# UNIVERSITY OF CALIFORNIA
# SAN FRANCISCO

# RULES AND REGULATIONS
# OF THE MEDICAL STAFF

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## 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:

**P**rofessionalism
**R**espect
**I**ntegrity
**D**iversity
**E**xcellence

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.

D. 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.

E. 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.

F. 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.

G. 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:

a. 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.

b. Report review findings and recommendations to the appropriate Medical Center and/or Medical Staff persons or entities.

c. Review third-party payor denials, make recommendations and/or take appropriate actions.

d. Collect and analyze data necessary to carry out its responsibilities.

e. 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. INPATIENT AND EMERGENCY DEPARTMENT CONSULTATIONS

A. Inpatient Consultations:

1. The purpose of a consultation is to provide prompt and expert specialty evaluation and management advice by clinically-expert members of the medical staff. The consultation benefits the patient and meets the expectation of both the patient and requesting attending physician. The attending determines the need for an authorized consultation with other services concerning patients under his/her direct care.

2. A consultation is obligatory in the event that the patient requires clinical expertise and/or knowledge that is outside the expertise and/or clinical privileges of the attending provider.

3. The attending physician requesting a consultation is responsible for contacting the consultant physician to initiate the consultation, as well as ordering and documenting the consultation request in the medical record. This responsibility can be delegated to an appropriate House Officer (Resident or Fellow) or an Advanced Health Practitioner (AHP) with credentials to fulfill this role. Once the consultation has been completed, the attending physician requesting the consultation will review the consultation note.

4. Consultant Physician Responsibilities

   a. The consultant must have sufficient expertise in his/her specialty to make prompt and definitive management recommendations.

   b. House Officers or Fellows on the consulting service may respond to the request for consultation, perform the preliminary consultation, and prepare a consultant note. Whenever the preliminary consultation is provided by someone other than the attending consultant physician, the attending consultant physician must also examine the patient, discuss the consult with the House Officer/Fellow/AHP, review the consultation note, and provide additional documentation in the medical record.

   c. In some cases, the consultations can be provided using telemedicine. If a telemedicine consultation is proposed, the requesting attending physician must agree that a teleconsultation is appropriate and sufficient.

   d. In some cases, the consultation involves a request for a focused and straightforward service such as a specialized component of the physical examination or discussion about therapeutic or diagnostic alternatives. In such cases, the attending physician requesting the consultation may determine that the requested service can be provided by a House Officer or Fellow with the requisite specific competency. In this limited circumstance, the attending consultant physician is still required to discuss the case with the House Officer or Fellow performing the examination and provide documentation in the medical record of the discussion and proposed plan. If there is any uncertainty about the physical findings or any other aspect of the clinical situation, the attending consultant physician will perform a personal assessment. Depending on the clinical situation, the assessment may be completed by teleconsultation, if acceptable to the referring attending physician.

5. Timing of Consultations

a. The consultation by the attending consulting physician must be provided as soon as possible but no later than 24 hours from the time the consult was ordered unless the requesting provider agrees that a slower response is acceptable.

b. The attending consultant physician must review the consultation note and provide documentation in the medical record within 24 hours from the time the consult was ordered whether the consultation is provided in person or using telemedicine, except in those circumstances in which the requesting attending provider agrees that a slower response is acceptable.

6. Follow-up of Consultations

For patients requiring ongoing involvement by the consulting service, the attending consultant physician will see the patient, review the House Officer or Fellow consultation note, and provide documentation in the medical record at least every three days or more frequently if clinically appropriate.

7. For all patients who have attempted suicide or who have had self-administered chemical overdoses, psychiatric consultation will be provided. The attending physician will request a consultation from a psychiatrist on the medical staff if a patient exhibits significant psychiatric illness with acute exacerbation of symptoms or new onset of symptoms, while hospitalized, or if the attending physician believes that management of the patient is beyond his/her scope of practice.

B. Emergency Department Consultations:

1. A request for consultation from the Emergency Department shall result in a consultant physician (attending consultant physician, House Officer or Fellow) responding within 30 minutes of contact unless the attending physician ordering the consultation agrees a slower response is acceptable.

2. The possible need for additional imaging or other testing shall not delay the initial direct examination of the patient by the consultant if so requested by the ED physician requesting the consult.

3. House Officers or Fellows may respond to the order for consultation, perform the initial consultation, and prepare the consultation note. The attending consultant physician will then be contacted by the consulting physician who has seen the patient, to discuss the history, findings, and recommendation before the patient is discharged from the Emergency Department. The consultant physician will then communicate recommendations to the Emergency Department physician who requested the consultation before the patient is discharged from the Emergency Department.

4. The attending consultant physician will review the consultation note and provide documentation in the medical record within 24 hours.

5. If desired, the Emergency Department attending physician will speak directly with the attending consultant physician before a disposition decision is made for the patient.

6. The Emergency Department attending physician may request that a more senior House Officer or the attending consultant physician personally see and examine the patient. In such cases, the Emergency Department attending physician should contact the senior House Officer or consulting attending consultant physician to communicate this request.

## VIII. ACGME & ABMS RESIDENTS AND FELLOWS (HOUSESTAFF)

A. Definition:

Residents and Fellows appointed through the UCSF Office of Graduate Medical Education who are participating in an ACGME or ABMS accredited graduate medical education program.

B. Clinical Competence and Supervision of Residents and Fellows:

The clinical activities of all Residents and Fellows must be supervised by a designated faculty member. The documentation requirements for attending physician attestation are inherent in the electronic medical record. The documentation in the medical record is not complete until the attending physician completes the attestation or provides independent documentation regarding the care provided. Clinical departments may reference the Privileges and Resident Competencies website at http://echo.ucsfmedicalcenter.org/echonet/privportal/msldir.asp to ensure levels of care are provided by appropriate level of Resident or Fellow. Each Graduate Medical Education residency and fellowship program has an individual supervision policy on file with the Office of Graduate Medical Education.

Levels of Supervision:

1. Direct Supervision – the supervising physician is physically present with the resident and patient.

2. Indirect Supervision:

    a. with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

    b. with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

3. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Clinical departments may reference the GME Housestaff Information Booklet for the policy regarding Resident and Fellow supervision at http://medschool.ucsf.edu/gme/.

C. Resident and Fellow Evaluation:

Written evaluation of Residents and Fellows shall be conducted at regular intervals, preferably after each clinical rotation, but not less than quarterly. The form of the evaluation is left to the discretion of each service but should include formal review of the Resident or Fellow's competence, as defined by the following competencies:

1. Patient care
2. Medical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

Evaluations will be filed by the clinical department. Clinical departments may reference the GME Housestaff Information Booklet for the policy regarding Resident and Fellow evaluations at http://medschool.ucsf.edu/gme/.

D. In-House Coverage:

Each clinical service shall have a provider available to respond to patient care needs in a timely manner. A Resident or Fellow supervised by an attending physician may qualify to provide in-house coverage for many services. Examples of providers who can fulfill this requirement include Attending Physicians, Residents, Fellows, AHPs, etc. The Executive Medical Board will identify which clinical services must have a provider onsite at all times, and which clinical services do not require onsite coverage. When in-house coverage is not required, each service will identify how emergency clinical situations will be managed until the Attending physician or other qualified member of service is available.

E. Duty Hours:

Programs and sponsoring institutions must educate Residents, Fellows and Faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. Each program must be compliant according to ACGME duty hours guidelines. Clinical departments may reference the ACGME website for specific program rules at http://www.acgme.org/acWebsite/navPages/nav_comRRC.asp.

Programs must educate all Faculty members, Residents and Fellows in alertness management and fatigue mitigation processes and to recognize the signs of fatigue and sleep deprivation. Programs must also adopt fatigue mitigation processes to ensure continuity of patient care in the event that a Resident or Fellow may be unable to perform his/her patient care duties.

F. Transitions of Care:

Each clinical service must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Handoff requirements vary considerably across programs and clinical settings. Each program must ensure that its Residents and Fellows are competent to provide appropriate communication with team members in the hand-over process. Clinical departments may reference the GME website for specific program rules at http://medschool.ucsf.edu/gme/. Faculty oversight of the handoff process must be provided, but can occur directly or indirectly, depending on trainee level, clinical competencies and experience. While the electronic health record (APeX) and other database systems can be used to support the transfer of information, the responsibility for appropriate communication of clinically relevant information resides with the providers.

G. Communication:

Each ACGME and ABMS Graduate Medical Education residency and fellowship program has an individual communication policy that clearly states when a Resident or clinical Fellow must contact an attending in the course of providing patient care. Residents and Fellows as individuals must be aware of their own limitations. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible attending physician may result in the removal of a Resident or Fellow from patient care services. Clinical departments may reference the following GME link to access individual program communication policies at https://na1.salesforce.com/sfc/p/30000000mjY4KwgGlUTWvagZ3hwVRXEFHcw5mI4=.

## IX. NON-ACGME & NON-ABMS FELLOWS

Non-ACGME and Non-ABMS Fellows are appointed by their Clinical Department. If consistent with the requirements of the fellowship program, the Department may also appoint the Non-ACGME or Non-ABMS Fellow to a faculty appointment. In this circumstance, the Fellow may be eligible for appointment to Active UCSF Medical Staff. Non-ACGME or Non-ABMS Fellows must request Medical Staff membership and privileges from the UCSF Medical Staff Office.

# SECTION TWO: PATIENT AFFAIRS

## I. MEDICAL RECORDS

A. Definition, Ownership, Control:

1. Medical records are legal documents under the custody of the Health Information Management Services (HIMS).

2. These rules and regulations related to the Medical Record apply to all forms of documentation in the Medical Record including documentation in the electronic health record (EHR) and all the paper medical

records.

3. Information may not be released from the medical record nor copies made of the entire medical record 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 provider.

4. Release of information included in the Medical Record may be provided under certain circumstances. A provider may release a subset of data such as immunization records, a recent set of laboratory study results, or interpretation of diagnostic imaging studies to a patient or approved guardian or family member through the electronic health record release of information, if the patient is in enrolled in MyChart. Documents can be personally provided to the patient if this release is documented in the EHR. Alternatively, information can be provided after a formal request is made to HIMS and a release of information request form is completed by the individual requesting such information.

5. Use of medical records for research shall be governed by procedures adopted by the Medical Records Committee and approved by the Executive Medical Board and by the UCSF Committee on Human Research (CHR).

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 and between Medical Center personnel and referring providers and primary care providers.

2. Medical records must be documented into the Medical Center's EHR, electronically signed and up-to-date.

3. Ambulatory providers will check their In Basket at minimum each business day. In Basket messages will be reviewed, triaged and acted upon as appropriate. When an In Basket is shared for coverage, the In Basket "owner" is still responsible to ensure that overall tasks and messages were completed and follow up occurs.

4. Inpatient providers or those who are on inpatient services must check their In Baskets daily while on service and as long as necessary when they are off service until all follow-up clinical activity has been completed. When an In Basket is shared for coverage, the In Basket "owner" is still responsible to ensure that overall tasks and messages were completed and follow up occurs.

5. All electronic messages between providers and patients or their proxy should be done through a medical center approved patient portal that is integrated into the patient's medical record.

6. All clinically relevant patient-related electronic communications between providers within the medical center should be documented within the EHR. Email is discouraged especially when clinically relevant information would best be available to all members of the care team.

7. For inpatient medical records, a provider must:

    a. Document orders for all medications and other treatment.
    b. Document 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.
    c. Document a consultative note within 24 hours and as defined by the Rules and Regulations.
    d. Indicate the admitting diagnosis at the time of admission, and note 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.
    e. Enter a daily progress note by the treatment team.
    f. Document by the attending physician that they have seen and examined the patient a minimum of every three (3) days.
    g. Document any imaging study performed at UCSF and used for diagnostic or therapeutic

purposes.

h. If the full operative or other high-risk procedure report cannot be entered into the record before the patient leaves the procedure suite, a brief operative note must be entered upon completion of surgery, before the patient is transferred to the next level of care. If there is a brief operative note, it must include the following information, all of which must also be included in the full operative note:

1) Name(s) of surgeon(s) or provider(s) who performed the procedure,
2) Name(s) of surgical assistant(s),
3) Name of the procedure performed,
4) A description of each procedure finding,
5) Any specimen(s) removed,
6) Preoperative and postoperative diagnosis,
7) Type of Anesthesia,
8) Complications, and
9) Estimated blood loss.

The Brief Operative note may be written by any member of the surgical team (i.e. resident or fellow).

i. The expectation is that discharge summaries are completed within 24 hours and cosigned within 48 hours of discharge. All inpatient stays >48 hours are required to have a discharge summary within 14 days to complete the inpatient chart. For all discharge summaries completed by residents, fellows and allied health professionals, an attending physician must review and co-sign the discharge summary.

j. This discharge summary should contain reason for hospitalization; significant findings; procedures performed and treatment rendered; condition of the patient on discharge; reconciled medications and specific instructions given to the patient and/or family particularly in relation to physical activity, medications, diet, and follow-up care. This discharge summary must be messaged, faxed, or mailed to the referring and/or primary care providers upon completion.

8. For ambulatory medical records, a provider must:

a. Document a complete visit encounter which must include a chief complaint, a progress note, a visit diagnosis, and a level of service.
b. Document allergies, a complete medication list, and an active problem list either within the EHR visit navigator (the preferred method) or within the body of the progress note.
c. Document orders for all medications and other treatment.
d. Send ambulatory consultations via a message, fax or letter to the referring provider within fourteen (14) days.
e. Close all visit encounters within fourteen (14) days.

9. Auto-populated information must be reviewed for timeliness and accuracy prior to signing the note.

10. Attending providers may choose to create their own documentation, edit documentation pended by Residents and Fellows, and/or choose to attest to office visits, admitting H&P, progress notes, discharge summaries, and/or operative/procedure reports completed by Residents and Fellows. When the attending provider is attesting to a note, they must confirm all the data are accurate and relevant to the current patient situation.

C. Completion of Medical Records:

1. A medical record may be considered incomplete if it is missing a history and physical examination, discharge summary or operative report.

2. The attending physician will be responsible for the completion of records of his/her patients.

3. 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.

4. Administrative suspension and/or referral to the UCSF Medical Staff Committee on Professionalism may result from failure to:

    a. Complete discharge summaries within fourteen (14) days after patient discharge
    b. Complete full operative reports within forty-eight (48) hours of a surgery or procedure
    c. Complete documentation required for ambulatory encounter closure within fourteen (14) days of a patient visit or procedure
    d. Close ambulatory encounters within fourteen (14) days of a patient visit or procedure.

## 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 at http:// infectioncontrol.ucsfmedicalcenter.org/. UCSF Medical Staff membership requires compliance with Infection Control and Safety Precautions/Environment of Care programs.

Included in the requirements:

A. 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/

B. 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.

C. 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.

D. 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/

E. 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

F. 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/2004ECBloodbornePathogens.pdf

G. 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

A. 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:

1. Safety Management and Administration
2. Security
3. Hazardous Materials and Hazardous Waste Management
4. Emergency Management
5. Fire and Life Safety
6. Medical Equipment Management
7. Utilities Management

B. 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, CONSENT FORMS, AND LEGAL AFFAIRS

A. Consents and Consent Forms

1. General Consent

General consent for ~~to~~ medical ~~or surgical~~ treatment via the Terms and Conditions of Admission 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 that require informed consent.

2. Informed Consent for Surgical and Diagnostic, Therapeutic and Surgical Procedures

    a. The attending physician or provider who has obtained procedural competency – as defined in the Medical Staff Policy on Informed Consent -- must fully inform the patient about the nature and benefits of the procedure to be done, the alternative methods, and the potential complications or risks. 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 absent a true medical emergency.

    b. Documentation of Consent: It is the responsibility of the attending or provider who has obtained procedural competency 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 advance of the procedure (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 consent form and the documentation of consent in the progress notes must be completed and signed before a patient goes to the Operating Room or before the procedure begins. Procedures will not commence before both types of documentation are complete.

d. Specific details for consent are found in the Medical Center's Policy on Informed Consent. Examples of procedures requiring consent are:

1) All major or minor surgeries/procedures require consent. There must be a valid consent form for each procedure or operation.

2) Any procedure involving general anesthesia, or moderate or deep sedation.

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) Administration of investigational drugs.

7) Blood Transfusion

e. Other situations that require consent include:

1) Release of information to the press or media and the taking of photographs, films, or televised pictures or tapes for teaching or research purposes.

2) Participation in clinical research protocols.

3. Implied Consent

In an emergency that threatens the life or health of a patient, when the patient is unable to consent, treatment of the emergent condition without 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 orthopedic procedures. Treat the emergency only.

b. Assess the possibility of obtaining the necessary written consent, weighed against the possibility that delay would jeopardize the health of the patient.

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 Consent

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 includes: 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. SMOKE-FREE ENVIRONMENT

The Medical Staff supports and reinforces the UCSF Medical Center policy to provide a smoke-free environment for patients, staff and visitors at UCSF Medical Center and throughout UCSF. Smoking is not allowed by anyone, including but not limited to patients, staff, visitors, vendors, medical staff, housestaff, trainees, volunteers, students or members of the community within any enclosed building or facilities (including parking) and all outdoor areas of UCSF. There are no designated smoking areas on the UCSF Campus.

These Rules and Regulations incorporate by reference the following in its entirety: UCSF Medical Center Policy #1.01.19: Smoke Free Environment at http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/SmokingRestrictions.pdf.

## XI. NAMETAGS

Providers are required to wear an official UCSF-issued photo identification (ID) while on duty to permit ready

identification by patients, families, visitors and staff.

## XII. PATIENT INFORMATION: PRIVACY AND SECURITY

A. Access, Use, and Disclosure of Patient Protected Health Information:

It is the policy of UCSF to protect the privacy and confidentiality of personal information, including Protected Health Information (PHI), when it is created, transmitted, and/or stored in any medium, including electronic systems, and to ensure that the handling of such information is consistent with federal and state laws and regulations and University policies.

PHI may be accessed, used, or disclosed for Treatment, Payment, and Operation (TPO) purposes:

1. Treatment:
   Providers on the health care team may access the medical record, or parts of it, based on their "need to know" for treatment purposes. Providers should not access the medical record for personal reasons, such as accessing a family member's record without the documented authorization of the patient. This is also applicable to adolescents, even if the adolescent is the provider's child, as authorization is required per law. Note: The patient's authorization to release health information is maintained in the patient's record.

2. Payment:
   PHI may be used and disclosed for purposes of billing and collecting payment from the patient, an insurance company, or a third party for medical treatment and services provided to the patient.

3. Operations:
   PHI may be used and disclosed for operational purposes, such as quality of care, research, UCSF health education and/or medical staff activities. Refer to the Medical Center Notice of Privacy Practices for a description of permissible uses and disclosures for operational purposes.

   a. For quality of care purposes, refer to the applicable policies pertaining to access and release of information for quality purposes.
   b. For research purposes, refer to Medical Center Policy 5.01.06, "Control of Access to and Release of Information from UCSF Medical Center Information Systems for Research Purposes"
   c. Written authorization is required to use and/or disclose patient photographs for research, external teaching, marketing, advertising and media. For other purposes, refer to Medical Center Policy 6.02.01, "Consent: Photography".

***For Payment and Operations purposes, providers may access only the minimum necessary information needed to accomplish that purpose. For rules governing medical records, see Medical Records Rules & Regulations (Section 2.1).

B. Privacy Controls:

1. Providers may only use mobile computing devices (e.g., laptops, mobile phones, tablets, memory sticks) that are **encrypted** with an approved UCSF data encryption solution before using them for any purposes involving PHI or other sensitive information.

2. Providers should be mindful in transporting paper documents containing PHI off campus, and to make sure they are always secure and are retained within one's exclusive control.

3. Providers should be mindful of not speaking about patients or disclosing PHI where the conversation may be overheard including, but not limited to elevators, shuttles, or in open registration or treatment areas.

4. Providers may not share their User ID and/or password with any other person and must keep their password confidential.

5. A provider's User ID(s) constitutes their signature and the provider is responsible for all entries made under his/her User ID(s).

6. Providers shall immediately report any unauthorized access, use or disclosure of PHI to the Privacy Office at (415) 353-2750.

C. **Compliance with Laws and Regulations**

1. In order to protect the privacy and confidentiality of personal information and protected health information, all providers must follow federal and state laws and regulations, including HIPAA, HITECH and California Civil Code § 56.10 (Confidentiality of Medical Information Act "CMIA") and California Health & Safety Code § 1280.15 as well as all applicable Medical Center and University policies regarding access to and releasing of patient information. For details refer to UCSF Medical Center Policies. See resources below.

2. The Medical Staff, Medical Center and/or University may initiate corrective action, up to and including termination or release during probation, when a provider has violated UCSF patient privacy or confidentiality policies and procedures. In addition, providers may be individually liable for any civil or criminal actions, administrative penalties or attorneys' fees the University incurs to defend UCSF in such cases.

D. **Resources:**

1. UCSF Medical Center Notice of Privacy Practices: http://www.ucsfhealth.org/pdf/3-03ucsfhipaa.pdf

2. UCSF Privacy and Confidentiality Handbook: http://hipaa.ucsf.edu/Privacy%20Handbook.pdf

3. UCSF Confidentiality Statement (also found at the end of the Handbook): http://hipaa.ucsf.edu/education/downloads/ConfidentialityStatement.pdf

4. UCSF Privacy and Security Survival Tips: http://hipaa.ucsf.edu/education/privacy/downloads/UCSF%20Privacy%20and%20Security%20Survival%20Tips%20Brochure.pdf

5. UCSF Medical Center Policy No. 5.02.01, Confidentiality, Access, Use and Disclosure of Protected Health Information and Patient Privacy: http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/ConfidentialityAccessUsePHI.pdf

6. UCSF Medical Center Policy No. 5.01.04 Information Security and Confidentiality Policy: http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/InformationSecurityConfidentiality.PDF

7. UCSF Medical Center Policy No. 6.02.01 Consent: Photography: http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/ConsentforMedicalPhotography.PDF

8. UCSF Medical Center Policy No. 5.01.06: Control of Access to and Release of Information from UCSF Medical Center Information Systems for Research Purposes http://manuals.ucsfmedicalcenter.org/AdminManual/IndividualPolicies/ControlAccess2Info.pdf

9. UCSF Medical Center Policy No. 1.03.07 Press Policy: http://manuals.ucsfmedicalcenter.org/AdminManual/IndividualPolicies/PressCode.pdf

10. UCSF Policy No. __ Workforce Sanctions for Patient Privacy Violations

11. UCSF 650-16 Information Security and Confidentiality Policy: http://policies.ucsf.edu/policy/650-16

12. UCOP IS-3 Electronic Information Security: http://policy.ucop.edu/doc/7000543/BFB-IS-3

13. UCSF Social Media Guidelines: http://www.ucsf.edu/about/social-media-guidelines

14. UCSF Advanced HIPAA Healthcare Provider Module in the Learning Management System (employee ID required to login): https://learningcenter.ucsfmedicalcenter.org/?activity=14017

15. Resources related to password sharing:

    a. Unified UCSF Enterprise Password Standard: http://it.ucsf.edu/policies/unified-ucsf-enterprise-password-standard-0
    b. UCSF Medical Center Policy No. 60.009 Workstation Use and Security Procedure
    c. UCSF Medical Center Policy No. 60.011 System Access Controls Procedure

## 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.

## XIV. DISCONTINUATION OF PATIENT-PROVIDER RELATIONSHIPS

It is the policy of UCSF Medical Center to make all reasonable efforts to prevent and/or resolve problems between providers or staff and patients prior to considering discontinuance of care. A decision to discontinue the care to a patient will include consideration of both the patient's health care needs and the obligations of UCSF Medical Center related to the safety of its employees, visitors and patients and responsible use of institutional resources. For details refer to UCSF Medical Center Policy #6.03.03: Discontinuation of Care at http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/DiscontinuationofCare.pdf.

# 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. HISTORY AND PHYSICAL (H&P)

A. A history and physical (H&P) is required for:

1. Inpatient admissions, the patient's history and physical examination must be documented in the medical record and signed to by an attending physician within 24 hours of admission. H&Ps performed within 30 days prior to admission as an inpatient must be documented in the medical record and updated within 24 hours after admission**.** If the H&P is older than 30 days, a new full H&P must be performed. However, if a surgery or procedure is planned, the H&P should be done before the surgery or procedure requiring anesthesia services.

2. Surgical[1] or other diagnostic or therapeutic procedures performed under anesthesia (regional and/or general anesthesia, monitored anesthesia care (MAC) or deep sedation) require a history and physical to be performed within 30 days prior to the surgery or procedure and documented in the medical record. If the H&P was performed more than 24 hours prior to the procedure, an interval update must be completed after registration, or inpatient admission, and no more than 24 hours prior to surgery or a procedure requiring anesthesia services and documented in the medical record. An interval update includes:

    a. Any changes in the patient's condition since the last H&P was performed,
    b. An appropriate condition-specific physical examination,
    c. Documentation of the pre-op diagnosis.

3. To fulfill this requirement, H&Ps must be performed by practitioners who have been granted the privilege to do so.

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[1] CMS (CMS Conditions of Participation/State Operations Manual; Appendix A; Tag A-0904; Section 482.51) definition of "surgery" means the following:

> Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.

B. A comprehensive history and physical examination is required for all inpatient admissions and for patients undergoing surgery or diagnostic procedures involving general or regional anesthesia, deep sedation, or monitored anesthesia care (MAC), and includes, at a minimum, the following information (or a statement that the information is unobtainable or not applicable):

Comprehensive H&P defined as:

1. Chief complaint
2. History of present illness
3. Identification of allergies
4. Current medications
5. Past medical and surgical history
6. Family history
7. Social history
8. Review of systems (must include heart and lung)
9. Physical examination
10. Assessment
11. Treatment plan

The comprehensive H&P, as defined above, may be completed by multiple providers in separate documentation. For example:

- A PREPARE history,
- An anesthesia examination to include airway, heart and lung examination and other physical assessment performed and documented within 24 hours prior to surgery, and
- An appropriate condition-specific examination of the body part being operated on as documented in the interval note.

The extent of the physical examination will be determined by the clinical context or the nature of surgery/procedure planned. The documentation will include clinically relevant information including the patient's co-morbidities, the patient's condition, and the procedure(s) being performed.

The interval H&P must include an appropriate condition-specific examination of the body part being operated on. Interval H&P must be completed prior to the patient's procedure and before the patient enters the operating room and must be signed by the attending proceduralist. For procedures taking place outside of the operating room, the interval H&P may be completed at the bedside, but prior to the procedure and before administration of anesthesia/sedation.

C. A focused history and physical examination may be conducted for procedures performed under moderate sedation.

1. The focused H&P includes the following information:

    a. A review of systems with documentation of clinically relevant information.
    b. Patient history
    c. Identification of allergies
    d. Current medications
    e. Cardiovascular and respiratory assessment
    f. An assessment of the system or body part undergoing intervention

2. The focused H&P must be conducted within the preceeding 30 days, with an interval update if the H&P was performed more than 24 hours prior to the procedure.

The documentation will include clinically relevant information including the patient's co-morbidities, the patient's condition, and the procedure(s) being performed.

D. For those surgeries or procedures in which minimal sedation, local anesthesia or no anesthesia is used, the H&P must include at least the following information:

1. Documentation of the plan for the procedure(s)
2. Identification of allergies
3. Current medications
4. An assessment of the system or body part undergoing intervention with documentation of clinically relevant information including co-morbidities.

The documentation will include clinically relevant information including the patient's co-morbidities, the patient's condition, and the procedure(s) being performed.

E. For recurring radiation oncology or other therapeutic procedures that are part of a planned course of therapy, a H&P will be done at the beginning of the course of the therapy, and updated as indicated, based on the patient's condition.

F. The H&P may be performed by any member of the medical staff who has been granted clinical privileges to perform an H&P.

G. History and Physicals performed by Non-Physicians: Individuals who are not licensed independent practitioners (non-LIPs) who have been granted privileges to do so may perform a history and physical under the responsibility and accountability of a physician and pursuant to the non-LIP's scope of or practice (e.g., Residency Competency, AHP Standardized Procedures or Privileges). Clinical findings that require additional consultation with the Supervising Physician must be completed by the Non-LIP.

H. Any patient receiving anesthesia (regional and/or general anesthesia, monitored anesthesia care (MAC) or deep sedation) 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: Physician 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:

1) date & time order was written
2) dose drug
3) name
4) route
5) strength
6) 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 procedures to be performed in the Operating Rooms.

2. 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.

3. 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 Chair of the Operating Room Committee for review and action.

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. Attending Surgeon Responsibilities:

In the interest of patient safety and operating room efficiency, a unique qualified surgeon must be either physically present or immediately available for each case, at all times, in the UCSF Medical Center Operating rooms.

1. No procedure, 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 24 hours prior to the procedure, an interval update must be completed (see UCSF Medical Center Rules and Regulations, Section Three, Article II, Examinations/H&Ps).

2. It is the ***attending*** surgeon's responsibility to document that consent has been obtained for the procedure. (For details refer to UCSF Medical Center Informed Consent Policy at http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/InformedConsent.pdf.)

3. The ***attending*** surgeon must be immediately available to proceed before anesthesia will be induced. The attending surgeon and anesthesiologist must be physically present in the operating room for the pre-procedure time-out verification. In emergency cases, a senior resident, after consultation with the attending surgeon, may proceed independently with the case, and will document the attending surgeon's agreement to accept responsibility for the patient in the informed consent note in the patient's medical record.

4. The attending surgeon and anesthesiologist will follow the UCSF Medical Center policy for Patient Identification and Surgical/Procedural Site Identification.

5. The attending surgeon or a designated alternate attending surgeon will be physically present for all critical portions of the operative procedure. The attending physician or a designated alternate attending surgeon must be able to be present in the operating room for the entire duration of the procedure, the end of which is defined as the transition to a postoperative care setting.

6. It is the primary attending physician's responsibility to designate a qualified alternate attending surgeon based on the procedure, and if the alternate is unavailable, to find another alternate attending surgeon. In cases where the attending surgeon expects a priori to be unavailable for any portion of the procedure (as in simultaneous or overlapping booking), the name of the designated alternate attending surgeon must be announced during the pre-procedure time-out. In the event of any change in status of the designated alternate attending surgeon during the procedure (e.g. becomes involved in a different case), nursing and anesthesia staff are to be notified immediately of the identity of a new designated alternate attending surgeon.

7. An alternate attending surgeon must also be designated for an urgent or emergent add-on case that will start while the attending surgeon is the surgeon of record and participating in the care of a patient in another room. The name of the alternate attending surgeon must be provided prior to anesthesia induction for the add-on case. Nursing or anesthesia staff may confirm that the alternate attending surgeon is immediately available prior to induction of anesthesia for the second case. Exceptions may be allowed in immediately life threatening cases.

8. OR Staff (nursing, anesthesia) may contact the designated alternate attending surgeon directly under the following circumstances:

    a. Primary surgeon incapacitated or otherwise unavailable for a case in progress and attending presence is required.

    b. Urgent change in medical status of a patient where the primary surgeon is not present or immediately available.

9. In the case of Team Surgery, in which more than one surgical service is involved in different portions of a procedure, the attending surgeon will transition from one service to another during the case. The primary surgeon (case booking) is the default responsible attending if there are any gaps in such transitions.

10. All tissues, aspirations, scrapings, and prostheses obtained from patients become the jurisdiction of the Department of Pathology. The pathologist must be notified of any division of the specimen performed in surgery. Tissues may be exempt, provided that these have been specified in a prior, formalized agreement between the Department concerned and the Department of Pathology (see UCSF Medical Center Exempt and Gross-Only Tissues Policy at http://ucsfpolicies.ucsfmedicalcenter.org/PeriOperative%20Services/ML_OR/04ExemptTissue.PDF).

11. It is the responsibility of the surgeon to ensure that an operative report is documented immediately following surgery. The operative reports will be considered delinquent if not documented 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 the recommendation of suspension of operating privileges to the President of the Medical Staff.

12. The attending surgeon is responsible for obtaining confirmation from the Medical Staff Services Office that temporary or visiting privileges have been granted (in accordance with UCSF Bylaws of the Medical Staff, Article 3, Section 3.11.2, Visiting and Temporary Privileges) for any visiting or guest surgeons who do not have current membership on the Medical Staff and participate in the patient's care.

13. The surgeon is personally responsible for the return of supplies, equipment, and instruments borrowed from the Operating Rooms for non-clinical or non-UCSF purposes. Permission for removal of all instruments must be secured from the OR Manager or his/her designee at the time of request. Payment

for damages will be the responsibility of the physician of the borrowing institution.

14. Violation of these responsibilities may lead to loss of designated block time to the attending surgeon's service, and possible suspension of operating room privileges. The Operating Room Committee shall be empowered to revoke designated block time, and may recommend to the President of the Medical Staff suspension of operating privileges.

C. Managing Differences of Opinion or Concerns Among Operating Room Personnel:

1. If there is a conflict between the operating surgeon, anesthesiologist or other Operating Room personnel as to the wisdom of proceeding with the surgery for reasons related to patient preparation, the medical condition of the patient, necessity for the procedure, or ethical concerns (eg; willingness to accept blood products, limitations to resuscitation), the participating providers will resolve all outstanding issues prior to induction of anesthesia. If they cannot resolve areas of disagreement, the Perioperative Medical Director will be notified to assist in clarifying the issues and facilitating resolution.

2. If concerns are raised by any Operating Room personnel about possible impairment or incompetence of any provider, the Perioperative Medical Director or designee will be contacted immediately to assist in determining whether a procedure should be terminated or alternative providers identified to assist in the care of the patient.

D. Retained Foreign Object:

A retained foreign object is defined as any object unintentionally left in a patient at any point after surgery ends.

1. Any count discrepancy is treated as an incorrect count. When a discrepancy is identified the attending surgeon will be notified immediately.

2. If an initial search, wound exploration and x-ray, read by an attending radiologist, do not resolve the count discrepancy the attending surgeon or his/her designated alternate attending surgeon will return to the operating room.

3. The attending surgeon or designated alternate attending surgeon is responsible for determining next steps in the process of locating the missing item including re-exploration, further imaging, etc.

4. The attending surgeon will document the final outcome regarding the count discrepancy in the medical record.

Clinical departments may reference the UCSF Medical Center Prevention of Retained Foreign Bodies Policy at
http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/PreventionRetainedBodies.pdf.

## 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.

D. 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, Western blots and other molecular diagnostic tests, platelet aggregation curves, and microscopic identification/classification of cells, inclusion bodies, body fluid crystals, and immunofluorescence patterns.

## XI. OUTSIDE DIAGNOSTIC STUDIES

Many patients seen at UCSF come for advice or treatment of conditions for which the interpretation of diagnostic or other testing has been performed at other institutions. These may include interpretation of pathology specimens with histopathology or molecular analysis, clinical laboratory testing and diagnostic imaging. It is the responsibility of the treating clinician to make a decision, based on a review of the risks, benefits and alternatives as to whether interpretations of outside tests should be independently confirmed at UCSF. Unless the treating physician is confident of the diagnosis upon which treatment is planned, consultation with the appropriate department is strongly recommended. The UCSF provider should make a decision with the patient whether to independently confirm the interpretations of the outside results. The outcome of the discussion must be clearly recorded in the patient’s electronic health record (EHR).

In deciding whether formal review is necessary, the treating clinician should consider not only the interpretation provided but other parameters including adequacy of the specimen, appropriate selection of diagnostic methodology, the subjective nature of test interpretation and the clinical complexity of the case.

When re-interpretation of outside tests or materials is indicated, a formal request must be submitted to the relevant department and a written order must be recorded in the electronic health record (EHR).

## XII. ADMINISTRATION OF RADIOPHARMACEUTICALS

Nuclear medicine uses a variety of radiopharmaceuticals to detect biologic processes and to treat different diseases. The diagnostic use of nuclear medicine procedures involves the administration of very small amount of radioactivity, with minimal risk to staff personnel and patients. The therapeutic use of sealed and unsealed radiopharmaceuticals deliver higher amount of radiation exposure. To prevent any undesirable effects the nuclear medicine radiation safety officer will communicate well in advance with the patient and/or family and, where appropriate, to the parents and/or legal guardian, including but not limited to explaining the procedure, patient involvement, length of stay, and radiation safety issues. When appropriate, telephone consult with the nuclear medicine technologist (licensed clinical laboratory technologist or registered nuclear medicine technologists) under supervision of the Head of Nuclear Medicine, or a designated qualified alternate, will be undertaken prior to the radiopharmaceutical being administered.

Prior to leaving UCSF Medical Center, the patient must attest to knowledge of specific precautionary measures that must be followed (for example, identifying appropriate accommodations) after therapeutic administration. This attestation is obtained by the Radiation Safety Officer or treating clinician.

For details refer to Society of Nuclear Medicine Scope of Practice and Clinical Performance Standards at http://interactive.snm.org/index.cfm?PageID=2637.

## XIII. SEDATION ADMINISTRATION BY NON-ANESTHESIOLOGISTS

A. Minimum requirements exist for the delivery of sedation for any purpose, by any route and to all patients in accordance with federal and state laws and regulations, The Joint Commission accreditation standards and professional guidelines.

B. Definitions:

The following definitions are from "Definition of General Anesthesia and Levels of Sedation/ Analgesia" approved by the American Society of Anesthesiologists in 1996 and incorporated into The Joint Commission standards:

**Minimal Sedation (Anxiolysis)**: a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

**Moderate Sedation/Analgesia**: a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

**Deep Sedation/Analgesia**: a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully* following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

**Anesthesia**: general anesthesia and spinal or major regional anesthesia. "Anesthesia" does NOT include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

**Monitored Anesthesia Care (MAC):** does not describe the continuum of depth of sedation, rather it describes "a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure."

C. Administration of more than Minimal Sedation requires specific competencies. For details refer to UCSF Medical Center Policy #6.07.01: Sedation Administration by Non-Anesthesiologists at http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/SedationAdministrationNon-Anes.pdf.

# SECTION FOUR: GOALS OF CARE

## A. Definitions

**Advance Health Care Directive:** An Advance Health Care Directive (AD) is a document that enables adult patients (and in the case of minors, those who are legally emancipated by court order, marriage or serving in the armed forces) to:

1. document their wishes regarding care and life sustaining treatment,

2. choose to forgo future medical interventions (including the right to refuse life-sustaining treatment), or
3. designate another person to make health care decisions if he/she loses decision-making capacity (surrogate decision-maker).

**Capacity to make health care decisions:** A patient's ability to understand the nature and consequences of a decision and to make and communicate a decision. It includes, in the case of proposed health care, the ability to understand the significant benefits, risks and alternatives of a chosen plan of care. The patient's physician should determine whether a patient has the capacity to make health care decisions. Conditions for which psychiatric or psychological treatment may be required do not, in and of themselves, constitute a lack of capacity to make health care decisions.

The **Palliative Care** plan is designed to prevent and relieve suffering by early assessment and treatment of pain and other physical, psychosocial and spiritual issues or concerns. It is developed in collaboration with patients, family and care team in the setting of a transition from aggressive management of disease to palliative goals of care.

**Legal Emancipation:** A minor 15 years of age or older who has been granted emancipation by court, marriage or service in the armed forces. This is generally documented by an identification card issued by the Department of Motor Vehicles that states that the minor is emancipated or, as applicable, a Self Sufficient Minor form. (See UCSF Medical Center Policy #6.02.02: Informed Consent.)

**Physician Order for Life Sustaining Treatment (POLST)**: A POLST is a patient-generated document that supplements an Advance Health Care Directive by expressing the patient's wishes regarding care and life sustaining treatment. In the ambulatory setting, the POLST serves as an order. In the hospital setting, the POLST suggests the physician will assess the patient and issue orders as indicated.

**Surrogate:** The person whom the patient has designated to make medical decisions in the event that he or she lacks the capacity to do so. A surrogate decision-maker can be an agent appointed in an advance health care directive, ~~or~~ a durable power of attorney for health care, a court appointed conservator of the person, a family member, a domestic partner, or persons with whom the patient is closely associated.

## B. General Considerations

1. A patient's health care team, led by his or her attending physician, is responsible for guiding the decision-making process in consultation with other specialties and services as needed. This includes involving the patient or surrogate in discussion of the goals of care.

2. In the course of clinical care, a transition from active management of disease to palliative care may occur. During these transitions, the primary team should discuss goals of care and therapeutic options with the patient and/or surrogate. Based on the discussion, any changes in goals of care should be documented by the attending physician in the patient's UCSF Medical Record. In many cases, discussion with a multi-disciplinary care team including consulting services and in some cases the Palliative Care Team and Ethics Committee, may be helpful in clarifying goals of care and making decisions about further options.

3. All admitted patients are to be offered the opportunity to complete an advance directive pursuant to UCSF Medical Center Policy #6.04.01: Advance Health Care Directives/POLST. A patient may provide a POLST to the UCSF Medical Center Medical Staff Physician as guidance regarding decisions about end of life care. Unlike in many other settings, POLST forms do not serve as orders prescribing the care of inpatients. Providers should review existing POLSTs with the patient or surrogate in the context of their current medical situation and goals of care. Any decisions regarding CODE status or other medical interventions must then be both documented in the UCSF Medical record and written as orders. If the guidance provided by the POLST is appropriate, those orders must be re-written in the UCSF Medical Record in order to be carried out/observed.

## C. Resources

1. Ethics Consultations

Ethics Consultations can be helpful when decisions about end of life care are particularly challenging. They are required by policy if the patient's family or surrogate decision maker disputes the attending physician's proposed withdrawal of life sustaining interventions or change in code status. Any member of the patient care team (including the patient or patient surrogate decision-maker) may call the Ethics Committee consultation service to request a formal consultation. Consultation can be obtained by calling the hospital operator and asking for the number of the on-call ethics consultation team.

2. Palliative Care

   a. Providers should be aware that UCSF Medical Center provides, and encourages providers to use, consultation services to staff and patients to assist with symptom management and defining goals of care in seriously ill patients. These services are provided by the Adult Palliative Care Service and the Integrated Pediatric Pain and Palliative Care Team.

      A Palliative Care Team is available for consultation to support the patient, family and staff. Consultations may be requested by calling:

      1) Adult Palliative Care Service
      2) Integrated Pediatric Pain and Palliative Care Team (Pediatric Comfort Care Suites); Compass Care Office

   b. Palliative Sedation

      Palliative sedation is the use of medications to intentionally induce sedation in a patient with intractable physical symptoms refractory to aggressive medical care, in an effort to provide relief from those symptoms. Providers are encouraged to consult with the Palliative Care Service regarding the use of palliative sedation. (See UCSF Medical Center Policy #6.07.04: Adult Palliative Sedation.)

## D. Decision Making Process

1. All patients adult and pediatric, should, to the extent possible, participate in clinical decision-making. There is not a specific age at which children are able to understand and be involved in their medical care; as children develop they gradually become capable of understanding their medical decisions and should become aware of and involved in their medical care. Attempts to obtain assent from minors capable of understanding their medical care are an essential part of family and medical team communication. Minors cannot legally provide consent for medical decision making, and parents are legally their proxy decision makers.

2. Only adults or legally emancipated minors have the legal authority to consent. Any adult patient or legally emancipated minor who has the capacity to make health care decisions has the right to refuse or discontinue any medical intervention, including artificial nutrition and hydration. Providers' decisions to initiate or continue, or to withhold or discontinue, any medical intervention, including artificial nutrition and hydration shall be consistent with this rule.

3. In some cases a patient may lack capacity to make health care decisions on his or her own behalf. The attending physician can make the determination that a patient lacks capacity to make decisions based on a thorough clinical assessment. It is not required that a psychiatrist make the determination as to whether a patient lacks decision-making capacity. In the event the patient has no surrogate decision makers, and lacks capacity, the Office of Legal Affairs or Risk Management should be consulted. (See UCSF Medical Center Policy #6.02.02: Informed Consent.)

4. When a patient lacks decision-making capacity, his or her decision-making right shall be exercised on his/her behalf by a surrogate decision-maker. This individual should make treatment decisions based upon his/her understanding of the patient's wishes.

5. The following individuals may be appropriate to act as surrogate decision-makers for adult patients:

spouse/domestic partner, parent, adult child, adult sibling, adult grandchild, or another adult relative.

When a family member as outlined above is not available, then such persons who are aware of the patient's wishes and are acting in the best interest of the patient are appropriate surrogate decision-makers. In these situations, the attending physician should determine that the surrogate is, in fact to the best of their knowledge representing the patient's wishes.

In the absence of a surrogate decision-maker, and the patient lacks capacity, the attending physician should contact Legal Affairs or Risk Management.

**E. Disagreement Regarding Life Prolonging Treatment**

1. Physicians are not obligated to initiate or continue life-sustaining interventions if specific criteria are met. (See UCSF Medical Center Policy #6.05.05: Withdrawal or Foregoing of Life Prolonging Treatment, § V.A.)

2. The attending physician shall promptly inform the patient or his/her surrogate decision-maker when he/she proposes to withhold or withdraw an intervention, including life-prolonging treatment, and has documented this determination in patient's UCSF Medical Record.

   If the patient or his/her decision-maker disputes the determination, the attending physician shall do the following (and document in the medical record each of the following per UCSF Medical Center Policy #6.05.05: Withdrawal or Foregoing of Life Prolonging Treatment, § V.C):

   a. offer a consultation from another physician who does not have significant involvement in the patient's care, and
   b. offer a consultation with the Ethics Committee, and
   c. advise the patient or his/her surrogate decision-maker that assessment or care by another provider and transfer to another hospital may be arranged within a time determined by the physician, in consultation with the Ethics Committee by the patient/surrogate if desired.
   d. If transfer to another hospital is not completed within the time determined by the physician or by the Ethics Committee, then life-prolonging treatment may be withdrawn per this policy.

3. In certain situations, when court intervention may be necessary, including the situation when a patient is determined to lack capacity and has no family or no surrogate decision-maker, or the situation when care will be withdrawn against the patient/family wishes, the UCSF Office of Legal Affairs or Risk Management should be contacted.

**F. Resuscitation Status (DNR)**

1. All patients will have full resuscitative efforts initiated, unless another resuscitation status has been identified and documented. All providers must be aware of a patient's current resuscitation status as reflected in the medical record. Any re-evaluation of and changes in the resuscitation status will be documented in the EHR. This rule applies to patients of all ages.

2. If a patient has a resuscitation status other than a full resuscitation:

   a. an order must be written in the patient's chart and co-signed by an attending physician within twenty-four hours
   b. a brief summary of the nature of the limited resuscitation must be documented in the problem list
   c. signed documents (Advance Health Care Directive) reflecting the patient's wishes, if one exists, must be included in the electronic health record (EHR) either by scanning or by an electronic signature

3. An order is required in addition to a patient's signed Advance Health Care Directive or POLST.

**G. This Rule and Regulation incorporates by reference the following UCSF Medical Center policies in their entireties:**

1. #6.02.02: Informed Consent
   http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/InformedConsent.pdf

2. #6.04.01: Advance Health Care Directives/POLST
   http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/AdvanceHealthcareDirectivesAdults.pdf

3. #6.05.02: Brain Death
   http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/BrainDeath.PDF

4. #6.05.03: End-of-Life Care
   http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/EndofLifeCare.pdf

5. #6.05.04: Death of a Patient
   http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/DeathofPatient.pdf.

6. #6.05.05: Withdrawal or Foregoing of Life Prolonging Treatment
   http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/WithdrawalorForegoingofLifeSustainingTreatment.PDF

7. #6.06.02: Ethics Consultations
   http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/EthicsConsultation.PDF

8. #6.07.03: Resuscitation Status (DNR)
   http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/DNRNoCode.PDF

9. #6.07.04: Adult Palliative Sedation
   http://ucsfpolicies.ucsfmedicalcenter.org/Shared%20Documents/PalliativeSedationAdult.pdf