsibility is transferred.

If a patient or physician requests a change of physician during their hospitalization, it is the attending physician's responsibility to arrange for the transfer of care.

B. Consultations

a. General. The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the seriousness of the illness and the proper diagnosis and treatment rests with the physician responsible for overall medical care. The Department Chair has oversight responsibility for assuring that consultants are called as needed.

b. Indications. The attending physician is responsible for requesting a consultation when indicated. Except in an emergency, consultation should be considered in cases which according to the judgment of the attending physician, additional skills and clinical advice or review might be beneficial to the treatment of the patient; including, without limitation, all cases in which:

i. a patient is not a good risk for an operation or treatment, the diagnosis is obscure after ordinary diagnostic procedures have been completed
ii. there is a question as to the choice of therapeutic measures to be used
iii. the specific skills of other practitioners may be needed because of the unusual complexity of the patient's problem
iv. the patient exhibits severe psychiatric symptoms
v. such consultation is requested by the patient or family
vi. the patient has a problem beyond the scope of privileges granted to the practitioner
vii. such consultation is required by Hospital, Medical Staff or Department Rules
viii. such consultation is recommended by the Director of the service, Chair of a department or the Chief of Staff

c. Completeness. Consultation includes examination of the patient and the medical record. The attending physician is responsible for contacting and supplying the consultant with all available and relevant information and the reason for the consultation. The consultant shall enter a signed, written opinion in the medical record. When a consultation precedes an operative procedure, the consultation shall be recorded before the operation, except in emergencies.

All consultations must be done in a timely fashion as requested by the attending practitioner based on the patient's acuity.

Psychiatric Consultations: In cases of attempted suicide there shall be a notation in the patient's medical record that psychiatric consultation and treatment has been offered.

VI. MEDICAL RECORDS DOCUMENTATION

Only Medical Staff members, Allied Health Professionals, and employees authorized by the Hospital to be professionally involved in the patient's care may make entries into the medical record. Changes in medical records documentation requirements, as they occur from time to time, are recorded in Hospital policy. See Medical Staff Policy for Completion of Medical Records.

A. Code Status

Any code status limitation is documented on the code status order form. A note should be made in the progress notes, H&P, code status order form and/or POLST form which includes documentation of discussion with the patient and/or family or surrogate. See Hospital policy.

B. Restraints and Seclusion

Restraint means controlling a patient's physical activity in order to protect the patient or others from injury by seclusion or mechanical forces.

Restraint shall be used only when alternative methods are not sufficient to protect the patient or others from injury and must be reordered every 24 hours.

See Hospital Policy.

C. Access to Medical Records

All original medical records, including x-ray films, and pathology slides and blocks, are the property of the Hospital and shall not be taken from the Hospital except in response to court order, subpoena or statute. Copies of the medical record and x-ray films and pathology slides and blocks may be released to the patient or other patient care providers, in accordance with Health Information Management (HIM) Policy and HIPAA requirements.

D. Completion of Medical Records

Completion of all medical records shall be accomplished within fourteen (14) days of the patient's discharge in compliance with State law. Failure to complete charts within fourteen (14) days will result in suspension of Medical Staff privileges (See Suspension Addendum).

E. Medical Record Suspension

All information related to reasons and causes of Medical Staff suspensions are addressed in the Suspension Addendum and the Medical Staff Bylaws Article VI, Section 6.3-6.

VII. TISSUE MANAGEMENT

A. Outside Tissue Review. All patients admitted (inpatient or outpatient) to SMCSR with outside tissue diagnoses of in situ or invasive cancer shall at the discretion of the treating physician have their slides and reports reviewed by the Department of Pathology of this Hospital prior to the initiation of surgery or other therapy for that specific diagnosis.

B. Removal of Tissue During Surgery. Specimens removed during a surgical procedure are sent to the Pathology Department for gross and/or microscopic examination. The types of specimens that are exempt from examination by a pathologist are jointly determined and approved by the Pathology Department and the Medical Executive Committee (Refer to Department of Pathology Policy). Specimens designated as exempt from examination may be submitted for examination by a pathologist upon request by the surgeon. However, specimens designated as exempt and not submitted to Pathology must have documentation in the chart regarding the nature of the specimen removed.

VIII. ON-CALL COVERAGE

Recognizing that the best interests of the patient are protected by concerted efforts, it is the responsibility of each Active, Provisional and Courtesy Medical Staff members to participate in Emergency Service Backup Coverage.

Emergency Service Backup Coverage is defined as providing consultation in the Emergency Department to any patients who are screened and referred by the Emergency Department physician on duty or inpatients referred by the attending physician.

Department Chairs will be allowed discretion in Emergency Service Backup Coverage assignments. It is the responsibility of each department chair to devise, and present to the Medical Executive Committee for review and approval, an equitable system for providing emergency service backup coverage for his/her department and the services included thereunder.

A. Call Response Time

Physicians on call must respond within a reasonable time when requested to see a patient. As a general guideline "reasonable response time" is defined as thirty (30) minutes. Other factors may affect the on-call physician's response time, including the severity of the patient's injury or illness, the adequacy of a telephone consultation in stabilizing the patient, the distance the on-call physician is from the hospital and any patient activity the physician is engaged in at the time he or she is called. Each on-call physician must be available by telephone and must remain close enough to the hospital to be able to arrive within the time as discussed heretofore. If a physician has agreed to take call

and will be encumbered and not available to respond, is the physician's responsibility to arrange for backup coverage. Any difficulty obtaining appropriate consultation or response shall be referred to the appropriate Department Chair, or designee, or to the Chief of Staff, or designee.

B. Exemptions to Call Schedule Requirements

Under-represented subspecialty groups are exempt from full participation in the Emergency call panels. For purposes of this section, "under-represented" is defined as a specialty group containing three or fewer physicians. i.e., each individual would be on call one (1) week per month (including one weekend – holiday coverage must be built into this as well) and this could be spread out throughout the month or taken in block, as per physician preference.

Physicians over the age of 60 may take emergency calls but are not required to do so.

C. Restraints

Refer to Hospital Policy.

IX. PATIENT RIGHTS

Refer to Hospital Policy.

X. RESIDENTS

A. General

Sutter Medical Center of Santa Rosa participates in a Family Practice Residency Program in conjunction with the University of California, San Francisco (UCSF).

B. Nature of Affiliation

Residents are not members of the Medical Staff and are not credentialed by the Medical Staff. They are employed by the Hospital pursuant to an affiliation agreement between the Hospital and UCSF. Residents are required to comply in all respects with the applicable provisions of the Medical Staff Bylaws and Rules and Regulations, and departmental or service Policies and Procedures.

The Hospital retains full responsibility for the care of its patients, including the administrative and professional functions pertaining thereto.

Residents do not enjoy the due process rights afforded Medical Staff members. Moreover, the Hospital retains the right to require the immediate suspension or

withdrawal of any Resident if such action is deemed warranted in order to protect patients or other individuals.

C. Supervision

Each Resident shall be under the supervision of one or more specified members of the Medical Staff ("Supervising Physician"). Each Supervising Physician must hold unrestricted clinical privileges that are appropriate to the nature and scope of the activities to be supervised. The Supervising Physician(s) shall be responsible for all patient care activities of the assigned Resident.

The authority to supervise Residents is granted by UCSF. Such authority does not constitute a "clinical privilege" under the Medical Staff Bylaws and the assumption of such responsibilities is not a condition of membership or privileges. However, at the discretion of the Medical Executive Committee, a member of the Medical Staff may be prohibited from serving as a Supervising Physician based on factors deemed relevant to such determination by the Medical Executive Committee. The Supervising Physician shall be given an opportunity to meet with the Medical Executive Committee to address its concerns before the decision becomes final, unless the Medical Executive Committee deems it necessary to immediately remove a Supervising Physician's supervisory responsibilities. Such decision will then be effective prior to the meeting, but the Supervising Physician will still be entitled to meet with the Medical Executive Committee to discuss the decision.

D. Authorized Activities

A Resident may make entries in the patient's medical record as delineated in the Medical Staff Guidelines: Residents ("Guidelines"). The extent to which the Resident may otherwise participate in patient care services and make entries in the medical record shall be determined by the Supervising Physician and Family Practice Residency Program and shall be consistent with the applicable Guidelines.

APPROVALS

Original Signed by Robert R. Wright, M.D. 11/27/2009
Robert R. Wright, M.D., Chief of Staff

Original Signed by Cynthia Nestle.
Cynthia Nestle, Secretary, Board of Trustees 12/11/2009