
INTRODUCTION

It is the goal of UCSF Medical Center to serve the community by providing the best medical care possible and, in so doing, to enrich our general and special training programs. Institutions and professions licensed by the State of California conduct their activities within a framework of law and government regulations that define standards of practice and institutional operation. The following Rules and Regulations augment such descriptions of good medical practice and are designed to maintain the best possible interactions with patients and referring physicians. The Medical Center Administrative Manual policies referenced herein are considered a part of the Rules and Regulations.

SECTION ONE: PROFESSIONAL AFFAIRS

I. CREDENTIALING

- A. Appointment: Pursuant to the Credentialing Policy and Procedures, as approved by the Governing Body and considered as part of these Rules and Regulations, each practitioner who expresses formal interest in appointment to the UCSF Medical Staff or Allied Health Staff shall submit a completed application including: delineation of privileges and/or standardized procedures, relevant certificates, CV, documentation of health status, and other information as requested during the credentialing process.
- B. Verification of Information: Applications will be deemed complete when all necessary verifications have been obtained, as specified in the Credentialing Policy and Procedures. The Medical Staff Office shall then transmit the application and supporting materials to the Service Chief for review of any significant issues and then to the Credentials Committee for action.
 - 1. If the Medical Staff Office is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the Medical Staff Office may delay further processing of the application, or may begin processing the application based only on the available information with a decision that further information may be considered upon receipt.
 - 2. If the missing information is reasonably deemed significant for a fair determination of the applicant's qualifications, the affected practitioner shall so be informed. If the applicant does not resolve the missing information within 30 days or any other date mutually agreed to, the applicant shall be deemed to have voluntarily withdrawn his or her application.
 - 3. Any application deemed incomplete and withdrawn under this Rule may, thereafter, be reconsidered only if all requested information is submitted, and all other information has been updated.
- C. Appointment Review and Actions:
 - 1. All credentialing files with original documents are triaged for significant issues and presented at monthly Credentials Committee meetings.
 - 2. Committee actions are forwarded to the Executive Medical Board for approval and recommendation to the Governing Body.

3. Committee actions are forwarded to the Governing Body for review and approval. The date of Governing Body approval serves as the effective date for appointment and reappointment.
4. Deferrals: A recommendation may be deferred in order to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation.
5. Notice of Final Decision: The Governing Body's decision to appoint shall be given to the applicant and shall include: Staff category, the department and/or section, clinical privileges, and any special conditions attached to the appointment.

Adverse Decisions shall not become final until the applicant has exhausted or has waived procedural rights per the Bylaws, Section G. Action thus taken shall be the conclusive decision of the Governing Body, which shall give great weight to the actions and recommendations of the Executive Medical Board, and in no event shall act in an arbitrary or capricious manner.

- D. Reappointment: At least 120 days prior to the expiration date of each Staff Member's term of appointment, the Medical Staff Office shall provide the member with a reappointment form, which has been approved by the Governing Body and shall be considered part of these Rules and Regulations. Completed reappointment forms shall be returned to the Medical Staff Office at least 90 days prior to the expiration date. Failure, without good cause, to return the form shall result in the automatic expiration or resignation of privileges as described in the Bylaws, Article III, Section C.7.
 1. The form shall seek information concerning the changes in the applicant's qualifications since last review, including requests for change in membership and/or clinical privileges.
 2. If the member's level of clinical activity is not sufficient to permit adequate evaluation of clinical competence, the member shall have the burden of providing evidence of clinical performance at his/her principal institution in whatever form the Credentials Committee may require.
- E. Verification of Information: The Medical Staff Office shall, in a timely fashion, seek to verify the additional information made available and to collect other materials or information deemed pertinent by the Credentials Committee, Executive Medical Board, and/or Governing Body, including, but not limited to:
 - Patterns of care and utilization as demonstrated in the findings of quality improvement, risk management and utilization management activities.
 - Attendance at Medical Staff, department and committee meetings.
 - Participation as a Medical Staff Officer and committee member/chair.
 - Timely and accurate completion and preparation of Medical Records.
 - Cooperativeness and general demeanor in relationships with other practitioners, personnel and patients.

- Compliance with all applicable Medical Staff Bylaws, Rules and Regulations and Hospital policies.

F. Reappointment Review and Action:

1. The Medical Staff Office shall triage and transmit the completed application and supporting materials to the Service Chief of the department(s) in which the member has or requests privileges.
2. The Service Chief of the department(s) shall review the application and relevant information and provide written recommendation for reappointment.
3. All credentialing files with original documents are presented at monthly Credentials Committee meetings.
4. Committee actions are forwarded to the Executive Medical Board for approval and recommendation to the Governing Body.
5. Committee actions are forwarded to the Governing Body for review and approval. The date of Governing Body approval serves as the effective date for appointment and reappointment.
6. Deferrals: A recommendation may be deferred in order to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation.
7. Notice of Final Decision: The Governing Body's decision to reappoint shall be given to the applicant and shall include: Staff category, the department and/or section, clinical privileges, and any special conditions attached to the appointment.

Adverse Decisions shall not become final until the applicant has exhausted or has waived procedural rights per the Bylaws, Section G. Action thus taken shall be the conclusive decision of the Governing Body, which shall give great weight to the actions and recommendations of the Executive Medical Board, and in no event shall act in an arbitrary or capricious manner.

8. Relinquishment of Privileges: A member who wishes to relinquish or limit particular privileges shall send written notice to the President of the Medical Staff and the appropriate Service Chief(s) identifying the particular privileges to be relinquished or limited. A copy of this notice shall be forwarded to the Medical Staff Office for inclusion in the member's file.

G. Flow of Information

Pursuant to the Credentialing Policy and Procedures, the credentials review and Medical Staff appointment and reappointment involve a system of records that is maintained in several forms: original documents, computer databases, network interfaces, queries and reports.

- Original Documents: All collected documents used to evaluate a provider's qualifications for membership are maintained in the Medical Staff Office. Requests for verification or copies are handled according to the Credentialing Policies &

Procedures and must include a release of information from the provider if requestor is an external entity.

- **Computer Databases:** The Medical Staff Office maintains and monitors provider information and credentialing processes within a vendor application to maintain and develop a centralized provider database. Various data elements are abstracted and interfaced to various clinical systems. A unique provider ID number (“UCSF ID”) is assigned to each applicant and is treated as the provider’s signature on system entries.
- **Queries and Reports (Q&Rs):** Custom queries and reports provide a foundation for submitting, merging, and analyzing data into relevant information. Requests for information shall be documented via the Q&R request form, specifying standard or custom data elements, purpose and contact information.
- **Network Interfaces:** Selected information from the MSO database is abstracted and provided for interfaces to clinical information systems throughout the UCSF environment, including: Radiology, Pharmacy, Pathology, Medical Records, Admitting, the Clinical Display System, Patient Registration, Finance, Operating Room and Laboratories.

II. DELINEATION OF PRIVILEGES

Pursuant to the Bylaws of the Medical Staff, the Credentials Committee recommends Delineation of Privileges forms, as developed and approved by each Clinical Service listed in the Bylaws. A delineated listing for Medical Staff and Housestaff members can be accessed via a web based search tool.

III. PEER REVIEW

As outlined in the Peer Review Policy, as approved by the Governing Body and considered as part of these Rules and Regulations, members of the medical staff are involved in activities to measure, assess and improve performance on an organization-wide basis. Peer review activities are used to establish an objective evaluation of medical practice, provide information for assessing physician competency at time of medical staff reappointment and identifying system-wide performance improvement opportunities.

Review of individual cases or adverse data may be performed by individuals or a panel of physicians, other healthcare professionals and hospital staff, under the auspices of a clinical department, the Medical Executive Board, or an interdisciplinary peer review body set up especially for the review. Comparisons with individual historical, departmental and external benchmarks may be made and where appropriate, referral for corrective action.

Members shall be selected based upon their professional knowledge, availability and willingness to participate. Members may be appointed by the President of the Medical Staff, Department Chief or other physician given responsibility by the Medical Executive Committee for conduct of the review.

All Medical Staff members are expected to participate in and respond to requests for peer review evaluations. Unless otherwise specified, a response is expected within two weeks. When a department, Quality Improvement Committee or Medical Staff Committee with quality-related functions is unable to enlist the timely cooperation of a member in an appropriate peer review evaluation, the Committee shall refer the matter to the President of the Medical Staff. Failure to participate in peer review evaluations upon request may result in a suspension of privileges.

IV. PERFORMANCE IMPROVEMENT PLAN

The Performance Improvement (PI) Plan, as approved by the Governing Body and considered a part of these Rules and Regulations, outlines the Quality Committee Structure and specific details of the organization's annual performance goals and measures. Reports of Medical Center PI activities are presented at least annually by the Quality Improvement Executive Committee (QIEC) to the Executive Medical Board (EMB). The EMB evaluates and responds to PI reports and directs them to the Chancellor and the Governance Advisory Council.

- A. **Organizational Mission & Vision:** The mission of UCSF Medical Center is caring, healing, teaching and discovering. Our vision is to be the best provider of health care services, to be the best place to work and to be the best environment for teaching and research.
- B. **Organizational Values:** All Performance Improvement activities are carried out with focus upon the following organizational values:

Professionalism
Respect
Integrity
Diversity
Excellence

As the mission and values statements convey that UCSF Medical Center is committed to providing health care of the highest quality and to achieving patient and staff satisfaction by meeting or exceeding requirements and expectations. The organization designs, develops and delivers services with a constant focus on Performance Improvement (PI), and value enhancement, recognizing the vital role of both staff and faculty in achieving these objectives. The Performance Improvement Plan is designed to encompass important aspects of care or service, provided within major functional areas of the institution, in support of the achievement of the mission statement and strategic goals.

- C. **Scope:** The scope of the Organizational Performance Improvement Plan includes performance of the following Medical Staff functions:
 - 1. The monitoring, assessment and evaluation of the dimensions of performance of patient care and the clinical performance of all individuals with clinical privileges. Performance improvement activities of the Medical Staff and all appropriate departments/services and disciplines that impact patient care and safety are reviewed through the Quality Committee Structure. Functions which will be reviewed, assessed and evaluated are:
 - a. Operative and invasive procedure monitoring
 - b. Medication use monitoring
 - c. Information management
 - d. Blood usage review
 - e. Pharmacy and therapeutics functions
 - f. Mortality and morbidity review
 - g. Safety management
 - h. Risk management
 - i. Infection Control
 - j. Utilization management

- k. Tissue use
2. The dimensions of performance of patient care and quality control activities in the following services are monitored, assessed and evaluated:
 - a. Anatomical pathology services
 - b. Cardiopulmonary resuscitation services
 - c. Care coordination and social services
 - d. Clinical laboratory services
 - e. Diagnostic radiology services/imaging services
 - f. Emergency services
 - g. Hospital sponsored ambulatory care services
 - h. Intensive care units
 - i. Nursing services
 - j. Nutritional care services
 - k. Pharmaceutical services
 - l. Physical rehabilitation services
 - m. Surgical and anesthesia services
 - n. Respiratory care services
 - o. Information technology
 - p. Environment of care services
 3. Assessment of the performance of the following patient care and organizational functions are included:
 - a. Patient rights and organizational ethics
 - b. Assessment of patients
 - c. Education of patients and family
 - d. Care of patients
 - e. Continuum of care
 - f. Leadership
 - g. Infection Control
 - h. Patient satisfaction/service excellence
 4. Relevant findings from performance improvement activities performed are considered part of:
 - a. Reappraisal/reappointment of Medical Staff members;
 - b. Renewal or revision of the clinical privileges of individuals who practice independently;
 - c. The mechanism used to appraise the competence of all those individuals not permitted by the hospital to practice independently.
- C. Definitions: Performance Improvement is a process that uses information from multiple sources to continuously improve care and services to our patients. A team approach is used to understand and analyze current practice, institute appropriate changes; measure the effect on identified outcomes through systematic monitoring processes to insure continued success.

- D. Organizational Philosophy And Principles Of Performance Improvement: Participation in performance and outcomes improvement activity is the responsibility of all members of the Medical Center community (faculty and staff). Activities will support the mission, values and goals of UCSF Medical Center and are guided by the following principles:
- The success of any performance improvement activity is dependent upon the active participation and contribution of each member of the team.
 - Each individual is an important contributor to quality.
 - An integral part of each individual's job is to work continuously to improve the quality of care and service in their work environment.
 - A multi-disciplinary approach, using an ongoing measurement process is critical to providing a comprehensive perspective and sustaining improvement.
 - Data is analyzed and information is used proactively to monitor, assess, and improve the quality of care.
 - UCSF is sensitive to emerging, unusual or urgent needs identified through assessment, data collection or customer (patient, families, staff, community and regulatory agencies) input which may supersede current or previously identified performance initiatives.
 - Ideas come from all levels of the organization but are prioritized by the Quality Improvement Executive Committee (QIEC).
 - Information from departments/services and findings of discrete performance improvement activities are used to detect trends, patterns of performance or potential problems that affect more than one department/service.

- E. Objectives Of The Performance Improvement Program
The Performance Improvement Plan is committed, but not limited, to meeting the following objectives:

- Providing a framework for continuously monitoring and improving the quality of care and services provided to our patients using the IMADIM Model.
- Integrating the measurement of clinical and operational performance with those of strategic planning and operations management.
- Facilitating the redesign of clinical care and key processes to achieve ready access and optimal outcomes at the lowest possible cost.
- Collecting performance data consistently and systematically.
- Providing forums for routine analysis, and stratification of data with multi disciplinary teams.
- Improving responsiveness and relations with all customers, including patients and their families, faculty, community or referring physicians, other participating providers, affiliated health plans, staff, regulatory and accrediting bodies.
- Meeting regulatory requirements
- Providing forums to address cross-population/department/service quality management issues related to patient care, professional practice, education and research.
- Engaging UCSF physicians and staff in performance improvement activities and encouraging accountability for quality at every level of the organization.
- Responding to the changing health care needs of the community.
- Identifying issues and improving the infrastructure of the Medical Center
- Utilizing internal and external benchmarks and regulatory standards to evaluate performance.

- Adding additional objectives as data and organizational needs indicate.

F. Performance Improvement Model

A rapid-cycle performance improvement model is used to transform information into activities that will improve the care delivery and outcomes for UCSF Medical Center. Questions that frame each performance improvement project are:

- What are we trying to accomplish?
- What change can we make that will result in improvement?
- How will we measure the improvement?

The Plan – Do – Study – Act (PDSA) improvement model is the approach to most projects.

Plan – Develop a plan, set objectives, make predictions regarding expected outcomes, identify actions, define responsibilities and timeframes and define the methods and frequency of measurement. Plan a small test of change to test approach.

Do – Teams implement small tests of change, make modifications to policies, procedures, or systems.

Study – Evaluate the data, compare results to anticipated results, summarize findings.

Act – Teams act based on the results of the study. Change the approach as indicated by the data and begin another cycle. Implement change in a broader setting.

Other, more rigorous models may be appropriate to a project based on the complexity of the endeavor and the skill of the project leader.

V. UTILIZATION REVIEW PLAN

A. Objectives:

All patients, regardless of type of insurance or source of payment, are monitored for over-utilization, under-utilization, and inefficient scheduling of resources. The primary objectives of utilization review are the following:

1. Assure Care at a Level Appropriate to Patient Needs

Utilization review monitors the level of care on an ongoing basis to ensure that patients receive care in a facility appropriate for their needs. A patient in an acute care facility requires the continuous availability of physicians, skilled nursing services, surgical services and/or ancillary services found only in the acute hospital setting.

2. Provide Professional Accountability

Utilization review provides professional accountability for the utilization of health care resources to the patient and the person or organization paying for his/her care. It addresses issues of quality and cost controls to ensure the highest quality patient care at the lowest cost.

3. Educate the Medical Staff and Other Health Care Professionals

The ongoing utilization review activity and the identification of problem areas provide continuous education on quality of care and utilization issues to the Medical Staff and other health care professionals.

B. Components of the Utilization Review Plan:

The Utilization Review Plan, as approved by the Governing Body and hereby included in the Rules and Regulations, is part of the Medical Center-wide Quality Assurance/Improvement Program and includes the following components:

1. Utilization Review Subcommittee

The Utilization Review Subcommittee is established as a standing committee of the Medical Staff and a subcommittee of the Quality Improvement Executive Committee. The Utilization Review Plan is developed by the Subcommittee and is incorporated into the Medical Staff Bylaws, Rules and Regulations following approval by the Medical Staff, Administration, and the Chancellor. The Subcommittee has the authority to give notice of non-coverage in accordance with federal and state law and other third party payor requirements.

The Subcommittee has the responsibility to:

- (1) Implement procedures for reviewing all stages of hospital admissions, including but not limited to, medical necessity for admission, over- and under-utilization of ancillary services, delays in services, quality of care indicators, adequacy of medical record documentation, lengths of stay, and timeliness of discharges.
- (2) Report review findings and recommendations to the appropriate Medical Center and/or Medical Staff persons or entities.
- (3) Review third-party payor denials, make recommendations and/or take appropriate actions.
- (4) Collect and analyze data necessary to carry out its responsibilities.
- (5) Analyze issues, problems, or individual cases identified through utilization review activities, make recommendations for resolution and/or refer to appropriate entities for resolution.

2. Utilization Review Activities

a. Admission Review

All designated admissions will be reviewed within one (1) working day of admission and a determination of necessity for admission based on InterQual® SI/IS (severity of illness/intensity of service) criteria shall be made. Initial review dates will be assigned when admissions are deemed appropriate.

b. Concurrent Review

The concurrent review process will follow the admission review and will continue as long as the utilization review nurse coordinator determines on the basis of the SI/IS criteria that the hospital stay is medically necessary and appropriate.

c. Focused Review

The Subcommittee will identify patients requiring focused review and will approve the designed study. Focused review consists of admission and continued stay review that is conducted for a pre-determined period. The purpose of such review is to monitor over-utilization, under-utilization, and/or inefficient scheduling of resources. Findings are presented to the Utilization Review Subcommittee.

d. Support Services Review

The effectiveness and appropriateness of ancillary and support services are reviewed through special studies conducted by the Utilization Review Subcommittee, other Medical Staff committees, or by the providers of the services. Studies are conducted concurrently or retrospectively. Criteria specific to the study are developed by non-physician professionals when appropriate to their specialties.

e. Quality of Care Review

Quality of care is monitored concurrently and retrospectively in accordance with the overall Performance Improvement Program. Concurrent monitoring is also performed as a utilization review activity and results are reported to the Quality Improvement Executive Committee. Quality improvement activities are described in the Performance Improvement Plan.

f. Discharge Planning

Discharge planning is a collaborative effort of a multi-disciplinary team of individuals performed as an integral component of the direct patient care process. The concurrent utilization review process is one of several mechanisms designed to identify and refer patients needing discharge Care Coordination. Discharge planning policies and procedures are found in the Medical Center Policy and Procedure Manual for Administrative and Clinical Staff, and in the Department of Care Coordination Policy and Procedure Manual.

3. Utilization Review Staff

The Utilization Review staff consists of qualified non-physician Medical Center personnel including, but not limited to, care managers, social workers, and assistants who function under the direction of a manager as staff to the Utilization Review Subcommittee.

4. Chief Physician Advisor

The Chief Physician Advisor provides regular time to the Utilization Review staff for problem referrals, medical record review, and consultation on utilization issues. He/she maintains current knowledge of third party payor requirements and is a member of the Utilization Review Subcommittee.

VI. REFERRAL COMMUNICATION STANDARDS AND PROCEDURES

The following minimum communication standards apply to all Medical Staff members, including House Staff, for all admissions to the Medical Center:

- A. All communications with referring and/or primary physicians should be clear, complete and timely. In addition to providing information, communication should seek to involve the referring physician in all unanticipated major decisions concerning the care of the patient.
- B. Ideally, all communications with referring (primary) physicians should be conducted by attending physicians, although this responsibility may be shared with a senior house officer, provided this is arranged initially with the referring physician; however, the referring physician should always be provided with the name and telephone number of the responsible attending physician.
- C. Unless hospitalization was anticipated, the admitting physician should immediately contact the referring (primary) physician when admission is desired; this communication should include at least the following:
 - 1. How the patient presented to the Medical Center (if self-referred); the patient's current condition, indications for admission, and treatment plan;
 - 2. An understanding of the preferences of the referring (primary) physician regarding the patient's future care; and
 - 3. The name and telephone number of the attending physician (or senior house officer) and expectations regarding future communication.
- D. During hospitalization, communication should occur whenever there is a significant change in the patient's clinical status or in the treatment plan. For a long stay, communication should occur at regular (weekly) intervals.
- E. If not providing immediate post-hospital care, the attending physician should telephone the referring (primary) physician immediately before discharge to communicate at least the following:
 - 1. Patient's condition and principal diagnosis at time of discharge;
 - 2. Plans for follow-up care including the anticipated role of Medical Center physicians and the referring (primary) physician; and
 - 3. Expectations for communication during the follow-up including the name and telephone number of the responsible Medical Center physician.

- F. Following discharge, the attending physician will send a written letter that includes the above information, with Discharge Summary, to the referring physician with copies to the primary physician and other physicians involved.
- G. Self-referred patients without a primary physician will be referred for follow-up to an appropriate Medical Center physician, clinic, or practice. These referral arrangements will include the communications outlined in paragraph E. above.
- H. Attending physicians will periodically be audited for compliance with the communication standards outlined above. The results of such audits will be forwarded to the Director of the Medical Center, the appropriate Department Chairperson, and to the appropriate committee of the Medical Staff. Repeated deficiencies by individual physicians may result in suspension of Medical Staff privileges.

VII. CONSULTATIONS

The purpose of a consultation is to provide prompt and expert specialty evaluation and management advice that benefits the patient and meets the expectation of both the patient and requesting physician. The attending physician determines the need for and authorizes consultations with other services concerning patients under his/her direct care pursuant to the following criteria:

- When the patient is not a good risk for an operative procedure
- Where the diagnosis remains obscure after ordinary diagnostic procedures have been completed
- Where there are significant differences of opinion as to the best choice of therapy
- In unusually complicated situations where specific skills of other practitioners may be helpful
- When specifically requested by the patient or his family and with concurrence by the attending physician
- For all patients who have attempted suicide or who have had self-administered chemical overdoses, psychiatric consultation will be provided

A. Non-Emergency Consultations:

The consultant must have sufficient expertise in his/her specialty to make a prompt and definitive management and disposition decision. House officers or fellows may respond to the request for consultation and prepare the consultant note. However, the consultation must be reviewed and confirmed in person or by telephone with the attending physician within 24 hours. The consultation should be documented in the medical record and counter-signed by the attending physician.

B. Emergency Consultations:

1. A request for emergency consultation shall result in a consultant physically seeing the patient within 30 minutes of contact (unless the requesting physician agrees a slower response is acceptable) for in-house physicians, and within 60 minutes for those services having physicians on call out of the hospital.

2. Consultants will not postpone their initial evaluation of the patient pending the ordering or obtaining test results. Services are encouraged to develop written guidelines for tests they consider valuable in specific emergency conditions, so that requesting physicians can order them in advance to expedite the consultant's management recommendation.
3. The consultant must have sufficient expertise in his/her specialty to make a prompt and definitive management and disposition decision and to directly authorize admission or emergency surgery or procedures (as needed) without further consultation.
4. For emergency consultations requested by services other than the Emergency Department, house officers or fellows may respond to the request for consultation and prepare the consultant note. However, the consultation must be reviewed and confirmed within two hours in person or by telephone with the attending physician. The consultation should be documented in the medical record and counter-signed by the attending physician.

VIII. HOUSE OFFICERS

A. In-House Coverage:

1. Each clinical department shall have a House Staff member on-site within the Medical Center complex at all times.
2. Upon request of the Chief of the Clinical Department, the Executive Medical Board may excuse that department from this requirement where patient care would not be compromised by the absence of at least one on-site house officer assigned to that clinical department.

B. House Officer Evaluation:

Written evaluation of House Staff shall be conducted at regular intervals, preferably after each clinical rotation, but not less than semi-annually. The form of the evaluation is left to the discretion of each service but should include formal review of the house officer's clinical knowledge and patient care skills, and an overall assessment of competence. Evaluations will be filed by the clinical department.

C. Supervision of House Staff:

The clinical activities of all House Staff are to be supervised by faculty preceptors and include the following documentation requirements: counter-signature on history and physicals and a note every three (3) days in the medical record. Clinical departments may reference a Residency Competency tool via the internet to ensure levels of care are provided by appropriate level of housestaff.

SECTION TWO: PATIENT AFFAIRS

I. MEDICAL RECORDS

A. Definition, Ownership, Control:

1. Medical records are legal documents and are the property of the Medical Center; they are under the custody of the Medical Records Department.
2. Medical records contain valuable and confidential information and are to be safeguarded against loss, defacement, tampering, or use by unauthorized persons. Nothing shall be removed or deleted from a medical record, and no irrelevant or facetious notations may be made in them.
3. Information may not be released from the medical record nor copies made thereof except by designated individuals following written guidelines (see Medical Center Policies and Procedures Manual, CHA Consent Manual). Patients' questions about the content of records should be referred to the attending physician.
4. Medical records are to be in the Medical Records Department or at the site of patient care service. Medical records may be used outside the Medical Records Department for specific occasions, such as conferences and meetings. Persons with records checked out to them must always have them immediately available for patient care. Records are not to leave UCSF Medical Center except pursuant to a court order, subpoena, or statute.
5. Medical records may be borrowed only by authorized borrowers, who must adhere strictly to established guidelines for request and return of records (see Medical Center Policies and Procedures Manual).
6. Medical records of inpatients must be returned to the Medical Records Department within 24 hours of discharge.
7. Medical records requested by clinics must be returned on the day of the visit. Records may be transferred to authorized borrowers or other clinics if a transfer form is completed and forwarded to the Medical Records Department.
8. Use of medical records for research shall be governed by procedures adopted by the Medical Records Committee and approved by the Executive Medical Board. The following are criteria for research review:
 - a. Approval must be obtained from the Committee on Human Research if the researcher plans to contact the patient directly.
 - b. Record must be reviewed in the Medical Records Department.
 - c. Record must be requested within 24 hours notification.
 - d. No more than twenty-five (25) records at a time may be requested.

- B. Content of Medical Records:
1. Complete and accurate medical records are indispensable for the proper care of patients, and are the focal point of communication among Medical Center personnel.
 2. Medical records must be signed, legible, and up-to-date.
 3. For the medical record, a physician must have:
 - a. Provided the demographic and patient information to the Admitting Department for the Patient Reservation form.
 - b. Written orders for all medications and other treatment. The physicians must have signed and noted the date and time of each order.
 - c. Recorded a complete history and physical examination as defined by the clinical service as well as Section 3.II.C and Section 3.I.A.9 & 10 of the Rules and Regulations.
 - d. Written a consultative note within 24 hours after each consultation
 - e. Indicated the admitting diagnosis at the time of admission, and noted any changes or additions to the diagnosis at the time of discharge. For expired patients, a death note must be written at the time of death.
 - f. Noted clinical observations including the results of therapy. These observations must be made by the attending physician as often as necessary but at a minimum of every three (3) days. In addition, these observations must always be noted immediately post-operatively.
 - g. If the full operative or other high-risk procedure report cannot be entered into the record immediately following the surgery or procedure, record a note in the medical record with information including date and time, name of surgeon(s) or practitioner who performed the procedure, name of surgical assistant, specimens removed, preoperative diagnosis, postoperative diagnosis, name of operation, type of anesthesia, principal findings and procedures, and estimated blood loss.
 - h. Ordered the minimum routine tests required by the clinical service. All tests and procedures performed on registered patients of the Medical Center shall be documented in the medical record.
 - i. Dictated in a discharge summary within 24 hours after discharge. (Except for normal obstetrical patients and newborn infants, and except for patients with problems of a minor nature who require less than a 48-hour period of hospitalization, in which instances a discharge note may be substituted for the dictated summary.) This discharge summary should contain reason for hospitalization; significant findings; procedures performed and treatment rendered; condition of the patient on discharge; and specific instructions given to the patient and/or family particularly in relation to physical activity, medication, diet, and follow-

up care. The original of the discharge summary will be filed directly in the record. Copies will be sent to the departmental offices and then to the referring physician by the clinical service. A discharge summary is recommended not to exceed three (3) pages.

4. Attending physicians may choose to dictate a corrected discharge summary or operative report. If such dictation occurs prior to the signing of the original report, the original report may be removed from the medical record. If the original report has already been signed, however, the dictation shall note that the original note is being corrected, and the original note as well as the corrected report must remain in the medical record.
5. The appropriate practitioner authenticates medical record documentation for which he/she is responsible. Authentication may be written signature or computer key. The use of a signature rubber stamp is prohibited in the PAPER medical record. All authentication of orders or documentation in the PAPER medical record requires a handwritten signature. Computer key identification will be used to authenticate electronic medical records. Computer key identification requires a log-on security authorization and a signed statement that computer key authentication is affixed by the authorized individual only. Use or sharing of computer log-on identification and/or authorization codes assigned to another individual is prohibited.

C. Completion of Medical Records:

1. Notes and entries made in the medical record should always include the date and time they were made. Thus the date of an entry reflecting a correction should be the date the correction was made, not the date the error was made, and appropriate cross-referencing should be placed in the record when necessary to explain the correction.
2. Medical records must be complete within two (2) weeks of discharge.
3. A medical record will be considered incomplete if it is missing a signed or authenticated history and physical examination, discharge summary and operative report. Medical records may be authenticated by the attending physician using a signature or computer key.
4. The attending physician will be responsible for the completion of records of his/her patients.
5. It is the responsibility of the chief of the clinical service to see that medical records are completed by members of their departments according to the established departmental guidelines and policies.
6. Failure to complete discharge summaries or operative reports within fourteen (14) days after discharge may result in loss of privileges for the attending physician. Certification of membership in good standing in the Medical Staff shall be withheld for all members with incomplete medical records.

II. INFECTION CONTROL AND COMMUNICABLE DISEASES

Each member of the Medical Staff has a personal responsibility to prevent the development and transmission of infection in patients and staff of the Medical Center. Infection control practices are an integral part of this process and must be practiced by everyone. Specific infection control policies and procedures are outlined in the Infection Control Manual

<http://infectioncontrol.ucsfmedicalcenter.org/>

UCSF Medical Staff Membership, requires compliance with Infection Control and Safety Precautions/Environment of Care programs.

Included in the requirements:

- Standard Precautions shall be practiced at all times. Standard precautions include hand hygiene before and after each patient contact, surface disinfection of all patient equipment between patient uses and appropriate use of personal protective equipment (PPE).
<http://infectioncontrol.ucsfmedicalcenter.org/>
- Patients with symptoms of communicable infection shall be placed in the appropriate Transmission-based precautions (Airborne/AFB, Airborne, Droplet or Contact precautions). All procedures shall be followed.
- Providers with infections shall refer to the Illness-Related Work Restrictions Table in the Infection Control Manual to determine work restrictions. Contact Employee & Occupational Health Services for further direction.
- Patients with legally reportable communicable diseases and conditions must be reported to Public Health per Title 17 of the California Code of Regulations. <http://www.sfdph.org/>
- OSHA Bloodborne Pathogen Standard shall be followed (e.g., correct disposal of sharps, correct handling of blood and body fluids, correct handling of sharps in a Surgery setting).
<http://www.dir.ca.gov/title8/5193.html>
- Following a blood or body fluid exposure the provider will be tested and followed according to the Bloodborne Pathogen Standard guidelines.
<http://manuals.ucsfmedicalcenter.org/EOC/2004ECBbloodbornePathogens.pdf>
- Evidence of immunity to specific infections per Employee Health and Occupational Services is required for all staff members working in patient care areas.

1) At the time of initial hire and annually thereafter:

- a) TB test/PPD
- b) Flu shot = Annual inoculation or declination
- c) Fit testing = Physicians working in selected specialties/units
- d) Safety training

2) For new appointments only:

- a) MMR
- b) Varicella
- c) TDap = inoculation or declination
- d) HepB = inoculation or declination

III. ENVIRONMENT OF CARE PROGRAM:

UCSF Medical Center has implemented an environmental health and safety management program administered by the Environment of Care Committee, chaired by the Medical Center Safety Officer and includes representatives from appropriate departments to address all Environment of Care issues. The program is intended to protect our patients and visitors, employees, and environment from potential harm. The program is defined in the Environment of Care Manual which addresses seven subjects:

- Safety Management and Administration
- Security
- Hazardous Materials and Hazardous Waste Management
- Emergency Management
- Fire and Life Safety
- Medical Equipment Management
- Utilities Management

The Environment of Care Manual is available in each department or via the manuals website for your reference. All staff must know where it is located and become familiar with it. Annual Safety training is offered by Medical Center to ensure staff are knowledgeable of current safety practices. Other technical manuals that address specific concerns are available for review.

IV. CONSENTS, PERMITS, AND LEGAL AFFAIRS

A. Consents and Permits:

1. General Consent

General consent to medical or surgical treatment must be signed when patients are admitted to the Medical Center. It provides a record of consent to routine services and medical treatment and informs the patient of participation in the educational programs of the Medical Center. A general consent cannot be used as a consent for specific procedures.

2. Special Consent

- a. The attending physician must fully inform the patient about the nature and benefits of the procedure, the alternative methods, and the complications or risks. An alternate (licensed) physician may be designated to inform the patient if, in the opinion of the attending physician, the alternate (licensed) physician is knowledgeable of the benefits and inherent risks of the procedure and alternative procedures. In the event that the procedure is discussed by a designated alternate licensed physician, he/she will be responsible for advising the patient and specifying on the consent form the name of the physician who will perform the procedure, or inserting a statement that the procedure will be performed (supervised) by a member of the Attending Staff. The patient's consent and signature attesting to the consent must be obtained before beginning any medical or surgical procedure that involves significant risk to a patient.

- b. Documentation of Consent: It is the physician's responsibility to make an appropriate entry in the medical record regarding the information given to the patient, and to assure that the patient's signature is on the proper consent form. If the consent form has not been signed in the physician's office (the preferred procedure), hospital personnel may assist in obtaining the patient's signature, provided the patient has no questions about the procedure. If the patient chooses to withdraw consent or refuses the proposed procedure, the physician will be contacted. The patient's signature must be obtained before anesthesia or pre-medication is administered and/or the patient is transported to the Operating Room.
- c. Both the Authorization for Surgery form and the documentation of consent in the progress notes must be completed and signed before a patient will be sent to the Operating Room. Patients having come-and-go or come-and-stay procedures will not be admitted to the Operating Room unless both types of documentation are complete.
- d. Any questions as to the necessity of obtaining a special consent from patients should be resolved in favor of obtaining consent.
- e. Examples of situations in which special consents must be obtained follow. Details are found in the CHA Consent Manual available in Medical Center Administration.
 - (1) All major or minor surgery which involves an entry into the body either through an incision or through the use of natural openings. There must be a valid permit for each procedure or operation. Once signed, the permit may be used for further stages of the original procedure or for complications arising therefrom.
 - (2) Any procedure involving general anesthesia, or moderate or deep sedation, whether or not entry into the body is involved.
 - (3) All non-operative procedures which involve more than a slight risk of harm to patients, or which involve the risk of a change in patient's body structures.
 - (4) All procedures where radium, x-rays, or isotopes are used in the therapy of patients.
 - (5) Sterilization.
 - (6) Release of information to the press or media and the taking of photographs, films, or televised pictures or tapes for teaching or research purposes.
 - (7) Participation in clinical research protocols.
 - (8) Administration of investigational drugs.

(9) Blood Transfusion

3. Implied Consent

In an emergency that threatens the life or health of a patient, when the patient is unable to consent, treatment without a written consent is authorized by law under the doctrine of implied consent. This is based on the theory that if the patient were able to, or if a legal representative were present, such consent would be given. Proceed as follows:

- a. Determine whether the treatment is required immediately and is necessary to prevent deterioration or aggravation of the patient's condition. This may be a matter of first aid or temporary medical care in lieu of surgery, or actual surgical or orthopaedic procedures. Treat the emergency only.
- b. Assess the possibilities of obtaining the necessary written consent, weighed against the possibility that delay would jeopardize the health of the patient.
- c. Obtain medical consultation to determine whether or not an emergency exists. Two physicians must sign the authorization attesting to the existence of an emergency when the patient is unable to sign.

4. Patient Refusing to Take Medical Advice

- a. All patients leaving against medical advice must be asked to sign a special release form. In cases where patients cannot sign, the signature of the nearest relative or guardian must be obtained. Notation should also be made in the medical record.
- b. When a patient refuses a blood transfusion, the physician must obtain the patient's or guardian's signature on a "Refusal to Permit Blood Transfusion" form. A court order may be obtained to allow blood administration under certain circumstances.

B. Other Legal Affairs:

1. Legal Documents

The following certificates are required by law:

- a. Birth (details available in the Delivery Room).
- b. Fetal Death (details available in the Delivery Room).
- c. Death (details available in the Morgue Pack). A licensed physician completes and signs the Death Certificate. The physician in charge of the patient notifies the family.

d. Autopsy Permit

- (1) The Medical Staff recognizes the importance of autopsies in correlating clinical and pathologic findings in individual cases, in benefiting society by identifying diseases and environmental hazards, and in training future physicians. It is essential that all persons concerned with the care of a dying patient give their whole-hearted cooperation toward securing permission for a post-mortem examination. Autopsies are particularly important in the situations specified in the Autopsy Procedures available from the Autopsy Service and distributed annually to new house staff members.
- (2) If a family is unwilling to consent to a complete autopsy, a limited autopsy may be suggested.
- (3) A family's wishes regarding an autopsy must be respected, except in Coroner's cases.
- (4) Special arrangements for autopsy of patients who die at home must be made with the Department of Pathology.
- (5) Indications for Autopsy:
 - Deaths in which an autopsy would explain unknown or unanticipated medical complications.
 - All deaths in which the cause is not known with certainty on clinical grounds
 - Deaths in which an autopsy would allay concerns of and provider reassurance to the family and/or public regarding the death
 - 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 that are apparently natural and not subject to the jurisdiction of the Medical Examiner
 - Natural deaths that are subject to, but waived by, the Medical Examiner, such as persons dead on arrival to the hospital; death occurring 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 neonatal and pediatric deaths
 - Deaths in which it is believed that autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs

- Deaths known or suspected to have resulted from environmental or occupational hazards
2. Unusual Incident
 - a. An unusual incident is any event which will, could, or did harm a patient. Incidents will be reported within 24 hours by a nurse or physician or other staff member witnessing the incident in the online Incident Report System. When medically indicated, a notation regarding the patient's status shall be made in the medical record.
 - b. Failure to report incidents may be grounds for disciplinary action by the Executive Medical Board.
 3. Service of Legal Papers

When members of the Medical Staff are served any legal paper concerning their clinical activities at UCSF Medical Center, they should immediately notify the Office of the Director of the Medical Center or the Office of Hospital Risk Management.
 4. Contact by Investigator

A physician contacted by any government or private investigator regarding patient care activities within the Medical Center should contact Medical Center Administration before submitting to questioning.
 5. Findings Reportable to Government Agencies

Physicians are responsible for reporting a variety of diseases and crime-related wounds and injuries to the police, Coroner, or other government agencies. Specific requirements are enumerated in the Medical Center Policies and Procedures Manual.

V. CONSENT FOR ORGAN AND TISSUE DONATION

A. Policies:

The "Organ and Tissue Donation" Policy #6.05.08 and the "Brain Death" Policy #6.05.02 can be referenced in the UCSF Medical Center Administrative Manual.

B. Definition of Brain Death:

An individual who has sustained irreversible cessation of all functions of the entire brain, including the brain stem, as determined by accepted medical standards, is dead. There shall be independent confirmation of the death by another physician. Neither the physician making the determination of death nor the physician making the independent confirmation shall participate in the procedures for removing or transplanting a part (California Health and Safety Code, Sections 7180-7182).

C. Procedures:

1. All cardiac deaths and imminent brain deaths must be reported to the California Transplant Donor Network (CTDN) by the physician or a designee as required by CMS (formerly HCFA).
 - a. All deaths of patients including newborns of gestational age of 36 weeks or more must be referred to the CTDN at (800) 55-DONOR within one hour of death.

- b. This referral needs to be made within one hour of circulatory demise, cardiac death, or imminent brain death.
2. The physician must document referrals to CTDN on the “Postmortem and Death Information” form along with other documentation required for all patient deaths.
3. Compliance with this mandatory reporting of deaths to CTDN will be audited on a regular basis as required by CMS (formerly called HCFA).
4. CTDN or the designated tissue bank coordinators will evaluate the potential organ/tissue donor to determine medical suitability.
5. Referral Process:
 - a. Notification of *All* patient deaths to CTDN within one hour of death.
 - b. Refer Imminent Brain Death or Withdrawal of Support or Potential Non-Heart Beating Donors (NHBD) as per protocol for Organ Donation (Organ Donor = Intact Circulation on a ventilator)
 - c. Call the Transplant Network at (800) 553-6667
 - d. Information Needed will include: Patient Name, age, medical, surgical and social history
 - e. Tissue Donor will be handled by phone evaluation
 - f. Organ Donor will require onsite evaluation
6. Identification of Organ vs. Tissue Donor. Most referrals made at UCSF will be potential tissue donors. The Tissue Bank can be accessed by calling CTDN at (800) 553-6667.
7. Consent for Organ Donation
 - a. The CTDN coordinator will assess the family’s readiness to be offered the option of organ donation. The family must be given time to accept the hopelessness of the situation and understand the concept of brain death before the donation option is presented.
 - b. The CTDN coordinator will coordinate a collaborative approach process with the hospital staff.
 - c. When appropriate, the legal next-of-kin or legally designated representative of the potential donor shall be informed of the option to donate organs and/or tissues by an organ procurement representative or a “trained designated requester”. (A trained designated requester is an individual who has completed a course offered, or approved by, the OPO and designed in conjunction with the tissue and eye bank in the methodology for approaching potential donor families and requesting organ and tissue donation.) The family’s response and the name of the person who made the request should be documented in the progress notes.
 - d. A copy of the consent form will be included in the patient’s medical record.
8. Consent for Tissue Donation
 - a. The tissue coordinator will assess the legal next of kin's or legally designated patient representative or family’s readiness to be offered the option of tissue donation. The family must be given time to accept finality of the loss of their loved one before the donation option is presented.
 - b. When and if appropriate, the tissue bank coordinator will contact the legal next of kin/legally-designated representative of the patient to conduct a medical/social history and record the consent for donation.
 - c. A transcribed copy of the consent will be faxed to the hospital for inclusion in the patient’s medical record.
 - d. The hospital will provide the tissue bank a copy of the patient’s medical record when requested.

VI. NOTIFICATION OF RECIPIENTS OF TRANSFUSIONS FROM DONORS WHO ARE POSITIVE FOR HIV ANTIBODIES

A. Policy:

It is the policy of UCSF Medical Center and its Medical Staff that patients who have received transfusions from donors who are currently positive for HIV antibodies be informed of such transfusions and advised to obtain appropriate follow-up and counseling. While the risk that such patients will develop AIDS is unknown, and there is no treatment for those who have been infected, patients may wish to know of their potential infection with HIV, and should take steps to prevent possible transmission of infection.

B. Procedure:

1. After the Blood Bank has identified surviving recipients (of blood from HIV-positive donors), the attending physician at the time of the transfusion will be notified by letter.
2. The attending physician will be asked which of the following options he/she considers the most appropriate:
 - a. Informing the patient personally;
 - b. Requesting that Irwin Memorial Blood Bank, through its trained staff, inform the patient;
 - c. Informing the patient jointly with Irwin Memorial Blood Bank; or
 - d. Not informing the patient because of clearly defined risk of harm to the patient.
3. All cases where the attending physician selects the option of not informing the patient will be referred for review by the Transfusion Committee; this committee will review the case with the attending physician and make its recommendation.
4. If the recipient of the transfusion has died, the attending physician will be asked to review the patient's medical record to determine if notification to the patient's family may be advisable.
5. Notification of the patient, or the rationale for not informing the patient, shall be documented in the patient's medical record by the attending physician.

VII. CALIFORNIA HEALTH CARE DECISIONS

- A.** The Medical Staff of UCSF Medical Center recognizes the rights of patients in the determination of their health care and the dignity and privacy which patients have a right to expect. California law provides that a patient, while competent, may designate another to make decisions on his/her behalf should he/she become mentally incompetent. A patient may also execute an advanced directive to the physician giving instructions regarding treatment. In those cases where a valid directive has been executed and the patient's condition is within the defined limits of the Act, the Medical Staff shall honor

the directive or otherwise comply with the law. In the absence of a directive, the Medical Staff shall continue to respect the patient's rights, dignity, and privacy and will render appropriate treatment consonant with the wishes and needs of the patient as well as the best standards of medical practice.

- B. Information about the Health Care Decisions Law (California Probate Code, Sections 4600 et seq.) will be made available to patients upon request.
- C. Information about Advanced Health Care Directives and appropriate documents will be made available to patients upon request.
- D. If a patient presents a directive under the Health Care Decisions Law, the physician must discuss the meaning and intent of the document with the patient. Since the Advanced Health Care Directive transfers authority for decision making about health care from the patient to his/her designee when the patient is no longer able to make such decisions, the significance of this decision should be reviewed by the physician with the patient.
- E. When a patient presents a validly executed directive, the original of the directive will be placed in the patient's medical record and a copy of the directive will be given to the patient.
- F. Medical Center personnel should be aware of the contents of the Health Care Decisions Law.
- G. No Medical Center personnel nor health care provider may be a witness to a directive relating to delivery of health care services.
- H. If a directive under the Health Care Decisions Law is revoked, the time, date, and place of the revocation will be recorded in the patient's medical record. The attending physician must be notified of such revocation.

VIII. PATIENT RIGHTS IN CALIFORNIA

In accordance with California Code of Regulations, Title 22, Section 70707, the Medical Center and the Medical Staff have adopted the following list of patient rights to:

- A. Exercise these rights without regard to gender, culture, economic status, educational background, race, color, religion, language, age, presence of a mental or physical disability, ancestry, national origin, sexual orientation or marital status, or the source of payment for care.
- B. Considerate and respectful care and treatment which optimizes the patient's dignity.
- C. Knowledge of the name of the physician who has primary responsibility for coordinating the care, and the names and professional relationships of other physicians and non-physicians who will see the patient.
- D. Receive information from the physician about the illness, the course of treatment, and the prospects for recovery in terms that the patient can understand.
- E. Receive as much information about any proposed treatment or the 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, the medically significant risks involved in this treatment, description of any

- alternate course 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. Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment and to be informed of the medical consequences of refusal.
 - G. Full consideration of privacy concerning the medical care plan. Case discussion, consultation, examination, and treatment are confidential and shall 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 hospitalization. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care, except under the Policy and Procedures of the Committee on Human Research. The patient and/or legally designated representatives are entitled to access information contained in the medical record, within the limits of the law.
 - I. Reasonable responses to any reasonable requests made for services within the Medical Center's capacity, stated mission, applicable laws and regulations. The Medical Center will give each patient necessary health services to the best of its ability. Treatment, referral or transfer may be recommended. If transfer is recommended or requested, patients will be informed of risks, benefits and alternatives.
 - J. Be informed of the patient's rights in writing and to receive care in a safe setting, free from abuse or harassment.
 - K. Unrestricted access to communication, visitors, mail, telephone calls, unless clinically contraindicated. Any restrictions are explained fully to the patient.
 - L. Appropriate care which reflects the patient's desires, or that of your legal representative, while acknowledging physical limitations, psychosocial, spiritual, and cultural concerns about the perceptions of illness, dying, and the expression of grief by the patient's family.
 - M. Expect that a family member or representative and physician will be notified promptly upon the patient's admission to the hospital, unless requested to not be done.
 - N. Have issues related to care at the end of life addressed with sensitivity.
 - O. Be provided information about how to access protective services if the patient is in a hazardous living situation or has been the victim of violence.
 - P. Actively participate with your physician/provider in making medical/ethical decisions regarding care. The patient's designated representative also has this right.
 - Q. The appropriate assessment and management of Pain.
 - R. Be free from restraints or seclusion imposed as a means of coercion, discipline, convenience, or retaliation by staff.
 - S. Formulate advance directives, and to designate a guardian, next of kin, or legally authorized responsible person to exercise to the extent permitted by law, the rights delineated on the patient's behalf when the patient has been adjudicated incompetent in accordance with the law, is found by the physician to be medically incapable of understanding the proposed treatment or procedure, is unable to communicate wishes regarding treatment, or is an unemancipated minor, or when the patient wants someone else to make healthcare decisions for them.

- T. Leave the hospital, even against the advice of physicians.
- U. Reasonable continuity of care and to know in advance the time and location of appointment as well as the identity of persons providing the care.
- V. Be advised if hospital/personal physician proposes to engage in research, investigation or clinical trials involving human subjects affecting care or treatment. The patient has the right to refuse to participate in such research projects and the patient's decision will not affect their care.
- W. Be informed of continuing health care requirements following discharge from the hospital.
- X. Examine and receive an explanation of the bill regardless of source of payment.
- Y. Know which Medical Center rules and policies apply to the patient's conduct while a patient.
- Z. Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- AA. 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.
- BB. 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 policy on visitation. At a minimum, the Medical Center shall include any person living in the household.
- CC. This section may not be construed to prohibit UCSF Medical Center from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

IX. ETHICAL CONSIDERATIONS

- A. Ethics Consultation:

A consultation regarding ethical issues may be requested of the Ethics Committee by all appropriate faculty and staff, patients, and, when appropriate, family members or surrogate decision-makers. Prior to consultation, the Ethics Committee shall inform the attending physician of the request.
- B. Disclosure of Medical Mistakes / Unanticipated Outcomes:

A medical mistake is defined as an act of omission or commission that caused or could cause harm to a patient that would likely be judged wrong by a peer. It is a guideline of the UCSF Medical Center that physicians will disclose medical mistakes. If a physician

believes that he or she has made a disclosable medical mistake, it is the responsibility of the physician to disclose the mistake to the patient or the patient's legally authorized representative as soon as appropriate given the circumstances. Resident physicians must involve their attending physician in the process. If a physician without direct responsibility for the patient is made aware of a medical mistake, this physician should first approach the attending of record. Whether harm occurred or not, further consultation with medical center staff leadership, risk management, and the relevant quality assurance committee is recommended to prevent future mistakes.

C. Inappropriate Sexual Contact:

The Medical Staff is in full support of the tenets of the American Medical Association and members of the Medical Staff shall comply with the following: 1) Sexual contact or a romantic relationship within the physician-patient relationship is unethical; 2) sexual contact or a romantic relationship with a former patient is likely to be unethical under some circumstances; 3) sexual contact or a romantic relationship with the parent of a minor patient is unethical; and 4) sexual contact or a romantic relationship with a relative or partner of an adult patient is unethical when it compromises therapy or undermines the therapeutic relationship.

X. SMOKING IN THE MEDICAL CENTER

There shall be no smoking in any Medical Center campus or facility, except in designated smoking shelters. ([See Admin Manual Policy 1.01.19](#))

XI. NAMETAGS

When in contact with patients, all Medical Center personnel are required to wear photo identification badges that clearly state their name and position.

XII. RELEASE OF PATIENT INFORMATION TO PRESS/MEDIA

The UCSF News and Public Information Services Department is responsible for initiating and handling all press/media inquiries about patients, clinical developments, research, and all other Medical Center matters. All staff members should consult with this department prior to any press contact.

XIII. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

In compliance with the federal Emergency Medical Treatment and Active Labor Act ("the Act"), every patient who comes to the Emergency Department is entitled to an appropriate medical screening examination to determine whether the patient suffers from an emergency medical condition or is in active labor (i.e., pregnancy with contractions present). If either condition is present, qualified medical personnel will provide treatment as may be required to stabilize the medical condition regardless of the patient's insurance status or ability to pay. The emergency needs of the patient will be met according to acceptable standards of medical practice.

A medical screening examination sufficient to detect the presence of an emergency medical condition or active labor will be performed by qualified medical personnel, which includes a registered nurse (RN) who is qualified in emergency care, a nurse practitioner (NP), a physician assistant (PA), a resident physician, or an attending physician. The RN, NP, PA or resident

physician will confer with the attending physician prior to transferring any patient from the Emergency Department to an outside (non-UCSF Medical Center) provider. The attending physician is ultimately responsible for screening examinations performed by RN's, NP's, PA's and residents.

If, after the screening examination, in the best medical judgment of the provider, the patient is not in active labor and no emergency medical condition is present, the patient will be treated, referred or transferred according to internal Emergency Department or Ambulatory Services procedures and appropriate standards of medical practice. Where the patient is transferred to another facility, appropriate documentation will be sent with the patient.

If the Medical Center receives a patient who, in the judgment of the appropriate Medical Staff member, was transferred in knowing violation of the Act, the violation will be reported promptly to the appropriate governmental agencies.

SECTION THREE: PATIENT CARE DELIVERY

I. ADMISSIONS, DISCHARGES, AND TRANSFERS

A. Admissions:

1. Eligible Patients

Patients may be admitted to the Medical Center by all eligible members of the Medical Staff. Admissions will be arranged consistent with Medical Center Patient Financial Policies and Procedures. No patient will be refused admission if a member of the Medical Staff has determined that doing so would endanger the patient's life.

2. Appropriateness of Hospitalization

Regulation of the appropriateness of hospital admissions and medical care is the responsibility of the Utilization Review Committee of the Medical Staff.

3. Provisional Diagnosis and Other Admitting Information

Patients admitted to the hospital must have a diagnosis explaining the need for admission and a record of additional diagnoses that could affect the length of stay. At the time of admission, the admitting physician must provide a brief treatment plan, estimated length of stay, date of scheduled surgery where appropriate, name of referring (or primary) physician, and general demographic information.

4. Medi-Cal and Other Payors Requiring Prior Approval

a. Admissions of patients with Medi-Cal, or an insurance requiring approval for elective admissions, must be pre-authorized under established procedures. Such admissions will be deferred until authorization is obtained.

- b. Prior authorization is not needed for an emergent admission, but a certificate of emergency containing the following must be prepared and signed at the time of admission by the admitting physician: nature of the emergency, patient's condition, and the reason services were immediately necessary.

5. Education Programs

Physicians and the Admitting Department shall inform patients that, while receiving care at the Medical Center, all patients participate in the teaching programs of the University of California.

6. Reservations

The Admitting Department makes all hospital room reservations. A "Patient Reservation" should be completed as far in advance as possible to permit pre-registration for all elective admissions.

7. Bed Assignment

- a. Whenever possible, each patient shall be admitted to the nursing unit most experienced in the care of the condition necessitating hospitalization.
- b. The Admitting Department is responsible for the assignment of beds in conjunction with the nursing units. Every effort will be made to have the patients admitted in time to make the most effective use of the first day of hospitalization.
- c. Requests for specific accommodations will be honored whenever possible but will always be contingent on meeting the medical care needs of all patients as the first priority.

8. Boarding

Adult patients will be admitted to a boarding unit when no bed is available at the designated service location. Subsequent relocation may be made in accordance with general Transfer Policy.

9. Dental Service

The Department of Hospital Dentistry has three divisions: Oral and Maxillofacial Surgery, General Dentistry, and Pediatric Dentistry. The guidelines for hospital admissions for each are as follows:

- a. Division of Oral and Maxillofacial Surgery
 - (1) Patients are admitted to the Oral and Maxillofacial Surgery Service.

- (2) Subject to the requirements of paragraph 3) below, a qualified oral surgeon may perform a history and physical examination on his/her patient, to determine the ability of the patient to undergo the surgical procedure the oral surgeon plans to perform.
- (3) If the patient has a pre-existing medical problem, prompt medical consultation will be obtained prior to the performance of any surgical procedure. If there is no pre-existing medical problem but one develops during the surgery or the subsequent hospital stay, prompt medical consultation will similarly be obtained. Management of the condition for which the consultation was obtained will become the responsibility of the consulting physician, as he/she deems appropriate.

b. Division of General Dentistry

Patients are admitted to the Oral and Maxillofacial Surgery Service. History and physical examinations are performed by both the general dentistry house officer and a medical consultant. The patient is subsequently managed by the general dentistry house officer along with the Oral and Maxillofacial Surgery resident and the medical consultant.

c. Division of Pediatric Dentistry

All patients are admitted to the Pediatric Service. History and physical examinations are performed by both the Pediatric Dentistry and the Pediatric Services.

10. Podiatry Service Admissions

All patients admitted to the hospital for podiatric care because of an underlying medical or surgical problem will be admitted, worked up, and managed by the appropriate medical or surgical service.

11. Admission Orders

Upon admission to the hospital, or prior to scheduled surgical procedures and/or anesthetics, appropriate laboratory testing, ECG testing and x-rays shall be performed according to individual departmental guidelines and the condition of the patient.

B. Discharges:

1. Discharge Planning

The Discharge Planning Policy, available at all nursing stations in the UCSF Medical Center Administrative Manual, should be followed for each patient. Discharge planning should begin at or before the day of admission.

2. Timing of Discharge Orders

Physicians discharge orders should be written by 7:00 p.m. on the day before discharge. The Patient Discharge Plan form, available at all nursing stations, should be utilized. Discharges from adult medical and surgical units should be scheduled so that the patient leaves no later than 11:00 a.m.

C. Transfers:

1. Transfers Within the Hospital

a. General Policy

Transfers are initiated to care for a patient in a more appropriate nursing unit, to honor a patient request, or to facilitate placement of incoming patients by the Admitting Department. Physician and nurse consensus, and consultation with the patient where practical, is expected prior to transfer.

b. Procedures

- (1) The Admitting Department coordinates the allocation of patient beds within the hospital. All requests for transfer must be coordinated with that department.
- (2) In coordination with the Admitting Department, nurses may move patients within a unit to effect better patient care or comfort.
- (3) A transfer of a patient to a different unit is made only with the approval of the physician.
- (4) For transfers between services:
 - (a) A transfer order must be written on the order sheet of the patient's chart by the relinquishing physician, stating the physician and the service to which the patient is being transferred.
 - (b) The receiving physician must sign and date an "on-service" acceptance note on the order sheet of the patient's chart within four (4) hours of the patient's transfer. The patient will continue to be the responsibility of the physician originally assigned to the patient until both the transfer note and the acceptance note are written.
 - (c) When a transfer involves a change of service, the receiving physician must write new care orders within four (4) hours of the transfer.

(d) Nursing will continue to carry out existing orders until the receiving physician's orders are written.

(5) For transfers to and from special or intensive care units:

Each intensive and special care unit has a medical director who is responsible for managing patient care within the unit. Admission and transfer from the unit is the responsibility of the director, or a designee, in consultation with the attending physician or house officer and nursing service.

2. Cross-Medical Center/Other External Support

No inpatient may leave Medical Center buildings for procedures unless ambulatory or in a wheelchair, appropriately covered for warmth and dignity, and accompanied both ways by a Medical Center employee. Exceptions to this policy must be approved by the Executive Medical Board.

II. EXAMINATIONS

- A. As a courtesy, examination and treatment of patients should not be performed during meals except in emergencies or because of unusual circumstances. Meal times may be altered, with advance notice to the Dietary Department, to ensure timely and appropriate treatment and diagnostic service.
- B. The request by a patient to have a chaperone present during a pelvic examination should be accommodated irrespective of the physician's gender.
- C. History and Physicals: Medical History and Physicals will be performed only by practitioners who have been granted the privilege to do so. The following requirements apply to the scope of pre-procedure assessment required in the following patient category:
1. Category 1: Acute Hospital Admission: The patient's history and physical examination, nursing assessment, and other screening assessments are completed within 24 hours of admission. H&Ps performed not longer than 30 days prior to admission as an inpatient must be in the medical record and updated within 24 hours of admission.
 2. Category 2: Surgical or other invasive diagnostic or therapeutic procedures performed under the care of an anesthesiologist (regional and/or general anesthesia or monitored anesthesia care (MAC)) or deep sedation performed under the care of a non-anesthesiologist require a history and physical (see IID below) performed within 30 days prior to the procedure and present in the chart. If and H&P was performed more than 24 hours prior to the procedure, an interval update must be done and recorded in the chart. An interval update records any changes since the last H&P was performed.
 3. Category 3: Procedures performed under moderate sedation require a directed history and physical examination within the preceding 30 days, with an interval update if the H&P was performed more than 24 hours prior to the procedure. This H&P includes, but is not limited to:

- A review of systems
 - Patient history
 - Identification of Allergies
 - Current prescriptions, over-the-counter medications, and herbal supplements
 - Cardiovascular and Respiratory assessment and
 - An assessment of the system or body part undergoing intervention.
4. Category 4: Procedures where minimal sedation and/or local anesthetic are used require:
- Documentation of the plan for the procedure
 - Identification of Allergies
 - Current prescriptions, over-the-counter medications, and herbal supplements
 - An assessment of the system or body part undergoing intervention
- D. The H&P may be performed by the surgeon, anesthesiologist, or allied health professional working within a standard procedure. (see II G below). It should include:
1. History:
 - Chief complaint
 - History of present illness
 - Review of Systems
 - Past, Family and Social History
 - Medications: Current prescriptions, over the counter medications, and herbal supplements
 - Allergies
 2. Physical Examination:
 - General Appearance
 - Vital Signs
 3. Examination of at least 9 elements from the 7 Body Areas or 13 Organ Systems:
 - BODY AREAS:
 - Head, including face
 - Neck
 - Chest, including breasts and axillae
 - Abdomen
 - Genitalia, groin, buttocks
 - Back, including spine
 - Each extremity
 - ORGAN SYSTEMS:

Ophthalmologic	Musculoskeletal	Allergic / Immunologic
Otolaryngologic	Integumentary	Gastrointestinal
Cardiovascular	Neurologic	Genitourinary
Respiratory	Psychiatric	Hematologic / Lymphatic
Endocrine		
- E. Surgeon's note: If the H&P was not performed by the surgeon, the surgeon must write a preoperative note describing the surgical assessment and therapeutic plans and confirming the discussion of alternatives, risks and benefits of the proposed treatment with the patient.

- F. Presedation or preanesthesia assessment: Any patient for whom moderate or deep sedation or anesthesia is contemplated must receive a presedation or preanesthesia assessment immediately prior to sedation or anesthesia induction.
- G. History and Physical performed by Non Physicians: Individuals who are not licensed independent practitioners (non-LIP's) may perform a history and physical under the responsibility and accountability of a physician and pursuant to the non-LIP's scope of practice (e.g., Residency Competency, Standardized Procedures, or Privileges).
- H. Any patient receiving anesthesia in any Medical Center location must receive a post-anesthesia evaluation by an individual qualified to administer anesthesia (not necessarily the same individual who administered the anesthesia). The evaluation must be based on an assessment of the patient and documented in the medical record within 48 hours after the administration of anesthesia and comply with State law and Anesthesia Department policies that reflect current standards of anesthesia care.

III. PHYSICIAN ORDERS

A. General Policy:

Orders must be written and signed by the attending or House Staff physician responsible for the patient's care. Upon admission to the hospital, or prior to scheduled surgical procedures and/or anesthetics, appropriate laboratory testing, ECG testing, and x-rays shall be performed according to individual departmental guidelines and the condition of the patient. No standing orders shall be allowed with respect to drug therapy.

B. Treatment Protocols/Pre-Printed Orders:

Treatment protocols and pre-printed orders shall be approved by the Medical Records and Pharmacy and Therapeutics Committees.

C. Repeat Orders:

Repeat orders for diagnostic procedures or drugs must be written with specific time frames but may not exceed seven (7) days.

D. Written Orders

1. New Orders

Treatments, diagnostic procedures, and administration of medications are carried out by a nurse upon written order of the Medical or Allied Health Professional (AHP) Staff (See Section F). Procedure manuals, located on each Nursing unit, specify aspects of various clinical procedures and whether a physician's order is necessary for implementation.

Patients shall not keep their own medications brought from home in their possession while in the hospital. Medications are sent home with the patient's family or representative. If the medications cannot be sent home, they shall be kept in the pharmacy's custody for storage during the patient's stay. (see Policy 6.09.06).

All orders must be written for the patient upon each admission, return from surgery, or transfer to a new service.

2. Patient Transition

Patient transition from one level of care to another requires review of all orders in their entirety by the treating physician or AHP with documentation of additions/deletions/revisions of orders. All discharge orders must be written in their entirety.

E. Verbal and Telephone Orders:

1. Definition: Verbal orders and telephone orders are orders for medications, treatments, interventions or other patient care that are communicated as oral, spoken communications between an authorized provider and an authorized recipient.
2. Policy: Verbal communication of orders should be limited to urgent situations where immediate written or electronic communication is not feasible.
3. Receipt of Orders: Verbal and telephone orders from authorized providers will be accepted and entered on the physicians order sheet (Moore form 602-025z) by designated staff members. The staff member taking the order shall record the order and read the order back to the authorized provider and request confirmation. Designated staff members include registered nurses, pharmacists, and respiratory therapists. Verbal and telephone orders shall be accepted by these staff members as follows:
 - a. Registered Nurses may receive and record verbal and telephone orders from an authorized provider.
 - b. Pharmacists may receive and record verbal and telephone medication orders from an authorized provider.
 - c. Respiratory Therapists may receive and record verbal and telephone orders related to respiratory therapy from an authorized provider.
4. Responsibility / Documentation:
 - a. All diagnostic and therapeutic verbal and telephone orders must be transcribed, dated, timed and signed by the authorized recipient in the patient's medical record.
 - b. The authorized recipient must document that the transcribed verbal or telephone order was read back and confirmed to the authorized provider.
 - c. The authorized recipient may abbreviate "read back and confirmed" with the initials "R&C."
 - d. Pharmacists and respiratory therapists, must notify the responsible registered nurse of any verbal or telephone orders they transcribe.
 - e. Verbal or telephone orders for restraints must be counter-signed as specified in the Medical Center Restraints policy.
 - f. Verbal and telephone orders must be counter-signed, dated and timed by the prescribing provider or an authorized provider within 48 hours. Countersignature by the prescribing physician is preferred. An authorized provider is defined as a provider responsible for the patient's care at the time the therapy is given to the patient.

5. Monitoring and Compliance:

Compliance with countersignature of verbal and telephone orders (full compliance defined as legibly signed, dated and timed within 48hrs) will be audited and reported by clinical service on a biweekly basis. Any clinical service that does not meet 100% compliance during a 2 week audit period may lose the ability to give telephone orders for up to 4 weeks.

F. Allied Health Practitioner Orders:

Orders may also be written by nurse practitioners, physician assistants and pharmacists who are functioning within their scope of practice and under Standardized Procedures approved by the Committee on Interdisciplinary Practice (CIDP) and the Executive Medical Board and are subject to the Rules and Regulations, Section Three, III.D. Written Orders.

G. Medical Students' Orders:

Medical students' orders must be counter-signed by a physician before the orders can be carried out.

H. Interns and Unlicensed Resident Orders:

1. Orders for the care of hospitalized patients written by interns and unlicensed residents will be carried out when written, except as specifically restricted (e.g. DNR or Restraints).
2. The attending physician shall write a note in the chart of each patient approving, correcting, or supplementing the recorded work-up of the intern or resident. If the patient stays more than three (3) days, the attending physician shall have a second note entered in the progress section.

I. Medication Orders:

1. Medications are available through a hospital formulary system. Copies of the Formulary are available on request and may be found at all nursing stations.
2. Drugs required for appropriate treatment that are not listed in the Formulary may be ordered with a Non-Formulary Request. This request may be approved by the chief pharmacist or designee.
3. Medication Order Writing Policy
 - a. All medication orders must contain:

date & time order was written	dose
drug name	route
strength	frequency
 - b. No blanket orders
 - c. Hold = Discontinue

A HOLD order will be interpreted to mean DISCONTINUE.

- d. Spell out medication names completely

Abbreviations for medications such as ANTIEPILEPTICS, CHEMOTHERAPY, and HIV agents are NOT acceptable.

- e.

DO	DON'T	WHY
0.4 mg	.4 mg	.4 can be misinterpreted as 4
4 mg	4.0 mg	4.0 can be misinterpreted as 40
mcg	µg	µg can be misinterpreted as mg
Unit	U	U can be misinterpreted as 0

J. Orders Not to Resuscitate (Guidelines for Foregoing Life-Sustaining Treatment):

1. Policy

- a. The policy of UCSF Medical Center is to provide high quality medical care to its patients to sustain life. The Medical Center has a standing order to initiate cardiopulmonary resuscitation for any patient who suffers cardiac or respiratory arrest. In the absence of an order not to resuscitate (DNR order), cardiopulmonary resuscitation must be initiated.

- b. Any exception to this standing order constitutes an order not to resuscitate (DNR order). A DNR order is a clinical decision that is medically, ethically, and legally appropriate under certain circumstances:

- (1) A competent informed adult patient may choose to forego attempts at cardiopulmonary resuscitation. These wishes must be respected.
- (2) When a patient lacks decision-making capacity, a surrogate decision-maker should be consulted regarding the appropriateness of cardiopulmonary resuscitation.
 - (a) When a patient has transferred authority for health care decisions in accord with the Durable Power of Attorney for Health Care Act, the designated agent has the same decision-making authority as the patient would have had.
 - (b) In the absence of a Durable Power of Attorney for Health Care, the physician should seek information from the patient's next-of-kin, family members, and friends as to what the patient would have wanted. If physicians and surrogates agree that CPR would not be wanted by the patient or is not in the patient's best interests, it is appropriate to write a DNR order.

- (c) If there are no surrogates or if the urgency of the clinical situation demands a decision before a surrogate has been located, resuscitation may be attempted or may be foregone, depending on the attending physician's assessment of the potential medical benefit of the procedure. This decision should be made in consultation with other physicians caring for the patient, including the primary care physician if available.
- (3) DNR orders may be written for minors when all of the following conditions are met:
- (a) The attending physician considers resuscitation not to be in the patient's best interest.
 - (b) Consent is obtained from the patient's parent(s) or legal guardian(s) or from a legally emancipated minor, and with assent from the minor when appropriate (e.g., older child or adolescent).
 - (c) It is the judgment of the attending physician that the patient is suffering from a severe incurable or life-threatening disease. This includes infants with severe congenital anomalies for which correction is not possible or which are incompatible with life, and extremely premature infants at or below the border of viability.
- (4) An attending physician need not provide a cardiopulmonary resuscitation if that procedure does not offer the patient any potential medical benefit. Therefore, if the physician judges that cardiopulmonary resuscitation offers no potential medical benefit, and the patient or surrogate is unwilling to forego attempts at resuscitation, a DNR order may be written without the patient's consent. In such an instance, the attending physician should ensure that all of the following are carried out:
- (a) The patient or surrogate should be informed of the DNR order; and
 - (b) Consultation with the Medical Ethics Committee or another attending physician not involved in the patient's care is required; and
 - (c) The attending physician should document in the chart his/her assessment of the probability that the patient would not survive even if resuscitation were attempted; and
 - (d) Care may instead be transferred to another physician or hospital. The patient or surrogate should be informed that transfer of care is an option.

2. Procedures

- a. When a decision has been made in accordance with the above policy that a patient is not to undergo attempts at resuscitation, a DNR order must be entered into the patient's medical record by the responsible attending physician. The order must be written on the goldenrod Cardiopulmonary Resuscitation (CPR) order sheet, Form #602-110. A verbal order from the attending physician can be entered on the order sheet, but must be signed by the attending physician within 24 hours. Such verbal orders must be witnessed by at least one other witness.
- b. The medical reasons for the DNR order, the circumstances regarding consent and discussions with the patient, family, and all consultations must be recorded in the progress notes.
- c. The DNR order must be completed to make explicit the specific medical interventions to be withheld, including, but not limited to, chest compressions, intubation, mechanical ventilation, cardioversion, and vasopressors. All other care shall be continued unless specific orders to discontinue are given.
- d. When a DNR order is entered in the order sheet, the order should be communicated to all relevant providers of care, including consultants.
- e. The circumstances justifying a DNR order shall be re-evaluated as the clinical situation changes. The results of the re-evaluation should be documented in the progress notes.
- f. When a patient is transferred from one nursing unit to another, a DNR order shall remain valid for 24 hours. Thereafter, the order must be rewritten by the attending physician.
- g. The DNR order shall stand unless explicitly rescinded by the attending physician or by the patient.

IV. AMBULATORY CARE

- A. Department Chairpersons are responsible for selecting chiefs for outpatient programs within their respective disciplines. The Chairperson, together with the clinic chief, arranges attending physician and House Staff coverage of adequate depth to provide patient care services of high quality. Attending physicians must be present during all periods that patients are examined/treated.
- B. No clinic in the Ambulatory Care Center will close on a regular business day without prior notice to the Ambulatory Care Committee and adequate arrangements for coverage.

V. EMERGENCY SERVICES

- A. Eligibility:
Emergency service is available to anyone requiring prompt care.
- B. Length of Stay in Emergency Department:

When the decision to hospitalize a patient is made, admission should be carried out promptly. Work-ups for admission to the hospital should not be done in the Emergency Department merely for the sake of convenience. It is the policy of the Medical Center that extensive evaluations, prolonged periods of observation, and extraordinary procedures or therapy will not be conducted in the Emergency Department.

C. Consultations in the Emergency Department:

Each clinical service must have a physician on call who is available to provide immediate consultation for the Emergency Department at all times.

D. Disaster Plan:

Because the Medical Staff plays an important role in disaster preparedness, members should be familiar with the Medical Center Disaster Plan and the Campus Emergency Operations Plan, and should understand their roles in disaster drills or in a real disaster.

VI. OPERATING ROOM

A. Scheduling:

1. A block system for priority, by service, will govern the scheduling of operative procedures in the Operating Rooms.
2. Abuses of the scheduling process (such as fictitious scheduling, double booking, frequent inaccurate time estimates for length of procedure) and delays by surgeon will be reported to the Chairperson of the Operating Room Committee for review and action.
3. Periodically there will be a review and assessment of the utilization of allocated block time by the Block Time Subcommittee. Subsequent reallocation of assigned block time may occur.
4. Only the first scheduled start time of the day is guaranteed to each Operating Room. Cases scheduled on a "not-before" basis do not have a guaranteed start time, although reasonable efforts will be made to accommodate these requests. It is the responsibility of the surgeon to make him/herself available at the time requested.

B. Physician Responsibilities:

1. No operation, except in an emergency, will be performed on a patient unless a history and physical examination is performed within 30 days prior to the procedure. If an H&P was performed more than 7 days prior to the procedure, an interval update must be done. (see II. Examinations).
2. It is the surgeon's responsibility to obtain surgical consent for the procedure. For details refer to Section Two, Patient Affairs, IV. Consents Permits and Legal Affairs.
3. The responsible surgeon must be immediately available to proceed before anesthesia will be induced. In emergency cases, a senior resident, after consultation with the responsible surgeon, may proceed independently with the

case, and will document the responsible surgeon's agreement to accept responsibility for the patient in the Informed Consent note in the patient's medical record.

4. The surgeon and anesthesiologist will follow the UCSF Medical Center policy for Patient Identification and Surgical/Procedural site Identification.
5. All tissues, aspirations, scrapings, and prostheses obtained from patients become the jurisdiction of the Department of Pathology. If specimens are to be shared with others interested in the specific specimen, prior arrangements must be made with the Department of Pathology. The pathologist must be notified of any division of the specimen performed in surgery. Tissues may be exempt from the above policy, provided that these have been specified in a prior, formalized agreement between the Department concerned and the Department of Pathology.
6. It is the responsibility of the surgeon to ensure that an operative report is dictated immediately following surgery. The operative report will be considered delinquent if not dictated by the end of the day following the date on which surgery was performed. The Operating Room Committee shall be empowered to take appropriate action in the case of delinquent operative reports, up to and including suspension of operating privileges.
7. If there is a conflict between the operating surgeon and the Operating Room personnel as to the wisdom of proceeding with the surgery for any reason including, but not limited to, impairment or incompetence of the surgeon, necessity for the procedure, or the medical condition of the patient, it shall be the responsibility of the attending anesthesiologist to notify the surgeon that the case will not proceed or must be terminated. If the anesthesiologist is unable or unwilling to perform this duty, the Chairperson of the Operating Room Committee, or his/her designee, should be contacted for assistance in resolving the issue.
8. The attending surgeon is responsible for obtaining temporary privileges from the Medical Staff Office for any visiting or guest surgeons who do not have current membership on the Medical Staff.
9. The surgeon is personally responsible for the return of supplies, equipment, and instruments borrowed from the Operating Rooms. Permission for removal of instruments must be secured from the OR Manager or their designee at the time of request. Payment for damages will be the responsibility of the physician or the borrowing institution.

VII. ASSESSMENT AND MANAGEMENT OF POTENTIAL SUICIDES

The attending physician with the aid of the House Staff is responsible for the evaluation of suicide risk and decision as to action to be taken, if any. This evaluation should be carried out without delay. If suicidal risk is present, the attending physician should request psychiatric consultation. Risk evaluation should be repeated as frequently as circumstances dictate. Detailed procedures appear in the UCSF Medical Center Administrative Manual.

VIII. RESTRAINTS

The UCSF Medical Staff recognizes that patients have a fundamental right to be free from restraints of any form that are imposed for coercion, discipline, convenience, or retaliation by staff. The Medical Staff also recognizes that restraining a patient may be appropriate and necessary both for patient safety and optimal medical care in certain situations.

A restraint is a device that is used to restrict the patient's freedom of movement, physical activity, or normal access to his or her body and is not a standard treatment for the patient's medical condition. The use of restraints is considered a temporary intervention employed after a thorough nursing/physician assessment. The cause of the patient behavior necessitating the use of restraints will be assessed and the least restrictive restraint device appropriate to the situation will be used. The term restraint does not apply to devices used for medical immobilization or protection (e.g., IV armboards, siderails) or to help patients maintain normal posture or balance.

- A. There are two categories of restraint use: Acute Medical/Post-Surgical Care Restraint and Behavior Management restraint.
 1. Acute Medical/Post-Surgical Care Restraint is used to restrict freedom of movement that puts the patient or others at risk for injury or interference with medical treatment necessary to promote medical healing. Use of restraints to protect a patient from pulling out lines, tubes or drains whose termination would impede medical healing is an example of acute medical/post-surgical care type restraint.
 2. Behavior Management restraint is an emergency measure that should be reserved for those situations when unanticipated, severely aggressive, violent or destructive behavior places the patient or others in imminent danger of physical harm and non-physical interventions would not be effective.

- B. Restraints require a specific, time-limited order written by a treating physician on the patient's care team (attending physician, critical care physician, resident, or hospitalist). A Restraint Order form is required to facilitate order writing. A registered nurse may initiate restraints in an urgent/emergent situation. For Acute Medical/Post Surgical Care restraint, the physician is notified as soon as possible and within 12 hours. The written order is obtained within 24 hours. For Behavior Management restraint, the physician is notified immediately and must do a face-to-face evaluation of the patient and write the order within one hour of application of restraints.
 1. Orders for acute medical/post-surgical care restraints are time-limited to not exceed 24 hours and must be renewed by the physician every calendar day after performing a face-to-face evaluation of the patient. A new Restraint Order form is used and the "renewal order" box is checked. Each order must include the type of restraint being used and the clinical justification for using restraint.
 2. Orders for behavior management restraint use are time-limited not to exceed:

- 4 hours for adults over age 18
- 2 hours for children ages 9-17 years
- 1 hour for children under age 9

The Registered Nurse evaluates the patient and may continue Behavior Management restraints with a verbal or written order by the physician at 4 hours for patients over the age of 18, at 2 hours for patient ages 9 – 17, and at 1 hour for children under age 9. The physician must perform a face-to-face evaluation of the patient every 4 hours for patients > 18 years of age and every 2 hours for patient < 17 years of age, and every 1 hour for patients 9 and younger to renew orders. Each renewal requires completion of a new Restraint Order from (“renewal order” and age-specific time limit boxes are checked). Each order must include the type of restraint being used and the clinical justification for the restraint.

- C. Patients in restraints must be observed for safety and well being by the nursing staff at least every 15 minutes. Care of the patient in restraints is outlined in the Department of Nursing Procedure Manual.
- D. The PI Measurement and assessment process at UCSF Medical Center related to restraint seeks to understand why restraint is used and to incorporate this understanding into identification of opportunities to reduce restraint use.

IX. X-RAYS

- A. A radiology examination may be ordered by a physician or AHP in accordance with the practitioner’s privileges or Standardized Procedures. The request must be in writing, containing the following information:
 1. Patient's name.
 2. Date of birth.
 3. Clinical history.
 4. Requested examination.
 5. Physician's signature and code number.
- B. Radiographic files are viewed as part of the patient's medical record. As such, they may not leave the Medical Center. High quality, diagnostically acceptable copies are provided for patient care purposes. In all situations, a written authorization from the patient is required for release of records.
- C. Radiographic records required for patient care purposes at the Medical Center may be requested from Radiology and borrowed for a 48-hour period.
- E. All radiographic records must be checked out from the film libraries. Removal of records from Radiology without benefit of said information will result in loss of Radiology privileges.

X. ORDERS FOR CLINICAL LABORATORY TESTS

Orders for a clinical laboratory test constitute a request for interpretation by a laboratory physician when interpretation is deemed necessary in accordance with Medicare regulations. Examples of such tests include review of electrophoresis and immunofixation of serum proteins, nucleic acid digests and Western blots, platelet aggregation curves, and microscopic identification of inclusion bodies, body fluid crystals, and immunofluorescence patterns.

XI. PATHOLOGY REVIEW OF OUTSIDE SLIDES

Physicians are required to have outside pathology slides reviewed by the Medical Center Pathology staff in cases where significant therapeutic decisions rely on the pathologic diagnosis. This review of outside slides must take place before interventions are initiated. It is the responsibility of the attending physician to identify cases where review of outside slides is required, and it is the responsibility of the attending physician to adjust therapeutic decisions based on the diagnosis rendered by the UCSF Medical Center Pathology staff.

XII. ADMINISTRATION OF RADIOPHARMACEUTICALS

Nuclear medicine technologists (licensed clinical laboratory technologists or registered nuclear medicine technologists) and nuclear medicine technologist trainees may be authorized to perform the following under supervision of the Head of Nuclear Medicine or an assigned and appropriately trained member of the physician staff: venipunctures for the injecting of diagnostic amounts of radiopharmaceuticals into patients in order to carry out diagnostic nuclear medicine procedures; and the compounding of radiopharmaceuticals according to approved directions from kits designed for this purpose.

**XIII. CENTRAL VENOUS CATHETER INSERTION & REMOVAL
PRACTITIONER MINIMUM COMPETENCY CRITERIA**

As part of vigilant patient safety efforts and in compliance with California law (Code of Regulations, Title 22§70739) Central Line Reporting Requirements and The Joint Commission National Patient Safety Goal to implement best practices/evidenced based infection control guidelines to prevent central line-related blood stream infections, UCSFMC Office of the CMO, Medical Staff Office (MSO) and Central Line Taskforce, have identified required, minimum competency criteria for all practitioners who insert or remove central venous catheters at UCSFMC. A Central Venous Catheter (CVC) is defined as a catheter whose tip terminates in the central venous system.

In order to independently insert and remove or supervise insertion or removal of central venous catheters, providers (residents, fellows and faculty) must demonstrate minimum competency as outlined by program specific requirements and in compliance with UCSFMC MSO Bylaws for safe and appropriate central line insertion and management.

The following outlines approved minimum insertion and removal competency criteria for adult and pediatric services.

For **Adult and Pediatric Services**, competency is demonstrated by:

1. Documented completion of the Physician Patient Safety & Quality Services: Central Venous Catheter Procedure Education and Training Module

AND

2. For **Adult Services** - documentation of at least **one** of the following:

- a. Board eligible/board certification in specialties that include CVC insertion procedure as part of the basic or delineated competencies (i.e., anesthesiology, cardiology, emergency medicine, general surgery, interventional radiology, and nephrology)
- b. Completion of one month experience/rotation in Interventional Radiology
- c. Attestation or certification by Service Chiefs or Program Directors
- d. Documented supervised insertion procedures (5 internal jugular, 5 subclavian, 5 femoral, 5 PICC).
Documented supervised removal procedures (2 non-tunneled lines)
 - Supervision will be noted via “attending signature” in the UCare CLIP Procedure Note.
 - Program Director evaluation and sign-off of competency completion.

For Pediatric Services:

- a. Board eligible/board certification or fellowship training in the following: pediatric anesthesiology, pediatric cardiology, pediatric critical care medicine, pediatric emergency medicine, neonatology (for neonates and children less than 5 kg.), pediatric surgery, pediatric cardiovascular surgery
OR
 - b. Attestation or certification by the Surgeon-in-Chief or Physician-in-Chief of the UCSF Children’s Hospital
OR
 - c. Documented supervised insertion procedures (5 internal jugular, 5 subclavian, 5 femoral, 5 PICC).
Documented supervised removal procedures (2 non-tunneled lines)
 - Supervision will be noted via “attending signature” in the UCare CLIP Procedure Note.
 - Fellowship Program Director evaluation and sign-off of competency completion.
3. Tracking of Competency: Individual programs will track completion of required components for competency. Individual programs will notify the Office of Graduate Medical Education (OGME) once a provider (resident, fellow) achieves competency. Upon completion of requirements, OGME will update the online UCSF Physician Privileges and Competencies database.