SIERRA VIEW MEDICAL CENTER
MEDICAL STAFF RULES & REGULATIONS

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SUBJECT: ADMISSION AND DISCHARGE OF PATIENTS	REFERENCE #1001
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RESPONSIBILITY: MEDICAL STAFF	

ADMISSION AND DISCHARGE OF PATIENTS:

- Only a member of the medical staff may admit a patient to Sierra View Medical Center. The official admitting policy of the hospital shall govern all practitioners.

- A podiatrist with clinical privileges may admit patients to the hospital when an appropriate physician member of the medical staff assumes responsibility for the overall aspects of the patient's care throughout the hospitalization, including the medical history and physical examination.

- A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for necessary special instruction and for transmitting reports of the condition of the patient to other practitioners and relatives as indicated. Whenever these responsibilities are transferred to another staff member, a note conferring the transfer of responsibility shall be entered on the order sheet of the medical record.

- Except in an emergency, no patient shall be admitted to the hospital until provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

- Practitioners admitting emergency cases shall be prepared to justify the said emergent nature of the admission in keeping with the Utilization Plan.

- Any patient admitted through the Emergency Department shall be seen and evaluated by their attending physician either immediately prior to or within twenty-four (24) hours of admission.

- Each member of the medical staff shall name a member of the medical staff who may be called to attend his/her patients in an emergency, or until he/she arrives. In case of failure to name such associate, the Department Chairman/Chief of Staff, shall have authority to call any member of the active staff in such event.

- A practitioner, who will be out of town, or unavailable for a significant period of time shall, on the order sheet of the chart of each of his patients, indicate in writing the name of the practitioner who will be assuming responsibility for the care of the patient during his absence.

- The Utilization Review Medical Director/Department Chairman/Chief of Staff will admit patients on the basis of the following order of priorities:

    - Emergency Admissions:

        - This category of patients includes those who have serious medical problems and who may be at risk of death or serious injury to their health if not admitted within four (4)

hours. Such patients have first priority for admission to available appropriate beds. When requested by the Utilization Review Committee, the admitting physician must furnish to that committee, within 24 hours of the request, a signed, sufficiently complete documentation of the need for the emergency admission. Failure to provide this information or evidence of willful or continued misutilization of this category of admission will be brought to the attention of the Medical Executive Committee.

- Urgent Admissions:
  - This category includes patients with serious medical problems who may be at risk of substantial injury to their health if not admitted within 24 hours. Admissions so designated by the attending practitioner shall be reviewed as necessary by the Department Chairman to determine priority when all such admissions for a specific day are not possible.
- Preoperative Admissions:
  - This category includes all patients previously scheduled for surgery. If it is not possible to handle all such admissions, the Chief Executive Officer/COO may decide the urgency of any specific admission, in consultation with the Department Chairman.
- Routine Admissions:
  - This category will include elective admissions involving all services.
- Admissions to Intensive Care Unit (ICU):
  - If any question as to the validity of admission to or discharge from the ICU should arise, that decision is to be made through consultations with the ICU Medical Director or with the Chairman of the appropriate clinical department. The Nurse Manager of the Critical Care Units shall act in a liaison capacity to facilitate the decision, if necessary.
- Patient Transfer:
  - Transfer priorities shall be as follows:
    - From Intensive Care Unit to general care area
    - From Post Anesthesia Care Unit to general care area
    - From temporary placement in an appropriate clinical service area to the appropriate area for the patient

- No patient will be transferred without such transfer being approved by the responsible practitioner.

- The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the Utilization Review Plan:

- Patients with known or suspected infections shall be admitted but must be isolated as indicated in the hospital Infection Control Manual. Contacting the Infection Control Nurse Practitioner and/or Chairman of the Infection Control Committee can facilitate implementation of isolation precautions. The Infection Control Nurse Practitioner, in consultation with the Chairman of the Infection Control Committee, will act as liaison in those matters affecting the infection potential of the hospital environment.

SUBJECT: RULES AND REGULATIONS RELATING TO ADMINISTRATIVE FUNCTIONS	REFERENCE #1002
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RESPONSIBILITY: MEDICAL STAFF	

RULES AND REGULATIONS:

- The Rules and Regulations of the medical staff must conform to the Bylaws of the medical staff, and must be approved by both the Executive Committee and the medical staff at a general meeting. Approval is based on a 2/3 thirds vote of the Active Medical Staff participating in the vote.

- Suggested changes in Medical Staff Rules and Regulations, may be initiated by individual staff members, departments, committees, and/or the Medical Executive Committee.

- Policies proposed by the standing committees of the medical staff when approved by the Medical Executive Committee, will be binding on the members of the medical staff upon completion of the Process for Approval of Policies and Procedures

- In an emergency, the Medical Executive Committee is empowered to act on behalf of the medical staff.

- Failure of physicians to comply with the Medical Staff Rules and Regulations renders them subject to disciplinary action.

- Physician compliance with policy and procedures in performance of Computer Provider Order Entry (CPOE)

SUBJECT: CONFLICTING RULES AND REGULATIONS	REFERENCE #1003
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RESPONSIBILITY: MEDICAL STAFF	

CONFLICTING RULES AND REGULATIONS:

These Rules and Regulations shall specifically relate to the role of the medical staff in the care of inpatients, ambulatory care patients, emergency patients and home care patients, as appropriate, and as further specified in Sierra View Medical Center policy and/or federal and/or state regulations. The rules and regulations of each department shall not conflict with each other, with the Bylaws, Rules and Regulations of the Medical Staff, with the policies of Sierra View Medical Center or the Bylaws of the Hospital and/or Board of Directors.

SUBJECT: RULES AND REGULATIONS RELATING TO PATIENT CARE	REFERENCE #1004
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RESPONSIBILITY: MEDICAL STAFF	

RULES AND REGULATIONS RELATING TO PATIENT CARE:

- All patients admitted to Sierra View Medical Center must be under the direct supervision of a member of the active or courtesy staff. Only those physicians with delineated clinical privileges to admit patients are allowed to do so.

- Admission, except in an emergency, will be effected only after a provisional diagnosis explaining the reasons for admission is provided.

- A thorough history and physical examination shall be dictated within 24 hours after admission.

- The attending physician must directly supervise the activities leading to the diagnosis and treatment of the patient. He/she will make rounds daily on his/her patients and review charts at frequent intervals.

- A Patient Bill of Rights is a Title XXII document and will presented to patients at the time of admission.

- The patient will be informed who is his attending physician, and will be given an explanation of the functions of any other healthcare personnel upon request.

- Reasonable efforts shall be made to assure the protection of patients, personnel, and the public from a patient who is a source of infection or dangerous from any cause whatsoever.

- Infectious disease will be reported in compliance with State law and federal regulations.

- Smoking is not allowed in this Hospital. Patients desiring to smoke must meet the criteria outlined in the organizational smoking policy. These patients will be allowed to smoke in the designated areas on the hospital grounds, under supervision from hospital personnel.

- Discuss Consultation is encouraged for the maintenance of high standards of patient care, professional accomplishment and education. Consults should be answered, written and signed without undue delay. If the circumstances are such that a delay is necessary, a brief note should be recorded in the chart pending completion of the consult request.

- A surgical procedure shall be performed only with informed consent of the patient or his/her legal guardian, except in an emergency. The patient shall be informed of the surgeons performing the procedure.

- All surgical procedures performed shall be recorded by the operating surgeon immediately following the procedure, with a detailed operative report dictated within 72 hours following the procedure. Dictated operative notes are to be signed within 14 days after discharge.
- Anesthesia shall be administered only with the informed consent of the patient or his legal guardian, except in an emergency.
- Special procedures which pose a potential hazard to the patient shall be performed only upon the informed consent of the patient or his legal guardian, except in an emergency.
- All tissues removed will be sent to the Department of Pathology in accordance with the department policy, where such examinations will be made as may be considered necessary to arrive at a diagnosis. Other objects as deemed necessary for diagnosis will also be sent to the Department of Pathology. Reports of such examination shall be filed in the patient's medical record.
- Laboratory tests, which are considered to be routine, will be determined by each clinical department.
- All orders including routine and standing orders shall be in writing. Standard orders may be adopted as needed by the various clinical services and divisions but they must be individually signed. Verbal orders may be accepted, written and signed by a professional Licensed Vocational Nurse or Registered Nurse. Verbal orders relating to medications to include IVs may be accepted, written and signed by a pharmacist. A Certified Respiratory Technician or a Registered Respiratory Therapist may accept, write and sign verbal orders related to respiratory therapy treatment if approved to take such order by the medical director of a specific unit. All orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient. Verbal orders must be authenticated within 48 hours. Cancellation of all existing orders will be effected upon transfer of patient to a different level of care (Reference §482.12)
- Automatic drug stop orders are managed according to the organizational policy.
- Blood and blood components must be signed for transfusion by a physician or registered professional nurse.
- Discharge notes should include:
    - Chief complaint, diagnosis,
    - Pertinent laboratory and radiographic results,
    - Treatment including operations,

- Course and results of treatment,
- Prognosis,
- Discharge medications and diet, and
- Disposition.

- All patients will be given instructions for follow-up care by the physician. This also applies to the ambulatory care and emergency services.

- The attending physician is responsible for dictating discharge summary. The discharge summary must be completed within 14 days of discharge.On the ambulatory care services, the referring physician will be kept apprised of developments after the initial visit and at appropriate times.

- All members of the clinical staff are expected to be actively interested in securing autopsies. All patient deaths should be evaluated against the medical staff approved criteria for performing autopsies, to determine appropriateness and benefit of this procedure. No autopsy shall be performed without recorded consent of the legally authorized agent. All autopsies shall be carried out by members of the Department of Pathology or the County Coroner's Office contracted pathology service. Physicians seeking permission for autopsies shall explain adequately what constitutes a routine autopsy and that the extent of the permit will not be violated. The Department of Pathology shall be notified regarding exceptions in autopsy procedures so that the intent of the person giving the consent shall not be violated.

- The attending physician is responsible for signing the death certificate. A copy of the death certificate shall be made a part of the final hospital record of the patient.

- When patients participate in research projects, the procedures must comply with federal, state and institutional regulations, including all aspects of informed consent and patient protection.

- Surgical sterilization procedures will be performed in accordance with the laws of the State of California and all applicable federal laws.

- Access to patients shall be regarded as a privilege and the consent of the patient's charge is privileged information. Persons desiring to interview or examine patients other than those directly involved with patient care must obtain the permission of the attending physician, the patient and follow the hospital media policy.

- Medical personnel attending patients or using the patient care areas must observe appropriate dress and decorum.

- No alcoholic beverages or personal drugs are allowed except on specific order of the physician for specific patients.
- The medical staff will be organized for disaster and respond if needed.
- The medical staff will carry out all performance improvement activities and quality of medical care review as required by the all regulatory requirements and the organizational Performance Improvement Program.
- In instances of suspected patient abuse and/or neglect, the procedures as outlined in state and federal regulations will be followed.
- Any hospitalized patient, whose behavior suggests they are a danger to self or others as a result of alcoholism, drug abuse, emotional, or mental illness, the physician will be notified immediately. Once that patient's medical condition can be stabilized the physician will work with Social Services to transfer the patient to the appropriate setting.
- Whenever possible, clinical measurements and drug doses will be recorded in the metric system.
- Informed consent is addressed according to organizational policy.
- Do not resuscitate orders are administered according to organizational policy.

SUBJECT: GENERAL RULES FOR ADMISSIONS, DISCHARGES AND PATIENT CARE	REFERENCE #1005
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RESPONSIBILITY: MEDICAL STAFF	

GENERAL RULES:

- Sierra View Medical Center can accept only those patients for care and treatment who have a medically or surgically justified need for hospitalization. Patients are financially responsible for the cost of hospitalization, and must be informed of their financial obligation once medical/surgical screening examinations have been performed. For humanitarian reasons, in the case of a true medical or surgical emergency, medical/surgical care shall be rendered to a patient who may not be able to meet the financial burden of hospitalization, until such time as the patient's condition is stabilized to the degree that he/she can be either transferred to another healthcare facility or safely discharged home.

- Admitting patients to a setting where a physician's admission history and physical exam is standard of care is restricted to admitting physicians, who are appointed to attend patients. (Qualified oral maxillofacial surgeons may admit patients eligible for admission by approved medical staff criteria without identified medical problems if granted specific privileges to do so.) Only professionals who have the above described admitting responsibilities may deny patients treatment.

- Except in an emergency, no patient shall be admitted until after a provisional diagnosis has been stated on the medical record. Sierra View Medical Center shall admit eligible patients (as defined by law and applicable hospital regulations) suffering from any type of disease or injury. The medical staff members will examine and make the proper disposition of all eligible applicants. Any patient may be admitted for emergency care.

- Upon admission to inpatient care at Sierra View Medical Center, each patient shall be assigned to the department deemed most appropriate for the care and treatment of the condition for which, hospitalization is required.

- In every setting where a physician's admitting history and physical examination is standard of care, a history and physical examination and initial plan of care shall be dictated and signed by the admitting physician within 24 hours of patient admission. In the event of an elective admission the admitting physician may dictate the history and physical up to thirty days in advance. A history and physical dictated over twenty-four hours in advance of admission will require a brief written update of his/her systems.

- With the exception of qualified oral and maxillofacial surgeons with privileges to admit patients without identified medical problems, the admission and care of a dental or podiatric patient shall be the responsibility of a physician member of the medical staff. The physician shall be responsible for the care of any medical problem present on admission or that may arise during the rest of the patient's hospitalization.

- Orders will automatically be canceled on moving from one service to another.

- A unit secretary or a nurse will be responsible for promptly notifying the receiving staff professional as soon as a new patient has arrived on the unit.

- Each patient shall be the responsibility of a member of the medical staff. Such medical staff member shall be responsible for daily medical care and treatment of the patient. For the prompt completion and accuracy of the medical record, necessary special instructions, transmitting reports of the condition of the patient to the referring medical staff member, and for communicating to relatives of the patient when indicated. Whenever these responsibilities are transferred to another medical staff member or service, or to another healthcare facility, an order covering the transfer shall be entered on the order sheet of the medical record. An order is not required for hospital based services due to schedule changes of physicians. Hospital based services include Emergency Medicine, Anesthesiology, Pathology, Radiology, Hospitalists and Intensivists.

  Patients shall be discharged only on written order of the medical staff.

- Plans should be made to discharge patients before noon if at all possible.

- Should a patient leave against the medical advice (AMA) of the attending physician without following the proper discharge procedure, notation of this incident shall be made in the patient's medical record. The appropriate staff shall be notified promptly for completion of administrative details. If for some reason, the physician desires not to discharge the patient AMA under the latter circumstances, a notation of this should be made on the clinical record.

- When patients are admitted primarily for dental and/or podiatric problems, the dentist or podiatrist will be responsible for documenting body part of the patient's history and physical examination related to their disciplines within 24 hours prior to the patient's admission to the hospital.

- A podiatrist or dentist with clinical privileges may, with the concurrence of an appropriate physician member of the medical staff, initiate the procedure for admitting a patient. This medical staff member shall assume responsibility for the overall aspects of the patient care throughout the stay. Patients admitted for dental or podiatric care must be given the same basic medical appraisal as patients admitted for other services. A physician member of the medical staff must be responsible for the care of medical problems of hospitalized podiatric or dental patients.

- Dental and oral and maxillofacial surgery privileges (in the operating room) must be specifically defined in the same manner as all other surgical privileges and may be exercised only under the overall supervision of the Department of Surgery.

SUBJECT: ADMISSION AND DISCHARGE OF PATIENTS	REFERENCE #1006
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RESPONSIBILITY: MEDICAL STAFF	

ADMISSION AND DISCHARGE OF PATIENTS:

- Only a member of the medical staff may admit a patient to Sierra View Medical Center. The official admitting policy of the hospital shall govern all practitioners.

- A dentist or podiatrist with clinical privileges may admit patients to the hospital when an appropriate physician member of the medical staff assumes responsibility for the overall aspects of the patient's care throughout the hospitalization, including the medical history and physical examination.

- A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for necessary special instruction and for transmitting reports of the condition of the patient to other practitioners and relatives as indicated. Whenever these responsibilities are transferred to another staff member, a note conferring the transfer of responsibility shall be entered on the order sheet of the medical record. A note is not required for hospital based services due to schedule changes of physicians. Hospital based services include Emergency Medicine, Anesthesiology, Pathology, Radiology, Hospitalists and Intensivists.

- Except in an emergency, no patient shall be admitted to the hospital until provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

- Practitioners admitting emergency cases shall be prepared to justify the said emergent nature of the admission in keeping with the Utilization Plan.

- Any patient admitted through the Emergency Department shall be seen and evaluated by their attending physician either immediately prior to or within twenty-four (24) hours of admission.

- Each member of the medical staff shall name a member of the medical staff who may be called to attend his/her patients in an emergency, or until he/she arrives. In case of failure to name such associate, the Department Chairman/Chief of Staff, shall have authority to call any member of the active staff in such event.

- A practitioner, who will be out of town, or unavailable for a significant period of time shall, on the order sheet of the chart of each of his patients, indicate in writing the name of the practitioner who will be assuming responsibility for the care of the patient during his absence.

- The Utilization Review Medical Director/Department Chairman/Chief of Staff will admit patients on the basis of the following order of priorities:

    - Emergency Admissions:

- This category of patients includes those who have serious medical problems and who maybe at risk of death or serious injury to their health if not admitted within four (4) hours. Such patients have first priority for admission to available appropriate beds. When requested by the Utilization Review Committee, the admitting physician must furnish to that committee, within 24 hours of the request, a signed, sufficiently complete documentation of the need for the emergency admission. Failure to provide this information or evidence of willful or continued misutilization of this category of admission will be brought to the attention of the Medical Executive Committee.

- Urgent Admissions:
  - This category includes patients with serious medical problems who may be at risk of substantial injury to their health if not admitted within 24 hours. Admissions so designated by the attending practitioner shall be reviewed as necessary by the Department Chairman to determine priority when all such admissions for a specific day are not possible.
- Preoperative Admissions:
  - This category includes all patients previously scheduled for surgery. If it is not possible to handle all such admissions, the Chief Executive Officer/COO may decide the urgency of any specific admission, in consultation with the Department Chairman.
- Routine Admissions:
  - This category will include elective admissions involving all services.
- Admissions to Intensive Care Unit (ICU):
  - If any question as to the validity of admission to or discharge from the ICU should arise, that decision is to be made through consultations with the ICU Medical Director or with the Chairman of the appropriate clinical department. The Nurse Manager of the Critical Care Units shall act in a liaison capacity to facilitate the decision, if necessary.
- Patient Transfer:
  - Transfer priorities shall be as follows:
    - From Intensive Care Unit to general care area
    - From Post Anesthesia Care Unit to general care area

- From temporary placement in an appropriate clinical service area to the appropriate area for the patient

- No patient will be transferred without such transfer being approved by the responsible practitioner.

- The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the Utilization Review Plan:

- Patients with known or suspected infections shall be admitted but must be isolated as indicated in the hospital Infection Control Manual. Contacting the Infection Control Nurse Practitioner and/or Chairman of the Infection Control Committee can facilitate implementation of isolation precautions. The Infection Control Nurse Practitioner, in consultation with the Chairman of the Infection Control Committee, will act as liaison in those matters affecting the infection potential of the hospital environment.

SUBJECT: ANCILLARY ASSESSMENTS	REFERENCE #1007
	PAGE: 1 OF 1
RESPONSIBILITY: MEDICAL STAFF	

LABORATORY:

- All patients admitted to the hospital shall have appropriate laboratory tests ordered by the attending practitioner or as per approved protocol.

- Laboratory, radiology, EKG, pathology and other essential reports must be incorporated into the medical record within 24 hours, as appropriate to the nature of the test.

NUTRITIONAL:

All patients, regardless of their nutritional status or need, receive a prescription or order for food or other nutrients. The food or other nutrients can range from nothing by mouth (NPO) to regular diets.

SUBJECT: DISCHARGE	REFERENCE #1008
	PAGE: 1 OF 1
RESPONSIBILITY: MEDICAL STAFF	

DISCHARGE:

- Plans should be made to discharge patients before noon if at all possible.

- Patients shall be discharged only on a written order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

- It shall be the responsibility of the attending practitioner to write a letter of justification for every denial of days or stay by Medicare, Medicaid or other agency. Compliance with this policy will be considered at the time of each member's reappointment to the medical staff.

- In the event of a hospital death, the deceased shall be pronounced dead in accordance with hospital policy.

- It shall be the duty of all staff members to secure autopsies in all deaths that meet criteria adopted by the medical staff.

SUBJECT: PATIENT TRANSFERS	REFERENCE #1009
	PAGE: 1 OF 1
RESPONSIBILITY: MEDICAL STAFF	

PATIENT TRANSFERS:

- Sierra View Medical Center, in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), along with all members of the medical staff, will comply with the policies regarding patient transfers and shall comply with all applicable laws regarding patient transfers.

- The medical record will reflect the reason for diagnostic testing, including laboratory and other invasive and noninvasive diagnostic testing and imagining procedures, relevant to the determination of the patient's healthcare or treatment needs.

- Patients shall not be transferred from one service to another or out of an ICU or Post Anesthesia Care Unit without an order by the attending physician responsible for the patient's care.

- Transfers from one bed service to another will be accomplished only by mutual agreement of the bed services involved.

SUBJECT: CONSULTATIONS	REFERENCE #1010
	PAGE: 1 OF 2
RESPONSIBILITY: MEDICAL STAFF	

CONSULTATIONS:

- All patient admissions, treatment of patients and performance of operative or other procedures, both medical and surgical will be performed either directly by, or under the supervision of, a licensed independent practitioner who has been granted delineated clinical privileges through the medical staff.

- The medical staff through its Department Chairperson shall assure that appropriate consultations will be requested. Any member of the medical staff may be requested to provide consultation within his/her area of expertise. On call physician shall be required to provide consultation when requested.

- Each consultation report should contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the medical record, and shall be a part of the medical record.

- A consultant must be well qualified to give an opinion in the field in which an opinion is sought. The status of a consultant is determined by the medical staff on the basis of the individual's training and experience and competency.

- A satisfactory consultation includes an examination of the patient and the medical record. When operative procedures are involved, the results of the consultation, except in an emergency, shall be reported prior to the operative procedure.

- The Department Chairman will make certain that members of their staff provide timely consultation as needed.

- Consultation will be initiated by the medical staff member, or Allied Health Professional. Consultation requests should clearly and legibly (if written) set forth the problem and provide information requested.

- Responding to Consultation Requests:

    - The responsibility of determining policy regarding answering of consultation requests rests with the appropriate Department Chairperson. Basic philosophy should be to provide consultation with a high level of professional competency, efficiency and promptness both for service to the patient and for educational purposes. The person actually examining and writing the consultation advice should affix his/her signature to the consultation, thus validating the medical and legal responsibility. All consultation notes should reveal the involvement of the appropriate staff person and his/her authentication of the record.

- Appropriate medical ethics should be followed in consultations. The findings and opinions of the consultant should be limited to the clinicians involved.

- If a nurse or any other healthcare professional has any reason to doubt or question the quality of care provided to any patient and feels that appropriate consultation is needed and has not been obtained, he/she shall direct said question(s) to the attending medical staff member. If after this, he/she still feels their question(s) has not been resolved; the matter should be called to the attention of his/her supervisor, who will attempt to solve the problem through appropriate channels. If not resolved, final disposition of such concerns shall be made through the medical staff's "Chain of Command."

- Consults will be written and reflective of actual examination of the patient and patient's medical record.

SUBJECT: PROCTORING	REFERENCE #1016
	PAGE: 1 OF 2
RESPONSIBILITY: MEDICAL STAFF	

PROCTORING:

- Practitioners to be proctored shall include the following:
    - All new members of the medical staff;
    - Practitioners granted temporary privileges pending appointment to the medical staff; or
    - Members of the medical staff applying for additional, or newly developed privileges.
    - Provisional members of the Medical Staff must satisfactorily complete proctoring requirements before being considered for medical staff advancement.
- Department Responsibility:
    - Upon approval of the applicants requested privileges the department, or the chairman will assign a proctor.
    - Applicants may not be proctored by a physician with whom they are affiliated in practice without the permission of the Department Chairperson.
    - The applicant is to be notified in writing his assigned proctor.
- Applicant's Responsibility:
    - It is incumbent upon the applicant to notify the proctor of his/her hospital activity.
    - The applicant is to notify the proctor of each case admitted to the hospital or scheduled for surgery; unless instructed otherwise.
- Proctor's Responsibility:
    - Required to maintain a written record of all cases concurrently or retrospectively reviewed.
    - Assist in assuring confidentiality of all completed proctoring forms.
    - Provide a review of no less than ten (10) cases that broadly reflective the scope of privileges granted. The documentation must be forwarded to the Medical Staff Office before approval can be granted by the respective medical staff department, to remove an applicant from proctoring.
    - Provide completion of any additional department requirements for specific privileges.

- Proctoring Evaluation Form:

    - The Medical Staff Office shall supply the department approved "Proctoring Evaluation Form" to the proctor.

    - This form will include data pertinent to medical and surgical management of each case and shall include a recommendation from the proctor on the status of the individual being proctored. This form will be considered a confidential peer review document, and as such, is not subject to discovery.

    - The Proctor is required to see this document remains confidential, and is forwarded to the Medical Staff Office for consideration at the time of the interim or final review.

RECIPROCAL PROCTORING:

The hospital may accept evidence of up to 50**%** of reciprocal proctoring from a nearby institution to supplement actual observation on the premises.

This arrangement is acceptable only if the following conditions are present - Proctor must be someone who would have been eligible to serve as a proctor in both hospitals; the same range and level of privileges must have been requested by the applicant in both institutions. Proctoring reports must have been completed by the nearby institution within one year of provisional staff membership at SVMC.

SUBJECT: ALLIED HEALTH PROFESSIONALS	REFERENCE #1018
	PAGE: 1 OF 1
RESPONSIBILITY: MEDICAL STAFF	

The Medical Staff of Sierra View Medical Center provides oversight of the following Allied Health Professionals (AHP) who are not hospital employees. Each AHP operates under scope of service developed and maintained through the Interdisciplinary Committee, and approved by the Board of Directors. The Medical Staff Bylaws address the Allied Health Professional in Chapter XV.

1. Certified Registered Nurse Anesthetist;

2. Certified Nurse Midwife;

3. Certified Physician's Assistant;

SUBJECT: EMERGENCY SERVICES	REFERENCE #1019
	PAGE: 1 OF 4
RESPONSIBILITY: MEDICAL STAFF	

EMERGENCY DEPARTMENT ON CALL PANEL:

1. It is the responsibility of Sierra View Medical Center ("SVMC") to provide emergency services and care within the capabilities of its facilities and staff in accordance with state and federal law. The Medical Staff will assist SVMC to discharge its responsibility to provide emergency services and care as provided in these Rules and Regulations.

2. SVMC shall maintain an Emergency Department staffed by qualified emergency medicine physicians and other qualified staff. It shall be the responsibility of Emergency Department personnel to provide appropriate screening examinations and required basic emergency care to individuals who need or request such services. When specialty emergency services or follow up care is required for emergency patients, the Emergency Department, whenever feasible, shall attempt to call in either qualified members of the Medical Staff requested by such patients, or qualified members of the Medical Staff who are contractually responsible to provide care to such patients.

3. Whenever, in the judgment of the Emergency Department physician on duty, it is not feasible to call in a requested or contractually obligated physician to provide needed emergency or follow up services or that physician is unavailable, the Emergency Department physician may call a qualified physician from an applicable emergency call panel.

4. It will be the responsibility of individual medical staff department to:

    a) Provide on-call coverage 24 hours per day, seven days per week, for ER for OB/GYN and General Surgery. On-call coverage for Cardiology, Neurology and Orthopedics will be as available.

    b) Any violation of on-call coverage will be resolved by Chief of Staff in consultation with Medical Executive Committee and the affected department in accordance to applicable federal and state laws or regulations.

5. Development of Department on-call panels shall be subject to the following conditions:

    a) Each Department shall develop, in writing, a description of its system for providing emergency service backup coverage to the Emergency Room and the services included thereunder.

    b) All active members of the medical staff are eligible and expected to provide service on the on-call emergency panel, as determined by individual departments.

    c) In departments with one active staff member the physician need only provide coverage a maximum of 8 days per month to the emergency room. If any of these physicians voluntarily wish to provide more coverage, the physician can notify the respective Department in this regard.

d) The following physicians need not participate on any on-call panels:

1. Physicians who have attained 60 years, unless the physician volunteers.

2. Those excused because of health. Physician exempt from call must have physician certification approved by the Medical Executive Committee, which is to be updated with each reappointment.

3. Physicians not on Active Staff, unless the physician volunteers.

e) If a voluntary call system is in place, all physicians who have agreed to participate in the call shall be obligated to honor the call assignments (i.e., responding to an assigned call is not itself "voluntary").

6. The Hospital shall provide financial support of the call panel, at a level mutually agreed upon between the Board of Directors and the Medical Staff. The prevailing rates, terms, conditions of the financial support shall remain intact until both parties mutually agree to a change. Financial support is available only to those physicians on call who execute the Hospital's standard emergency call services contract.

7. Physicians on emergency call shall be within 30 minutes of the hospital. Should the on-call physician find that he/she is unable to provide coverage due to either the physician's own serious illness, or of a death or serious illness in his/her immediate family (defined as spouse, natural/step/adoptive parent, child/ brother/sister or grandparent), the physician shall make every attempt to secure coverage in his/her stead. If the physician is unable to secure coverage, he/she shall immediately report the circumstances to the Department Chairperson.

   The Department Chairperson will then make coverage arrangements with other Members of the Department and notify the Emergency Department of the change. Should the Department Chairperson also be unable to secure coverage he/she shall so notify the Chief of Staff of the circumstances, who will notify the hospital administrator of the situation immediately. The Medical Staff Office also needs to be notified of the call change.

8. Emergency services and care shall be subject to the following:

   In no event shall the provision of emergency services and care be based upon, or affected by, the individuals' race, ethnicity, religion, national origin, citizenship, age, sex or sexual orientation, pre-existing condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, pre-existing medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the individual.

a) Physicians who serve on the on-call schedule for the hospital may not refuse to respond to a call for any of the reasons listed above.

b) The provision of emergency services and care will apply to any individual who presents seeking medical care of treatment for a medical condition on the hospital property, or to any hospital department or service, including those in the ambulance on the hospital premises or persons on the access walks.

9. Failure to comply with these Emergency Services Rules shall be grounds for disciplinary action, in accordance with the Medical Staff Bylaws, Rules and Regulations, and applicable federal or state laws or regulations.

ATTENDING PHYSICIAN RESPONSIBILITY:

Patients shall be attended by their own physician member of the medical staff. In emergencies patients may be attended by the emergency physician on duty but will be immediately referred thereafter to their own physician.

EXPANDED SCOPE FOR MEDICAL SCREENING EXAMINATIONS

1. As set forth in Section F, on Emergency Services On-Call Coverage "Emergency Services and Care" means an appropriate "medical screening examination" and evaluation within he capability of the facility, including ancillary services routinely available for patient care. The Screening examination must be sufficient to determine whether the patient has an emergency medical condition or is in labor, and will vary according to the medical condition and history of the patient.

2. The "medical screening examination" must be performed in hospital departments operated under the hospital's MediCare provider number and located in buildings contiguous to the inpatient facility (Emergency Department, Woman's and Infant's Department). A patient who is awaiting a screening examination cannot be referred outside of the hospital, until the hospital has performed an adequate "medical screening examination" and determined that the patient does not have an emergency medical condition and or is "stable" for discharge.

3. The "medical screening examination" must be performed by a physician. Other qualified medical personnel may be designated to perform examinations under the following conditions:

   a) Registered Nurses in the Women's and Infant Services Department working under approved Standardized Nursing Procedures, and following approved protocols may be authorized to perform the Medical Screening Examination for women presenting in labor. Disposition may be made after consultation with patient's physician. All standards, functions, and granting of privileges must have approval of the Hospital Board of Directors.

b) Family Nurse Practitioners in the Emergency Room, working under an approved Standardized Procedures, and working in consultation with their supervising physician, may provide the Medical Screening Examination for those patients presenting for care in the Emergency Room. The standards, functions, and granting privileges must have approval from the Hospital Board of Directors.

c) Physician's Assistant in the Emergency Room, working under an approved Standardized Procedures, and working in consultation with their supervising physician, may provide the Medical Screening Examination for those patients presenting for care in the Emergency Room. The standards, functions, and granting privileges must have approval from the Hospital Board of Directors.

d) A Certified Nurse Midwife, working under approved Standardized Procedures, and working in consultation with their supervising physician, may provide the Medical Screening Examination for those patients presenting for care in the Women's and Infant Services Department. The standards, functions, and granting privileges must have approval from the Hospital Board of Directors.

5. An individual whose medical condition is not stabilized may not be discharged or transferred for any reason unless the patient requests the transfer or the physician certifies that the medical benefits outweigh the increased risks. REFER TO: SVMC Structure Standards: Inter-facility Transfer of Emergency Department Patients, and Structure Standards: In-Patient Inter-facility Transfer and Temporary Absence. All verbal orders must be authenticated within 48 hours.

SUBJECT: GENERAL RULES OF SURGICAL CARE	REFERENCE #1021
	PAGE: 1 OF 3
RESPONSIBILITY: MEDICAL STAFF	

Shall be formulated by the surgical staff with the cooperation of the Operating Room Supervisor. The completed rules shall be approved by the staff and include in these Rules and Regulations.

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

2. With reference to patients admitted for dental or podiatry care, the dentist or podiatrist shall be responsible for patient care within the scope of his license and a physician member of the Active, Provisional, or Temporary Medical Staff and shall act as a consultant with reference to the medical needs of such patients beyond the scope of the dentist or podiatrist license. A patient admitted for dental or podiatric care is a dual responsibility involving the dentist or podiatrist and a physician member of the Medical Staff.

    a) Dentist's responsibilities:

        1. A detailed dental history justifying the hospital admission.

        2. A detailed description of the examination of the oral cavity and a preoperative diagnosis.

        3. A complete operative report, describing the findings and technique. In cases of extraction of teeth, all teeth and fragments shall be sent to the hospital pathologist for examination.

        4. Progress notes as are pertinent to the oral condition.

        5. Clinical resume (or summary statement).

    b) Podiatrist's responsibilities:

        1. A detailed history, justifying hospital admission.

        2. A detailed history of his examination of the feet.

        3. A complete operative report describing the findings and the technique followed. All tissue removed shall be sent to the pathologist for examination.

        4. Progress notes as are pertinent to the condition of the feet.

        5. Discharge summary.

c) Physician's responsibilities:

1. Medical history pertinent to the patient's general health.

2. A physical examination to determine the patient's condition prior to anesthesia and surgery.

3. Supervision of the patient's general health status while hospitalized.

4. Review all appropriate laboratory reports, electrocardiograms, x-ray reports pertaining to the patient.

d) The discharge of the patient shall be on written order of he dentist or podiatrist and the physician member of the Medical Staff.

3. A written, signed, informed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents or guardians, circumstances shall be fully explained on the patient's medical record. Should a second operation be required during a patient's stay in the hospital, a second consent specifically worded should be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they all may be consented to on the same form.

4. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic evaluation and post-anesthetic follow up of the patient's condition.

5. An assistant who is a physician is preferred for all major surgeries, but at the request of the surgeon, and approval of the Operating Room Supervisor, another qualified person may be used. Qualifications of other individuals acting as a first assistant at surgery will be approved in the same manner as any other Allied Health Professional as provided in the Bylaws of the Medical Staff, Article XV.

6. All tissues removed at the operation shall be sent to the hospital pathologist who shall make such examination as may be necessary to arrive at a diagnosis, except the following which may be exempted from the requirement to be examined by a pathologist, but need not be limited to these:

a) Specimens that by their nature or condition do not permit productive examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;
b) Therapeutic radioactive sources, the removal of which is guided by radiation safety monitoring requirements;

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

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

e) Specimens known to rarely, if ever, show pathologic change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant;

f) Placentas that are grossly normal and have been removed in the course of operative and nonoperative obstetrics; and

g) Teeth, provided the anatomic name or anatomic number of each tooth, or fragment of each tooth, is recorded in the medical record;

h) When exemptions are not authorized because id federal or state regulation, the most strict requirements apply.

SUBJECT: GENERAL RULES OF OBSTETRICAL CARE	REFERENCE #1022
	PAGE: 1 OF 1
RESPONSIBILITY: MEDICAL STAFF	

1. Obstetrical patients shall have the following laboratory tests:

    a) Complete blood count, serology, Hepatitis B, blood type, Rh, all done before admission, except in emergencies where no previous records are available or no testing has been done. In such cases the tests will be ordered on admission to the hospital and, in addition, consent for HIV and hepatitis testing and urine screening for substances of abuse will be obtained.

    b) Evidence of immunity to rubella.

    c) Coombs test if Rh negative mother.

    d) T4, PKU galactosemia and hereditory hemoglobinopathies test done on the baby before dismissal.

    e) CBC done on mother upon admission, and 6 hours postpartum.

    f) Cord blood for type, Rh and RPR on all infants.

2. Obstetrical record: The obstetrical chart shall include the record of the pregnancy and the Hollister or other approved forms. It shall contain as a minimum-

    a) History of previous pregnancies;

    b) Record of routine pregnancy examination with blood pressure, pulse rate, fetal heart rate, urinalysis, abnormal symptoms and complications.

    c) Record of labor- progress, blood pressure, pulse rate, fetal heart rate, including record of fetal monitoring when done (fetal monitor strips to be maintained as part of the medical record) and medications.

    d) Record of delivery- presentation, surgical procedures, instrumentation, time and method of delivery, complications.

    e) Record of postpartum course.

SUBJECT: MEDICAL RECORDS GENERAL INFORMATION	REFERENCE #1023
	PAGE: 1 OF 1
RESPONSIBILITY: MEDICAL STAFF	

MEDICAL RECORDS GENERAL INFORMATION:

- The hospital and attending physician shall be jointly responsible in the area of their respective responsibility for the preparation of a complete medical record for each patient. This record shall include identification data, chief complaint, personal history, family history, history of present illness, physical examination, special reports such as consultation, clinical laboratory, x-ray and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge notes and autopsy report, as appropriate.

- The attending practitioner shall be responsible for the preparation of a complete, durable and legible medical record for each patient admitted or accepted for treatment. All significant clinical information pertaining to a patient shall be incorporated in the patient's medical record. Each clinical event shall be documented as soon as possible after its occurrence.

- The hospital is the custodian of all medical records. A medical record may not be removed except in accordance with a court order, subpoena or statute. Except as otherwise allowed by law, the information contained in the record shall be made available only to persons or agencies to which the patient has specifically authorized the release.

- The attending practitioner shall be responsible for the preparation of the complete medical record for each patient of said practitioner. No medical record will be considered complete unless certified by written signature of the attending medical or osteopathic practitioner, and no medical record may be filed until it is so completed, or filed by the respective Medical Staff Department as "incomplete."

SUBJECT: MEDICAL RECORDS GUIDELINES	REFERENCE #1024
	PAGE: 1 OF 4
RESPONSIBILITY: MEDICAL STAFF	

PURPOSE:

To ensure timeliness, meaningfulness, authentication and legibility of information contained in the medical record.

PROCEDURE:

- General Outlines:
    - All entries must be timed, dated and authenticated. (Joint Commission)
    - Records shall be completed and authenticated within two (2) weeks following patient discharge. (Sierra View Medical Center Bylaws)
    - In no event shall the completion of chart exceed 14 days following patient discharge. (Title 22 and Joint Commission)
    - Records will be considered complete when all dictated reports are transcribed and all entries authenticated.
    - Final diagnosis and complications must be recorded without abbreviations or symbols.
- History and Physical Examinations:

    Performing, if granted the requisite privileges, or arranging for the performance of, a history and physical (H&P) on every patient he/she admits or performs surgery on within twenty-four hours of admission with a Update Note immediately prior to surgery or procedure, in accordance with the requirements set forth in the rules and regulations. *[If a history and physical has been performed up to [30] days prior to admission/surgery, such history and physical may be accepted, subject to the conditions set forth in the medical staff rules and regulations, and H&P documentation in the medical record within twenty-four hours of admission and an Update Note immediately prior to surgery or procedure.*

History & Physical shall be completed within the first 24 hours of admission and include the following:

- Chief complaint;
- details of the present illness;
- Relevant past, social and family history;
- Allergies;

- Review of systems;
- Physical examination to include inventory of body systems and vital signs;
- Pelvic, rectal, breast and for diabetic patients, funduscopic examination or reason for deferral, along with results if done in the hospital;
- Conclusions or impressions;
- Course of action or plan.

- Progress Notes:
  - Must be written on a daily basis as per Joint Commission, CMS, CDPH
  - Should give a pertinent chronological report of patient's course.
  - Should reflect any change in condition.
  - Should reflect the results of treatment.
  - Must be timed and dated.
- Consultation:
  - Should contain written opinion reflecting actual examination of the patient and the patient's medical record.
- Operative Reports:
  - History and physical examination must be on the chart prior to the surgical procedure.
  - An immediate post-procedure note must be included and include the following:
  - The operative report must be dictated or written immediately following surgery.
  - Must include the following:
    - Name of the procedure/operation;

- Preoperative diagnosis;
- Postoperative diagnosis;
- Name of primary surgeon and any assistants;
- Description of the findings;
- Technical procedures;
- Specimens removed;
- Condition after surgery;
- Estimated blood loss.

- The operative report must be signed and in the chart as soon as possible.
- Any surgeon who has not dictated/written an operative report 72 hours following surgery may be subject to suspension of surgical procedures.

- Clinical Summary Reports:
  - Must contain the principal and associated diagnosis.
  - Must list all procedures performed.
  - Must be dated and authenticated.
  - Cannot contain any abbreviations or symbols.
  - In the event of death, a summation statement shall be made as to the immediate cause of death.

- Discharge Summary:
  - Should be dictated within 24 hours following patient's discharge except in unusual situations where pathology or autopsy findings are awaited.
  - Must recapitulate the reason for the hospitalization.
  - Must include significant lab/history and physical findings.

- Must include procedures performed and treatment rendered.
- Must include the condition of the patient on discharge.
- Must include any instruction relating to physical activity, medication, diet and follow-up care.
- Must include final diagnosis.
- Must be dictated for all deaths.
- Final progress may be substituted for a discharge summary if:
    - The patient was hospitalized less than 24 hours for a minor problem (does not include deaths).
    - The patient had an uncomplicated obstetrical stay.
    - The patient was a normal newborn infant.
    - Final progress note should include instructions to the patient and/or family.
- Provisional autopsy results are on the charts within three (3) days and complete the protocol within 60 days.

SUBJECT: ENTRIES IN THE MEDICAL RECORDS	REFERENCE #1025
	PAGE: 1 OF 1
RESPONSIBILITY: MEDICAL STAFF	

PURPOSE:

To ensure that entries in the medical record are only made by authorized individuals.

PROCEDURE:

- The Health Information Management Department is responsible to monitor all medical records for appropriate documentation in the medical record.

- Individuals authorized to document in the medical record are as follows:

    - Progress Notes:

        - Physicians;

        - Pharmacy as part of ongoing medication monitoring standards;

        - Physical Therapy - Utilization Review/Case Management;

        - Clinical Dieticians

        - Any other department providing care for the patient who does not have a designated form for alerting physicians of a patient's progress.

    - Physician's Orders:

        - Physicians: All orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient. Verbal orders must be authenticated within 48 hours. Cancellation of all existing orders will be effected upon transfer of patient to a different level of care (Reference §482.12)

        - Nursing personnel accepting telephone or verbal orders from the caregiver;

        - Pharmacist

- Other Departments such as ~~Dietary~~, Respiratory, Physical Therapy, Nursing, Utilization Review, etc., who have their own designated progress notes in the medical record, are responsible for the documentation on their forms.

- Any department wishing to create new forms or revise any existing forms must submit new drafts or revisions to the Forms Committee for approval. They must state the purpose of the form, justification for its use and if it is replacing an existing form. This information may be submitted in a memo or in person at the Forms Committee meeting.

SUBJECT: DELINQUENT IN THE MEDICAL RECORDS	REFERENCE #1026
	PAGE: 1 OF 1
RESPONSIBILITY: MEDICAL STAFF	

PURPOSE:

To ensure proper notification to a practitioner regarding delinquent medical records.

PROCEDURE:

- Physicians will be notified on a weekly basis of their number of incomplete charts through a letter until the charts are complete or the physician is on suspension.

- Responsible physician, on the chart deficiency computer system, notes all deficiencies. Deficient records are then placed in the Physician's box in the Health Information Management Department.

- Should the Health Information Management Department not receive a physician response to complete his/her medical records within 7 days of the first notice, the physician will be notified by the Physician Deficiency Clerk via telephone call and a second reminder letter.

- Should the medical record(s) remain incomplete on the 15th day after patient discharge, the Health Information Management Department will notify the physician, via certified mail, that his/her admitting, consultative and surgical privileges will be suspended within 7 days from the date of the letter until his/her medical records have been completed. The Health Information Management Department also submits his/her name to Administration,Utilization Review, Medical Executive Committee and other departments.

- Copies of all suspension letters mailed are placed in the physician's peer review file housed in the Medical Staff Office.

- The hospital departments are notified, by the Health Information Management Department, when the suspension of privileges has been lifted.

  If a physician is on suspension for a total of 30 cumulative days in the fiscal year, his/her name shall be submitted to the Medical Executive Committee.

SUBJECT: HANDLING OF AUTOPSIES	REFERENCE #1027
	PAGE: 1 OF 3
RESPONSIBILITY: MEDICAL STAFF	

HANDLING OF AUTOPSIES:

- In the interest of improving patient care and professional knowledge, every member of the professional staff is expected to actively participate in securing autopsies on all deaths. No autopsy shall be performed without consent of the patient's next of kin or legally authorized agent. In every case of death in the hospital, the medical staff member or house staff member should contact the patient's next of kin or legal agent and request permission to perform an autopsy.

- The pathologist will be responsible for notifying the attending practitioner of the time and place of when an autopsy is been performed on one of their patients.

- Consent for autopsies will be obtained by signature of the next of kin on the appropriate form, including any limitation imposed by the next of kin. Permission for donation of any organ or tissue would be included. The physician staff will provide information regarding clinical diagnosis and concerns to the pathology staff prior to the autopsy, specifically including any infection hazards.

- The College of American Pathologists advocates the autopsy as a valuable medical procedure and resource for quality of determining the effectiveness and impact of therapeutic regimens, discovering and defining new and/or changing diseases, increasing the understanding of biological processes of disease augmenting clinical and basic research, providing accurate public health and vital statistical information and education as it relates to disease, and obtaining medical-legal factual information.

- The College of American Pathologists recommends that a request be made for autopsy on every death. It is, however, recognized that performing an autopsy on every death may not be possible. The medical staff criteria for which an autopsy should be especially encouraged are:

    - Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician;

    - All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds;

    - Cases in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same;

    - Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies;

    - Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards;

- Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction;
- Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as:
  - Persons dead on arrival at hospitals,
  - Deaths occurring in hospitals within 24 hours of admission, and
  - Deaths in which the patient sustained or apparently sustained an injury while hospitalized.
- Deaths resulting from high-risk infectious and contagious diseases;
- All obstetric deaths;
- All perinatal and pediatric deaths;
- Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs;
- Deaths known or suspected to have resulted from environmental or occupational hazards.

- Autopsies under the jurisdiction of the County Coroner may not be performed by the hospital pathologist. The attending physician must report such cases to the County Coroner immediately after death. The Hospital Report - Coroner's Case Form must be completed in duplicate. Until this report is available the Coroner's Office will not remove the body from the hospital. The County Coroner may waive his/her jurisdiction and permit or request the autopsy to be performed at the hospital. The Coroner will usually request a copy of the completed report. Cases in which the Coroner must be notified at the time of death are:
  - Persons dead on arrival at the hospital;
  - Deaths occurring in the hospital within 24 hours of admission;
  - Deaths in which the patient sustained or apparently sustained an injury while hospitalized that might have contributed to his/her demise.
- As soon as permission for autopsy is signed, the Pathology Department should be notified so that the autopsy may be performed with the least possible delay.

- Documentation of efforts to get permission for an autopsy in cases that meet the criteria where the family or guardian refuses. The physician or the nurse must document in the medical record the refusal.

- A system of payment may be established for cases in which funding is not available.

- Family members or legal guardians may request copies of the autopsy examination. The Health Information Management Department will handle such requests according to hospital regulations.

- It is expected that a copy of the gross findings will be completed in four working days and the entire autopsy completed in 30 days unless extenuating circumstances such as special toxicological studies, special fixing and staining, pertain.

- As part of the performance improvement program, a copy of the autopsy results will be sent to the treating service, and findings from autopsies may be used as a source of clinical information in seeking to continually improve patient care at the hospital.