UC San Diego Health

Medical Staff Rules and Regulations
UC San Diego Health

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UC SAN DIEGO HEALTH RULES & REGULATIONS

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PREAMBLE

These Rules and Regulations are adopted in recognition of the University of California San Diego Health Medical Staff's responsibility for overseeing, on behalf of the Governing Body, the quality of patient care, treatment, and services provided by Practitioners of the Medical Staff at UCSDH. Through these Rules and Regulations, the Medical Staff provides guidance as to the specific practices regarding patient admission, consultation, and documentation of patient encounters.

DEFINITIONS

The definitions that apply to the terms used in these Rules and Regulations are set forth in the UC San Diego Health Medical Staff Bylaws.

ARTICLE 1
PRACTITIONER RESPONSIBILITIES

Practitioners of the UCSDH Medical Staff agree to provide continuous care and attend to patients at UCSDH according to the principles established in the Medical Staff Bylaws, Policies, Plans, and these Rules, in accordance with the criteria established by their Service and the UCSDH Medical Staff.

In addition to the Responsibilities set forth in the UCSDH Medical Staff Bylaws, Policies, Plans, and the UCSDH policies and processes, Practitioners have the following responsibilities:

1.1. Attending Practitioner Responsibilities

1. A patient may be admitted to UCSDH, consistent with UCSDH's admitting policy, only by Practitioners who have admitting Privileges.

2. Notwithstanding state licensing laws and privileges held by Practitioners, Medicare and Medi-Cal patients must be under the care of a Physician or, with respect to care and services within their scope of practice, a dentist, podiatrist, oral surgeon, or clinical psychologist. Physicians may also delegate tasks to other Practitioners or APPs, consistent with their Privileges, state law, the Bylaws, and these Rules and Regulations.

3. Practitioners on call for a service must be available on site within one hour if needed. Stricter requirements may be imposed by UCSDH, the Service, or Division or as the result of narrow time windows for specific therapeutic interventions.

4. Patients accepted by transfer from an outside facility and not yet seen by the accepting service Physician shall be evaluated by the attending Physician or Practitioner designee on the admitting service within:

    - 30 minutes to an ICU unit
    - 3 hours to an IMU unit
    - 6 hours to a medical/surgical unit

5. Patients admitted through the Emergency Department and not yet seen by the accepting service Physician shall be evaluated by the attending Physician or Practitioner designee on the admitting service within:

    - 30 minutes for an ICU level of care admission
    - 3 hours for an IMU level of care admission
    - 6 hours for a med/surg level of care admission

6. Patients who are admitted from the Physician’s office or for an elective procedure shall be seen within 6 hours of admission by the attending Physician or their Practitioner designee.

7. The Nursing Service shall notify the Physician or their Practitioner designee if a medical necessity requires earlier evaluation.

8. All patients shall be attended by a Practitioner of the Medical Staff with the appropriate Privileges and shall be initially assigned to the Service primarily concerned with the treatment of the condition that necessitated admission. The attending Practitioner has supervisory responsibility for all diagnostic and therapeutic procedures used in the care of the patient. When the attending Practitioner will be absent from UCSDH, transfer of responsibility to an identified covering attending Practitioner or their designee must occur, and this transition shall be documented in a progress note.

9. Each day and more often as medically appropriate, the attending Practitioner or their designee will supervise and document care of all hospitalized patients assigned to their service. The designee must be a Practitioner in the same specialty with appropriate privileges to provide the level of coverage required.

10. If a pediatric patient is admitted to the hospital, the CMO should be contacted to ensure appropriate coordination of care with the Pediatrics Service. This requirement is not appliable to patients in the inpatient burn service at Hillcrest, the neonatal intensive care unit, and the newborn nursery.

1.2 Informed Consent

1. Practitioners will comply with all UCSDH Policies and Procedures regarding providing patients Informed Consent. (see UCSDHP)

1.3 Consultation

1. To ensure the most informed and timely management of patients and to utilize the variety of special expertise at UCSDH, consultations are encouraged. The following are indications for consultation:

    a. When a patient requires care which is outside the scope of privileges granted to the Practitioner.

    b. When the diagnosis is obscure or when there is doubt as to the best therapeutic measure to be utilized.

    c. Whenever the consultation is expected to assist in the patient's continuing care, particularly for high-risk patients or those patients with underlying chronic problems.

    d. The President of Medical Staff, Chief Medical Officer, ACMO, and/or Service Chief of the Service where the patient is admitted shall have the right to require consultation when it is deemed to be in the best interest of the patient or UCSDH.

e. All patients admitted to an intensive care unit must be admitted to a critical care service or have a consultation with critical care services initiated by the primary admitting service Practitioner, unless otherwise set forth in UCSDH policies and procedures.

2. All requests for consultation shall be made with the Practitioner's knowledge and concurrence. Responsibility for the performance of a consultation lies with the consulting Practitioner.

3. An order for consultation is required; this order must include the indication for the consultation and identity of the requesting Practitioner.

A. Inpatient Consultation Guidelines:

a. Routine consultations should be seen within 24 hours of the request.

b. Urgent Consultations should be seen within 6 hours of the request.

c. Consultations on critically ill or unstable patients should be seen within 30 minutes of the request.

All consultations must involve a qualified Practitioner. The consulted Practitioner must comply with the timelines set forth above and have the appropriate Privileges to perform the consultation.

If House Staff respond to the consultation request, they must involve their supervising Physician in the consultation. The discussion with their supervising Physician must take place within the time frame specified for each category of consultation and the patient must be seen in person by the supervising Physician within twenty-four (24) hours.

B. Emergency Department Consultation Requests

Unless otherwise indicated pursuant to the consult request or the standard of care, consults and recommendations to the ED consult-request staff should be performed and provided within 90 minutes (less time for consults on critically ill or unstable patients) by the consulted Service. Recommendations can be provided by a Practitioner, or a House Staff who has acted in collaboration with their supervising Physician.

C. Consultation Communication and Documentation

A summary of the consultation should be verbally communicated to the requesting Practitioner at the time of the consultant's involvement and a note consisting of the consultant's assessment and recommendation must be entered in Health Record.

If the consultant becomes a part of the ongoing treatment of the patient, the consultant (or their designee) is required to see the patient at least every 24 hours, and more often as is medically appropriate and/or indicated based on changes in the patient's acuity or need for consultant input in order to advance patient care. The consultant's designee must be a Practitioner in the same specialty with appropriate privileges to provide coverage. House Staff may be involved in the ongoing care of the patient, however, a physician or their designee is required to see the patient in the timeframes set forth in this section.

All ongoing consultations will be documented in the patient's Health Record. When the issue or concern the Practitioner is consulting on has resolved, the consultant is no longer required to see the patient as required by this section.

1.4 Surgery

Surgery is performed only by a Physician, an oral surgeon, or a podiatrist. When a major surgical procedure is performed, the surgeon automatically becomes the attending Practitioner during the procedure. After the procedure, the Practitioner who was the attending Practitioner before the surgical procedure resumes the role of attending Practitioner unless otherwise documented.

1.5 Disagreements Between Providers

1. The basic medical and legal responsibility for patient care rests with the attending Practitioner. When disagreement occurs regarding the management of a patient, the following guidelines should apply:

    a. When there is a patient management disagreement between two Services and/or specialties over a major issue of patient care, the attending Practitioners should personally discuss the case in an attempt to agree on a treatment plan. The details of this discussion should be documented in the Health Record at that time. The policy should apply equally to disputes concerning treatment or the performance of diagnostic procedures.

    b. If the Practitioners are unable to reach a mutually satisfactory decision, the case should be referred to their Service Chief(s). If the Service Chief(s) cannot resolve the dispute, the POMS, ACMO and/or Chief Medical Officer should be contacted.

1.6 Infection Control and Communicable Diseases

Each Practitioner has a personal responsibility to prevent the development and transmission of infection in patients and other individuals on the healthcare team at UCSDH. Infection control practices are an integral part of this process and must be practiced by everyone. UCSDH Medical Staff membership and privileges requires compliance with Infection Control and Safety Precautions/Environment of Care programs at UCSDH. Specific infection control

policies and procedures can be found on the UCSDH Pulse website under the Department of Infection Prevention Clinical Epidemiology Policies.

1.7 Autopsy

Practitioners are required to comply with all UCSDH policies and procedures regarding Autopsies.

ARTICLE 2
HEALTH RECORDS

2.1 Preparation of Health Records

1. The attending Practitioner shall be responsible for the preparation of a complete, accurate, timely, and legible Health Record for each patient.

2. Each Health Record shall contain the following: identification data; complaint; personal history; family history; history of present illness; physical examination; provisional or admitting diagnosis; laboratory data; medical or surgical treatment; pathological finding; progress notes; final diagnosis; condition on discharge; discharge summary; and follow-up and autopsy report when available.

3. Each Health Record shall contain evidence of a critical review of the patient and the written record by the attending Practitioner.

4. The attending Practitioner must authenticate the history and physical examination, operative/invasive procedure reports, and consultation reports as required by the Bylaws, these Rules and Regulations, and UCSDH policies. The attending Practitioner or designated Practitioner must authenticate the discharge summary.

5. The documentation shall adequately reflect the patient's condition and treatment plan.

6. The Health Record for each patient must be completed, authenticated by the date and signature of the author of the note and filed pursuant to the timelines set forth in UCSDHP 320.1, Timely Preparation and Authentication of Medical Records.

2.2 History & Physical Exam

1. The responsibilities for appropriate completion of a History & Physical Exam is set forth in the UCSDH Medical Staff Bylaws.

2. *Full H&P*. A full History & Physical shall contain at a minimum:

    - Date of admission
    - Chief complaint
    - Details of the present illness
    - Family and social history
    - Allergies
    - Past medical and surgical history including medications and allergies
    - Current medications, including over the counter medications and herbal supplements
    - Relevant past psycho-social history (appropriate to the patients age)

- A physical examination inventoried by body systems, including vital signs. Unless relevant to the chief complaint or necessary to establish diagnosis, a breast, pelvic and/or rectal exam need not be performed.
- A statement on the conclusions or impressions drawn from the history and physical examination.
  A statement on the course of action planned for the patient for that episode of care.

3. *Abbreviated H&P*. An abbreviated History & Physical may be utilized as set forth in the Bylaws. A completed abbreviated History & Physical shall contain at a minimum:

   - A chief complaint
   - Details of present illness
   - The type and number of operations or procedures scheduled to be performed.
   - Relevant past medical and surgical history pertinent to the operative or invasive procedure being performed including medications, allergies, and comorbidities.
   - Relevant past psycho-social history pertinent to the operative or invasive procedure being performed.
   - A relevant physical examination of those body systems pertinent to the operative or invasive procedure(s) being performed but including at a minimum an appropriate assessment of the patient's cardio-respiratory status and their age. Unless relevant to the chief complaint or necessary to establish diagnosis, a breast, pelvic and/or rectal exam need not be performed.
   - A statement on the conclusions or impressions drawn from the history and physical examination.
   - The level of anesthesia required for the operation or procedure.
   - A statement on the course of action planned for the patient for that episode of care.

4. *Interval H&P***.** An interval H&P is defined as a statement entered into the patient's Health Record that a valid full or abbreviated H&P has been reviewed, the patient is examined, and that: (a) there are no significant changes to the findings contained in the full or abbreviated H&P since the time such H&P was performed, or (b) there are significant changes and such changes are subsequently documented in the patient's Health Record. It is recommended that the interval H&P be documented on or appended to the full or abbreviated H&P. The interval H&P still requires that the patient be assessed, components of the patient's current medical status that may have changed since the prior H&P be updated, and areas where more current data is available are documented. The assessment should also address the plan of care and confirm the necessity for admission, procedures, or surgery. The depth of the assessment should reflect the patient's condition, co-morbidities, and indication(s) for admission.

5. For patients receiving monitored sedation, anesthesia, or when post-procedure observation of the patient elsewhere in the hospital is required, the H&P must include

sedation-related required elements: ASA score, airway assessment, plan for sedation, patient/family history of anesthesia/sedation complications prior to the procedure, medication reconciliation, same day pre-procedure assessment of patient's mental status, including an assessment of the airway documented by the physician, and NPO status and review of medications that may affect NPO status. Such assessment is the responsibility of the Practitioner prescribing/administering the sedation/anesthesia. (see UCSDHP 370.1)

2.3 Operative and Other Procedures

1. Operative Records and Reports

    a. Responsibility for the preparation of the operating room record shall be with the OR charge nurse.

    b. All records from the operating room, *e.g*., Operation Records (prepared by OR nurse), Operative Reports (completed by the surgeon), etc., concerning a particular operation should list the surgeons' names in the same sequence.

    c. The Operation Record, prepared by nurses in the operating room shall be the reference document; transcribers of the dictated Operative Report will be instructed to use surgeons' names and status as listed in the Operation Record. (The Operation Record is the one document always available without delay).

    d. A surgeon's name should not be listed on a patient's operative records as surgeon or assistant unless they have been present and have actively participated in or directed a portion of the operation. In such instances they must sign the completed Operative Report.

    e. The senior surgeon or designee will inform the OR nurse of the name or names of the responsible surgeons and the order in which they are to be entered in the Operation Record.

    f. In operations requiring two or more teams of surgeons (usually with different skills, *e.g*., a urologist and a general surgeon in the creation of ileal conduit), the operating room record will include each procedure.

    g. A brief post-operative progress note shall be entered into the patient's Health Record immediately after surgery before the patient is transferred to the next level of care. It shall include at minimum elements of the comprehensive operative report including the name of the primary surgeon and assistants, procedures performed and description of each procedure, findings, any estimated blood loss, any specimens removed, and the post operative diagnosis.

    h. A comprehensive Operative Report shall be completed within 24 hours following surgery and shall include operative findings, procedures performed, specimen(s)

taken, pre-and postoperative diagnoses, type of anesthesia, estimated blood loss, and names of the primary surgeon and assistants.

2. Tissue Specimens: Specimens removed during a surgical procedure shall be sent to Pathology for evaluation. The pathologist shall make such examinations as considered necessary to arrive at a pathological diagnosis and shall sign the report. The Patient Care and Peer Review Committee ("PCPRC"), in conjunction with Pathology, may develop a gross only listing.

3. Anesthesia: Anesthesiologists shall complete a pre-anesthesia assessment with following components – pertinent information relative to the choice of anesthesia and the surgical or obstetrical procedure anticipated and review of the patient's condition immediately prior to the induction of anesthesia.

4. Availability of Delineation of Privilege (DOP) Forms: A current list of delineated surgical privileges shall be available online via the UCSDH intranet (Practitioner Privileges). Delineated privileges are also available by calling Medical Staff Administration.

2.4 Orders

Orders must be completed pursuant to the requirements set forth in UCSDHP 321.3, Patient Treatment and Medication Orders.

2.5 Original Records

1. All original Health Records are the property of UCSDH and may not be removed unless Health Information Services has established the validity of a court order, subpoena, or relevant statute. In case of readmission of a patient, all previous records shall be available for the use of the attending Practitioner.

2. Radiographs may be sent to another Practitioner for the care of a patient but may not otherwise be removed from UCSDH.

ARTICLE 3
GRADUATE MEDICAL EDUCATION SUPERVISION

OBJECTIVE

In order to maintain high clinical and educational standards and to assure compliance with applicable regulations in these areas, UCSDH assures adequate resident supervision appropriate to each level of training, recognizing that graduate medical education is based on a system of graded responsibility in which the level of resident responsibility increases with years of training. UCSDH assures that training at all affiliates is in accordance with these principals.

DEFINITION GME TRAINING PROGRAM: The responsible program within a UCSD SOM Department that recruits residents, oversees their training, and conducts evaluations.

RESIDENT: Any M.D. or D.O. in a training program that leads to eligibility for either general certification or subspecialty certification by an approved ABMS Specialty Board, or any M.D. or D.O. in a training program where ABMS Specialty Board certification has not been created. This would include all trainees in ACGME and/or non-ACGME accredited programs.

SUPERVISING PRACTITIONER: Licensed, independent Physicians, dentists, podiatrists, optometrists, credentialed and privileged at UCSDH. A supervising Practitioner must be approved by the sponsoring entity in order to supervise residents. In some training settings, other health care professionals with documented qualifications and appropriate academic appointments may function as supervising Practitioners for selected training experiences. Supervising Practitioners can provide care and supervision only for those clinical activities for which they have clinical privileges.

SUPERVISION GUIDELINES

Communication and collaboration between supervising Practitioners and residents are required. Identification of the respective duties and responsibilities of supervising Practitioners and residents provides that foundation upon which supervision is based. Residents must be supervised in such a way that the residents assume progressively increasing responsibility for patient care according to their level of training, ability, and experience. The GME Training Program must determine the appropriate level of responsibility afforded each resident.

COMPONENTS OF SUPERVISION

- Educational objectives are defined.
- The supervising Practitioner assesses the skill level of the resident by direct observation.
- The supervising Practitioner authorized independent action by the resident.

- The supervising Practitioner defines the course of progressive independence from performing functions together with decreasing frequency of review. This process starts with close supervision, progressing towards independence as skills are observed and mastered.
- Documentation of supervision by the involved supervising Practitioner must be customized to settings based on guidelines for best practice and regulations by the ACGME and TJC. One of the four components listed below must always be present in the Health Record:
    - Progress notes by the supervising Practitioner.
    - Addendum to the resident's progress note by the supervising Practitioner.
    - Counter-signature of the progress note by the supervising Practitioner.
    - A Health Record entry documenting the name of the supervising Practitioner and that discussion occurred about the case.
- Written evaluation and feedback are considered in the progression levels. At all times, and at any level, the resident has access to advice and direction from the supervising Practitioner.

POLICY

- Each GME Training Program will comply with external regulatory agency requirements regarding the supervision of residents and the care of patients. To the extent that the individual ACGME Program Requirements exceed the UCSD GME Supervision Policy, those requirements must also be met.
- There will be a report provided periodically to the organized medical staff, the MSEC, and the EGB about the safety and quality of patient care, treatment and services provided by, and the related educational and supervisory needs of, the participants in the UCSD GME program.

Ambulatory Sites

- Residents will be able to identify an available supervising Practitioner at all times during patient care.
- A supervising Practitioner will be physically present and available to residents during the entire ambulatory clinic session, or outpatient procedure.
- Return patients will be seen by, and discussed with, the supervising Practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate. The supervising Practitioner will be identifiable for each resident's patient care encounter.
- A supervising Practitioner will personally see all new patients referred for consultation. Documentation must at a minimum include co-signature of the consultative note.

Emergency Department Sites

- Residents will be able to identify an available supervising Practitioner at all times during patient care.

- Each new patient to the Emergency Department will be seen by or discussed with the supervising Practitioner. The supervising Practitioner will be identified in each resident's patient care encounter.
- The supervising Practitioner, in consultation with the resident, ensures that the discharge of the patient from the Emergency Department is appropriate.
- Patients scheduled for direct hospital admission are not required to be seen by the supervising Practitioner for the Emergency Department.

Operating Room for Inpatient or Outpatient Procedures

- For all elective and scheduled surgical procedures, the supervising Practitioner will evaluate the patient and will write a pre-procedural note describing the findings, diagnosis, plan for treatment and/or choice of specific procedure to be performed. This pre-procedural evaluation and note may be completed up to 30 days in advance of the surgical procedure.
- Staff involved in procedures will be documented according to the following scale:
    - Level A: Supervising Practitioner doing the operation. The supervising Practitioner performs the case but may be assisted by the resident.
    - Level B: Supervising Practitioner in OR, scrubbed: The supervising Practitioner is physically present in the operative or procedural room and directly involved in the procedure. The resident performs major portions of the procedure.
    - Level C: Supervising Practitioner in OR, not scrubbed: the supervising Practitioner is physically resent in the operative or procedural suite and immediately available for resident supervision or consultation as needed.
    - Level E: Emergency Care: Immediate care is necessary to preserve life or prevent serious impairment. The supervising Practitioner has been contacted.
    - Level F: Non-OR procedure: Routine bedside and clinic procedure done in the OR. The supervising Practitioner is identified.

Non-Operating Room Procedures

- Residents can perform routine bedside and clinic procedures include skin biopsies, central and peripheral lines, lumbar punctures, centeses, incision and drainage. For these procedures, the Resident will be supervised in the manner required by the Training Program.
- Non-routine, non-bedside diagnostic or therapeutic procedures include endoscopy, cardiac catheterization, invasive radiology, chemotherapy, and radiation therapy. Supervising Practitioners are responsible for authorizing performance of such Procedures and must be physically present in the procedural area, but not necessarily in the same room as the resident. Supervision for the procedures takes into account the complexity and inherent risk of the procedure, the risk of the procedure, the experience of the resident, and assigned graduated levels of responsibility.

Inpatient Sites

- Residents will be able to identify an available supervising Practitioner at all times during patient care.
- Supervising Practitioners must be immediately available to Residents.
- The supervising Practitioners must physically meet, examine, and evaluate new patients on the inpatient service within 24 hours, including weekends and holidays, of admission to the hospital. Documentation of the supervising Practitioner's findings and recommendations regarding the treatment plan must be in the form of an independent progress note or an addendum to the resident note and must be entered by the end of the calendar day following admission.
- Supervising Practitioners are expected to be personally involved in the ongoing care of patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated responsibility of the resident.
- Evidence that the supervising Practitioner approves the discharge or transfer of the patient from an inpatient service will be documented by the signature of the supervising Practitioner on the discharge summary.
- Supervising Practitioners for specialty consultations on hospitalized patients must evaluate the patients and demonstrate concurrence by countersignature of the consultative note written by the resident.