

SUTTER MEDICAL CENTER OF SANTA ROSA  
and  
SUTTER WARRACK HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS

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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.

*Title 22 §70717*

### 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.

*Title 22 §70717 (c)*

- a. Patients admitted to the hospital for podiatric services shall receive the same basic medical appraisal as patients admitted for other services. This shall include the performance and recording of the findings in the health record of an admission history and physical examination which shall be performed by a physician member of the Medical Staff.

*Title 22 70717 (c)(1)*

- b. A physician member of the medical staff shall be responsible for the care of any medical problem arising during the hospitalization of podiatric patients.

*Title 22 §70567(c)*

- c. A physician member of the medical staff shall be responsible for the care of any medical problem arising during the hospitalization of dental patients.

*Title 22 §70473(c)*

### 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).

## II. AUTOPSY

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).

*CMS § 482.22 (d) JCAHO MS.3.10*

A. 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.

B. 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. Without medical attendance;
2. During the continued absence of the attending physician and surgeon;
3. Where the attending physician and surgeon are unable to state the cause of death;
4. Where suicide is suspected;

5. Following an injury or accident; or
6. Under circumstances which raise a reasonable suspicion that the death was caused by the criminal act of another.

*Health & Safety Code §102850*

C. Fetal Death

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

*Health & Safety Code §102950*

D. 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 Association of Hospital and Health Systems (CAHHS) manual.

E. 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.

F. Coroner's Report

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

### III. CONSENTS

A. General – Refer to California Association of Hospital and Health Systems (CAHHS)

B. Informed Consent

It is the treating physician's responsibility to obtain informed consent. In order to give informed consent, the patient must be informed of:

1. The nature of the procedure;
2. The risks, complications, and expected benefits or effects of the procedure;
3. Any alternatives to the treatment and their risks and benefits;
4. Any potentially conflicting interest the physician may have (such as research or financial interests). *CAHHS Chapter I, 1.4*

C. Autopsy – Refer to Rules and Regulations Section II

D. Blood Treatment

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 *CAHHS Chapter 4, Section IX A*

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".  
*Health and Safety Code Section §109275*
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

*CAHHS Chapter 4, Section IX A*

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.

*Health and Safety Code Section §109280*

#### IV. DISCHARGE OF PATIENTS

##### A. Required Order

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

Patients shall be discharged only on the direct order of an attending practitioner. The order will be timed, dated, and signed by an attending practitioner  
*Title 22 §70749*

##### 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.

*JCAHO IM.6.10 Title 22 §70749(16)*

##### 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:

*Title 22 §70717(f)*

a. Arrangements have been made in advance for admission to such health facility.  
*Title 22 §70717(f)(1)*

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.  
*Title 22 §70717(f)(2)*

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.  
*Title 22 §70717(f)(3)*

2. A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the Transitional Care Unit (TCU) of the Hospital. The 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.

*Title 22 §70753*

## V. GENERAL CONDUCT OF CARE

### A. Attendance of Patients

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.

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.

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.

### B. 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.

*JCAHO PC.15.10*

### C. Consultations

Consultation is advisable in all cases, in which the diagnosis is obscure, or there is doubt as to the best therapeutic measures to be utilized, or there are unusual complications. Additionally, consultation may be required whenever the Chief of Staff or designee determines that the patient would benefit from such consultation. Each consultation report shall contain a written opinion by the consultant in the medical record that reflects, when appropriate, an actual examination of the patient and the patient's medical record.

*JCAHO MS.2.20 Title 22 §70703 (h)*

#### 1. Responsibility to Contact Consultant:

When indicated, the attending practitioner is responsible for requesting consultation by direct communication with a qualified consultant.

2. Consultant's Report:

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

D. 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.

## 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, and that policy shall supersede this section as necessary. Medical records shall be completed promptly.

*CMS 482.24 JCAHO*

*IM.6.10*

### A. Scope of Medical Record Documentation

The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

*CMS §482.24 (c)*

*Title 22 §70747*

#### 1. Legibility\* and Authentication of Entries

All entries must be legible and complete, and must be authenticated, dated and timed promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

- a. The author of each entry must be identified and must legibly authenticate his or her entry.
- b. Authentication may include signatures, written initials or computer entry.

\* Illegibility is defined as the inability of two (2) healthcare professionals to understand (interpret) the documentation.

#### 2. Documentation Requirements of Medical Records

All records must document the following, as appropriate:

- a. Evidence of a physical examination, including a health history, performed no more than seven (7) days prior to admission or within twenty four (24) hours after admission.
- b. Admitting diagnosis.
- c. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.
- d. Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.

- e. Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.
- f. All practitioners' orders, nursing notes, reports of treatment, medication orders, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.
- g. Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care. *CMS §482.24 (c)(vii)*
- h. Final diagnosis with completion of medical records fourteen (14) days following discharge. *Title 22 §70751 (g)*

3. Additional Documentation Requirements of Medical Records

- a. Patient Identification data as outlined in Title 22 §70749(a)1
- b. Consent form(s)
  - 1) In addition to the patient's signed consent, the physician will provide documentation in the medical records that the physician has described the procedure or treatment and explained the risks and alternate courses of treatment and non-treatment and the risks involved in each.
  - 2) In the case of elective sterilization, the physician will obtain informed consent from the patient in accordance with the appropriate sterilization booklet published by the State Department of Health Services.
- c. Special reports such as consultants, clinical laboratory, x-ray and other findings
- d. Provisional diagnosis
- e. Medical or surgical treatment
- f. Pathological findings
- g. Daily progress notes in acute care services, including current or working diagnosis

- h. Final diagnosis (date and signed by the responsible practitioner at the time the discharge order is written)
- i. Discharge follow-up instructions
- j. Autopsy report, when available.

B. History and Physical (H&P)

*Title 22 §70749*

Requirements for a history and physical examination are divided into three (3) categories:

- 1. Inpatient – for all patients admitted to the Hospital.
- 2. Outpatient Surgery – for all patients undergoing outpatient surgical procedures.
- 3. Ancillary Services – for all patients undergoing outpatient procedures in an Ancillary Department, i.e., Radiology.

INPATIENT

- 1. A complete history and physical examination will be recorded by the attending practitioner within twenty four (24) hours after the patient is admitted to the Hospital. *Title 22 §70717 (d)*
- 2. Patients admitted to the Hospital for podiatric services shall receive the same basic medical appraisal as patients admitted for other services. This shall include the performance and recording of the findings in the health record of an admission history and physical examination which shall be performed by persons lawfully authorized to do so by their respective practice acts. *Title 22 §70717 (c) (1)*
- 3. An oromaxillofacial surgeon, who has been granted such privileges by the medical staff in accordance with State law, may perform history and physical examination for patients admitted only for oromaxillofacial surgery. *CMS 482.22 (c)(5)*
- 4. A physician member of the medical staff shall be responsible for the care of any medical problem arising during the hospitalization of dental patients. *Title 22 §70473 (c)*
- 5. The history and physical examination shall include:
  - a. appropriate patient identification data
  - b. a notation of allergies

- c. medical history, including the chief complaint
  - d. details of the present illness
  - e. relevant past, social and family histories (appropriate to the patient's age)
  - f. an inventory by body system
  - g. a summary of the patient's psychosocial needs, as appropriate to the patient's age,
  - h. a report of relevant physical examinations
  - i. a statement on the conclusions or impressions drawn from the admission history and physical examination
  - j. pediatric patients' charts must include documentation of immunizations, height, and weight. For patients under the age of 24 months, head circumference must also be documented.
6. Elective surgical patients
- a. The pre-operative H&P shall be physically in the medical record at least one (1) hour prior to surgery and not be more than seven (7) days old unless it has been updated (see interval history and physical exam in b.) below).
  - b. If the patient's history and physical examination was performed more than seven (7) days prior to surgery, an interval history and physical exam must be recorded in the medical record within twenty-four (24) hours prior to the surgery.
  - c. If the H&P is over thirty (30) days old, it may not be updated; a new H&P must be submitted.
  - d. The pre-operative history and physical must include all of the components identified in (5) above and plans for post-operative care of the patient. Appropriate screening tests, based on the needs of the patient, must be accomplished and recorded within seven (7) days prior to surgery.

## OUTPATIENT SURGERY

The attending practitioner shall perform a history and physical examination relevant for the outpatient procedure to be performed. This will include the

patient's vital signs, allergies, cardiac and respiratory history and current medications to determine appropriate choice of anesthesia.

- a. The pre-operative H&P shall be physically in the medical record at least one (1) hour prior to surgery and not be more than seven (7) days old unless it has been updated (see interval history and physical exam in b.) below).
- b. If the patient's history and physical examination was performed more than seven (7) days prior to surgery, an interval history and physical exam must be recorded in the medical record within twenty-four (24) hours prior to the surgery.
- c. If the H&P is over thirty (30) days old, it may not be updated; a new H&P must be submitted.

#### ANCILLARY SERVICES

For patients referred by physicians not on the Medical Staff, a history and physical examination by the referring physician will be accepted only when a Medical Staff member administering the general anesthesia and/or sedation/analgesia completes the following:

- Review the history and physical examination document;
- Conduct a second assessment to confirm the information and findings;
- Update any information and findings as necessary (including a summary of the patient's condition and course of care during the interim period) and the current physical/psychosocial status; and
- Sign and date the information as an attestation to it being current.

#### C. Documentation After Surgery

##### 1. Operative Progress Note

Immediately after surgery\*\* an operative progress note is entered into the medical record to provide patient information for any individual required to attend to the patient.

##### 2. Operative Reports

Operative reports shall be dictated or legibly written immediately after surgery\*\* and shall record the name of the primary surgeon and assistant(s), findings, procedures performed and description of the procedure, estimated blood loss, as indicated, specimens removed, and postoperative diagnosis.

\*\*"Immediately after surgery" is defined as "upon completion of surgery, before the patient is transferred to the next level of care."

*JCAHO IM.6.30*

D. Code Status

Any code status limitation is documented on the code status order form. At the time an order to limit life-sustaining treatment is written, a note should be made in the progress notes, H&P, or code status order form which includes documentation of discussion with the patient and/or family or surrogate.

E. Consents

In addition to the patient's signed consent, the physician will provide documentation in the medical record that the physician has described the procedure or treatment and explained the risks and alternate courses of treatment or non-treatment and the risks involved in each.

F. Discharge Summary

For all patients hospitalized more than 48 hours, a discharge summary shall be written or dictated, except for normal obstetrical deliveries, normal newborn infants, and certain selected patients with problems of a minor nature. For these exceptions, a final summation-type progress note shall be sufficient.

The discharge summary shall briefly recapitulate the significant findings and events of the patient's hospitalization, his condition on discharge and the recommendations and arrangements for future care. *Title 22 §70749(16)*

G. 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. *Title 22 §70059*

Restraint shall be used only when alternative methods are not sufficient to protect the patient or others from injury. *Title 22 §70577 (j)(1)*

H. Access to Medical Records

All 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 original x-ray films and pathology slides and blocks may be released to other patient care providers if done in accordance with Health Information Management (HIM) Policy and HIPAA requirements. *Title 22 §70751 HIPAA*

I. 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 Section M below). *Title 22 §70751(g)*

J. Medical Record Suspension

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

## VII. ON-CALL COVERAGE

Recognizing that the best interests of the patient are protected by concerted efforts, it is the responsibility of each Active, Provisional after completion of proctoring, 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

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. 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.

## VIII. ORDERS

Medical Staff members and Allied Health Professionals may write orders and prescribe medications within the limits of their licensure, delineation of clinical privileges, and any applicable provisions of the Medical Staff Bylaws and Rules and Regulations and Hospital policies. All orders for treatment of patients shall be in writing and must be on a physician order form, dated, timed, and signed by the practitioner for a specific patient. Faxed signed orders are acceptable.

### A. Admitting

Patients are admitted to the Hospital only upon the order of a Medical Staff member. The order shall include a clinical diagnosis. *Title 22 §70717(c)*  
(Please refer to Medical Staff Rules and Regulations - I. ADMISSIONS)

### B. Emergency Verbal or Telephone Orders

*JCAHO IM.6.50*

Orders for drugs and treatments shall be received only by practitioners authorized to receive orders within their scope of licensure: RN, LVN, Pharmacists, Physician's Assistants from their supervising physicians only, Psychiatric technician, Registered Physical Therapists, Radiology Technician, Certified Respiratory Therapists (when the orders relate specifically to respiratory care), and Registered Dietitian. Such orders shall be recorded immediately in the patient's medical record by the person receiving the order and shall include the date and time of the order. The order shall be signed, dated, and timed by the prescriber within forty-eight (48) hours. Refer to Administrative Policy – Physician Orders.

*CMS 482.23 CMS 482.24 (c) (1) (Title 22 §70263 (g - i)*

### C. Restraints

Patients shall be placed in restraint only on the written order of the physician. This order shall be time limited and include the reason for restraint and the type of restraint to be used. A patient may be placed in medical surgical restraint at the discretion of a registered nurse and a verbal or written order obtained within one (1) hour of application. If a telephone order is obtained it shall be recorded in the patient's medical record and be signed, dated and time within twenty-four (24) hours by the physician.

Behavioral restraints, may be used in the following areas: 1) The inpatient psychiatric unit. 2) The Emergency Department for assessment, stabilization, or treatment, even if awaiting transfer to a psychiatric hospital or psychiatric unit. 3)

Awaiting transfer from a nonpsychiatric bed to a psychiatric unit after receiving medical or surgical care. The RN may initiate if there is immediate danger to

patients or others but the provider must observe and assess patient in person within one (1) hour of application of behavioral restraint. The provider must reevaluate (face-to-face) patients in behavioral restraints every eight (8) hours for patients eighteen (18) years of age and older or every four (4) hours for those patients seventeen (17) and younger.

The document dictating the use of restraints and seclusion is the Hospital's Administrative Policy entitled "Restraints and/or Seclusion of Patients for Behavioral Health Care Reasons and Restraint Use for Medical Surgical Reasons."

IX. PATIENT RIGHTS

*Title 22 § 70707 CMS § 482.13 (a)*  
*(JCAHO RI.2.10, HIPAA)*

A patient's rights shall include but not be limited to:

- A. The exercise of these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, or the source of payment for care.
- B. Considerate and respectful care.
- C. Knowledge of the name of the physician who has primary responsibility for coordinating the care and the names and professional relationship of other physicians and non-physicians who will see the patient.
- D. Receipt of information about the illness, the course of treatment and prospects for recovery in terms that the patient can understand.
- E. Receipt of information about the illness, the course of treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, medically significant risks involved in this treatment; alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment;
- F. Active participation in decisions regarding medical care, including appropriate assessment and effective management of pain and a discharge process that addresses continuing care based on the patient's assessed needs at the time of discharge related to pain management. To the extent permitted by law, the right to actively participate in decisions includes the right to refuse treatment;
- G. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual;
- H. Confidential treatment of all communications and records pertaining to the care and the stay in the Hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care;
- I. Reasonable responses to any reasonable requests made for service;
- J. Leave the Hospital even against the advice of physicians;
- K. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care;

- L. Be advised if the Hospital/personal physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects;
- M. Be informed of continuing health care requirements following discharge from the Hospital;
- N. Examine and receive an explanation of the bill regardless of source of payment;
- O. Know which Hospital rules and policies apply to the patient's conduct while a patient;
- P. Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient;
- Q. Designate visitors of his/her choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
  - 1. No visitors are allowed,
  - 2. The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility,
  - 3. The patient has indicated to the health facility staff that the patient no longer wants this person to visit.
- R. Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the Hospital on visitation. At a minimum the Hospital shall include any person living in the household;
  - 1. This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.
- S. A procedure shall be established whereby patient complaints are forwarded to the Hospital administration for appropriate response.
- T. Receipt of Health Insurance Portability and Accountability Act (HIPAA) information.

X. RESIDENTS

JCAHO MS.2.30

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).  
*Title 22 §70705*

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**



Robert R. Wright, M.D., Chief of Staff

October 27, 2003



~~Sandra DeBella~~, Secretary, Board of Trustees  
Edward Dermott

December 12, 2003