UC San Diego Health

MEDICAL STAFF
RULES & REGULATIONS

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APPENDIX I RULES & REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary to supplement the general principles found within these bylaws. Such rules and regulations shall be accepted or amended on approval by majority vote of the Executive Committee and shall be reviewed annually by the Executive committee. Any changes or additions to the rules and regulations shall be distributed to the Medical staff in a timely manner. These rules and regulations shall apply to the care of outpatients, inpatients, and emergency room patients, under the detailed requirements of the UCSD Medical Center Policies and Procedures (MCP). Chief Medical Officer shall be responsible for coordinating these two (2) codes.

Each medical center department shall adopt internal rules and regulations to supplement, as necessary, those of the medical staff, as long as they are not in conflict with the Bylaws, Rules and Regulations of the medical staff.

Admissions

1. All patients shall be admitted to UCSD Medical Center, without restriction based upon race, color, religion, ancestry, national origin, disability, medical condition, marital status or sexual orientation.
2. Except in emergency, no patient shall be admitted to the medical center until a provisional diagnosis has been made and CEO, UCSD Medical Center, or a designee has been informed. In case of emergency, a provisional diagnosis shall be recorded as soon after admission as possible. The responsible Emergency Room faculty physician (a) will ensure that all patients are evaluated according to established policies and procedures of the Medical Staff Executive Committee and (b) retain ultimate authority to admit any patient to any medical center medical service.
3. All medical center medical departments will make arrangements to provide prompt referral coverage to the Emergency Room.
4. The UCSD Medical Center may admit patients suffering from all types of diseases.
5. Practitioners admitting patients shall be held responsible for giving information as may be necessary to assure the protection of other patients from those patients who are a source of danger for any cause whatsoever.
6. The procedures for both elective and emergent admissions to the medical center shall be formulated or modified by conference between the Medical Staff Executive Committee and the CEO, UCSD Medical Center, with the advice of the Chief Medical Officer.
7. There are no required admission laboratory tests. Testing should be appropriate to the patient's admitting complaint. If surgery or other operative procedure is anticipated, the practitioner is referred to the *Suggested Routine Preoperative Laboratory Examination* guidelines.

Attending Practitioner's Responsibilities

1. As required by Section 1317.3 of the Health and Safety Code, UCSD Medical Center prohibits discrimination in the provision of emergency services and care based upon a patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical

condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient. It is the policy of the UCSD Medical Center that healthcare workers, including physicians at all levels, will provide care consistent with their roles within the Medical Center to all UCSD Medical Center patients regardless of their known or unknown diagnoses.

2. Practitioners on call for a service must be available on site within one hour if needed. Stricter requirements may be imposed by the department or division or as the result of narrow time windows for specific therapeutic interventions.
3. Patients admitted through the Emergency Department or accepted by transfer from an outside facility and not yet seen by the accepting service physician shall be evaluated by the attending or licensed physician designee on the admitting service within:
   - 30 minutes to a critical care unit
   - 3 hours to a progressive care unit
   - 6 hours to a medical/surgical unit
4. Patients who are admitted from the physician's office or as an elective pre-operative shall be seen within 6 hours.
5. The Nursing Service shall notify the physician if a medical necessity requires earlier evaluation or if the time limit is approaching.
6. All patients shall be attended by a member of the Medical Staff or Temporary Staff or a designated Allied Health Professional Staff practitioner 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 of record will be absent from the Medical Center, transfer of responsibility to an identified covering attending must occur and this transition shall be documented in a progress note. Additional responsibility of the attending practitioner is defined below.
7. It is the responsibility of the attending physician or alternate designated physician/practitioner to inform their patients or patients' alternative decision-maker about outcomes of medical treatment and procedures, including significant adverse outcomes.
8. It is the responsibility of the attending practitioner to determine the time of discharge. At the time of discharge, the record is to contain a final diagnosis, discharge note and practitioner's signature. In the event the patient leaves AMA, the practitioner shall document the fact in the progress note. (Refer to Medical Center Records below.) The attending practitioner or alternate physician/practitioner shall also notify those responsible for the patient after discharge. This shall include, but not be limited to, making provision for proper medication, arrangement of social services, physical therapy, visiting nurse care and follow-up visits.

UCSD Medical Center Records

Preparation of Medical Records

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Such a medical record shall include the use of symbols and

abbreviations only when the medical staff has approved them and there is an explanatory legend. The "Do Not Use" Abbreviation List shall be observed for all medical record entries.

Content of Record: Each record shall contain: 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.

Discharge Summary: A discharge summary is required for hospital admissions with the exception of uncomplicated stays for normal newborns and obstetrical deliveries.

AMA Discharges: The attending medical staff and house staff shall document AMA discharges in the progress notes to include reference to discussion(s) with the patient regarding the possible consequences of leaving AMA. Even if a patient insists on leaving before the practitioner has a chance to talk to him/her or if the patient simply "walks out" of the hospital without informing anybody, it is important that that be documented in the progress notes. In such a situation, it would also be important to record whether or not any other medical personnel had spoken to the patient and had attempted to outline the consequences of leaving AMA.

2. Each record shall contain evidence of a critical review of the patient and the written record by the attending practitioner or a licensed physician designated by the department chairperson. The attending practitioner must authenticate the history and physical examination, operative/invasive procedure reports, and consultation reports. The attending practitioner or designated licensed physician must authenticate the discharge summary.
3. Each day and more often as medically appropriate, the Attending physician (or his/her Attending Back-up) will supervise and document care of all hospitalized patients assigned to his/her service. The documentation shall adequately reflect the patient's condition and treatment plan; the note shall be dated and timed.
4. A brief operative report shall be written in the patient's chart immediately following surgery before leaving the operating or procedural area; a full report shall be completed immediately after surgery (defined as "upon completion of surgery, before the patient is transferred to the next level of care") or the physician will be subject to suspension. The authenticated copy shall be filed in the patient's chart as soon as possible.
5. Authentication of medical record entries via electronic signature is permitted. It is the author's responsibility to review the document online before signing it electronically.
6. No medical record shall be filed until it is completed. The medical record for each patient must be completed, authenticated by the date and signature of the author of the note and filed within 14 days of discharge.
7. The attending practitioner shall cooperate with UCSD Medical Center Administration in the timely preparation, completion, authentication, submission and maintenance of all records and reports, which are designated within these bylaws, Rules and regulations and in accordance with regulatory agency requirements (i.e., inpatient and outpatient visits, test and image interpretations, and procedures). An attending practitioner who fails or refuses to complete or maintain medical records as requested may be subject to one or more of the

following: formal reprimand, retention of notification of failure to complete medical records in the physician's credentials file, denial or suspension of privileges (resulting in an 805 report being filed with the Medical Board of California, as described in Article 12 of these Bylaws) until the records are complete. In the event a practitioner is suspended or privileges modified, an appeal may be initiated in accordance with the provisions of Article 12 of these Bylaws.

8. The following activities may result in disciplinary action in accordance with the Bylaws: improper alteration of the medical record; unauthorized access, use, or disclosure of medical records and other protected health information; sharing passwords or log-on access to health information systems; or damage to any information systems and applications.

History/Physical Exam

1. Admission
   All patients admitted for inpatient care will have a complete medical history and physical examination performed by a qualified physician, licensed independent practitioner, or Allied Health Professional, who has been granted such privileges, within 24 hours of admission. All or part of the H&P may be delegated to another licensed independent practitioner or Allied Health Professional in accordance with State law and hospital policy, including house staff, nurse practitioners and physician assistants. The supervising medical staff member is responsible to authenticate and sign the H&P and as applicable, the update note, and assumes full responsibility for the H&P. H&Ps performed by medical students shall not be used as the sole admission history and physical.
2. Interval Assessments for H&P
   An H&P performed prior to admission but less than 30 days is acceptable provided an interval assessment performed by a qualified practitioner, which includes a physical assessment of the patient to update components of the patient's current medical status that may have changed since the prior H&P and addresses any areas where more current data is available. This assessment should also address the care plan and confirm the necessity for admission, procedures or surgery. The depth of the assessment should reflect the patient's condition and any co-morbidities and indication for admission. The interval assessment must be authenticated by the supervising medical staff member within 24 hours of admission and should be attached to the original H&P. If a patient is readmitted within 30 days of a previous discharge for the same or a related condition, an interval assessment, as defined above, may be performed provided a copy of the prior admission's complete H&P is attached to the interval assessment.
3. A completed H&P shall contain at a minimum:
   History Elements:
   - Date of admission
   - Chief complaint
   - History of present illness
   - Family and social history
   - Allergies
   - Past medical and surgical history
   - Current medications, including over the counter medications and herbal supplements
   - Review of systems

Physical Elements:
1. Vital signs
2. Review of body systems (general, HEENT, cardiovascular, breast, respiratory, abdominal, neurological, genitalia, musculoskeletal and extremities)
3. Pelvic & rectal exams, if pertinent to the chief complaint and necessary to establish diagnosis.

Initial Diagnosis
Plan for admission and/or studies/procedures to be performed.

Abbreviated History and Physical

General Rule: An abbreviated H&P will be completed for all procedures that involve monitored sedation or anesthesia and any time written informed consent is required for the procedure under MCP 339.1E, Consent for Anesthesia, Surgery, Special Diagnostic, or Therapeutic Procedures.

Exception: *A UCSD provider performing an invasive procedure that requires informed consent ("Interventionalist") may rely on an H&P that has been completed by another UCSD licensed independent practitioner within the last thirty (30) days if and only if: (a) the Interventionalist reviews the H&P and documents his/her review of the H&P in the patient's medical record prior to the procedure and (b) the H&P contains all the required elements.*

Content of Abbreviated H&P
An abbreviated history and physical focusing on the immediate care needs and major co-morbidities, complications, and risk factors will be accepted. Such an H&P shall include:
- The study/procedure to be performed and reason
- Current conditions
- Pertinent co-morbidities or prior surgeries
- Drug allergies or any adverse response to medications
- Adverse responses particularly to sedation agents
- Current medications including over the counter medications and herbal supplements
- A basic physical examination: heart, lungs, vital signs and appropriate lab results
- Documentation that risk/benefits/alternatives have been discussed with the patient.

For patients receiving moderate sedation, the physician will document a brief short H&P to include the sedation-related required elements (ASA score, airway assessment, plan for sedation, patient/family history of anesthesia/sedation complications) prior to the procedure.

A pre-procedure assessment of medical status also must be performed immediately prior to any procedure in which anesthesia, moderate or deep sedation will be administered. Such assessment is the responsibility of the physician prescribing/administering the sedation/anesthesia.

Operative and Other Procedures

A history and physical examination is required for surgery or other procedure requiring monitored anesthesia care or deep sedation prior to the procedure. A complete H&P performed prior to the procedure but less than 30 days is acceptable, provided an interval assessment as defined above is performed and attached to the original H&P. The history and physical must be authenticated by the attending physician.

For inpatients undergoing surgery, or procedure, a daily progress note written within 24 hours constitutes as an updated History & Physical, provided a complete H&P is documented in the medical record. If the H&P or progress notes were not performed by the surgeon or his/her designee, the surgeon or designee must write a preoperative note describing the surgical assessment. In the event that a delay created by documentation would constitute a hazard to the patient, a physician must document the reason in the progress record. In an emergency, the physician will note the emergency, any pertinent data (vital signs, allergies and any medical history that can contribute to the outcomes) in a brief admission note prior to the procedure if possible.

Anesthesiologists shall complete a pre-anesthesia 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.

Informed Consent

1. The UCSD Medical Center policy on Informed Consent is attached hereto (see Appendix V). No elective surgery or invasive procedure, as defined in Appendix V ("Procedure") shall commence without the ascertainment by those in control of the patient (attending surgeon, anesthesiologists, Interventionalist/proceduralist or charge nurse of the involved department) that a properly executed consent is a matter of record.
2. In order to give an informed consent, the patient must be given sufficient information to make an informed choice of whether or not to undergo the Procedure.
3. The patient shall not be asked to sign the consent form until the appropriate physicians and/or Allied Health Professional Staff have explained the nature, purpose and expected benefits of the Procedure and the major and usual risks involved in the Procedure to the patient.

Consultation

1. In order to ensure the most informed and timely management of patients and to utilize the variety of special expertise in the University of California, San Diego Medical Center, consultations are encouraged. The following are indications for consultation:
    a. When a patient requires care which is outside the scope of privileges granted the Attending Physician.
    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. Whenever a physician whose practice does not have a pediatric focus cares for children less than 12 years of age or severely handicapped adolescents, the Attending Physician should request a consultation from the Pediatrics Department. A practice that has a pediatric focus specifically refers to pediatricians, family practice physicians and pediatric surgeons. High risk infants always require a consultation request to the Pediatrics Department. Normal newborns delivered by Family Practice do not require consultation.
e. The CEO, CMO, Vice Dean for Clinical Affairs, Department Chairpersons or the Chief of Staff, shall have the right to require consultation when it is deemed to be in the best interest of the patient or medical center.
f. 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 physician. The only exception is non-ventilated cardiology patients admitted to the critical care unit at the Sulpizio Cardiovascular Unit or Thornton Hospital. The covering intensivist is authorized to diagnose, treat, and write orders for a patient in the ICU under his/her own authority in emergent clinical settings. Intensivist is defined as a physician board certified (ABMS or UCNS) in Critical Care Medicine, or board eligible in Critical Care Medicine. Physicians who completed training prior to availability of subspecialty certification in critical care in their specialty (Medicine, Anesthesiology, Pediatrics Surgery, Neurology, Neurological Surgery, or Emergency Medicine), who are board certified in one of these specialties and who have provided at least six (6) weeks of full-time ICU care annually since 1987.

2. Quality consultations result from well-established ongoing, working relationships between services. Individual departments, in case review, will make determinations as to the appropriate use of the consultation by their members. The department chairperson will be asked to include a statement relative to the use of appropriate consultation of each member of the department when recommending reappointment. When a department determines that a consultation was not obtained when required, the responsible physician will be counseled. Should a persistent pattern of failure to obtain appropriate consultation be noted, the department chairperson will inform the Credentials Committee. This information will be considered when reappointments are made.
3. All requests for consultation shall be made with the Attending Physician's knowledge and concurrence. Responsibility for the performance of a consultation lies with the Consulting Attending Physician.
4. An order for consultation is required; this order must include the indication for the consultation and identity of the requesting Attending Physician.
   A. Inpatient Consultation Guidelines:
      a. Routine consultations should be seen within 24 hours of the request.
      b. Urgent Consultations should be seen within six hours of the request.
      c. Emergency consultations should be seen within 30 minutes of the request.

      All consultations must involve a Consulting Attending Physician. House staff may respond to the consultation request, but must involve their supervising Attending in the consultation. The discussion with the Consulting Attending must take place within the

time frame specified for each category of consultation and the patient must be seen by the Consulting Attending within 24 hours.

B. Emergency Department Consultation Requests
Emergency Department Consultation requests should be initiated within 30 minutes of the request. Recommendations to the ED consult-request staff should be provided within 90 minutes (less time for emergencies) by the consulted service. Recommendations can be provided by a physician designee who has acted in collaboration with his/her attending staff.

C. Consultation Communication
A summary of the consultation should be verbally communicated to the requesting physician at the time of the Attending involvement and a note consisting of the consultant's assessment and recommendation should be entered in the patient record.

5. The basic medical and legal responsibility for patient care rests with the Attending Physician. 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 over a major issue of patient care, the Attending Physicians should personally discuss the case in an attempt to agree on a treatment plan. The details of this discussion should be documented in the medical record at that time. The policy should apply equally to disputes concerning treatment or the performance of diagnostic procedures.
   b. When the Attending Physicians are unable to reach a mutually satisfactory decision, the case should be referred to their Department Chairpersons. If the Department Chairpersons cannot resolve the dispute, the CMO, Vice Dean for Clinical Affairs or Chief of Staff should be contacted.

Orders

Details may be found in the UCSD Medical Center Policies and Procedures.

1. Inpatient treatment/medication
    a. Orders for inpatient treatment/medication shall be written on the "Physician's orders" form; orders for outpatient treatment/medication shall be written on the progress record.
    b. Treatment orders shall be signed, dated and timed by the initiating physician/practitioner. The physician/practitioner shall note his/her five-digit physician identification number immediately following his/her signature.
    c. Only a physician, dentist, podiatrist, nurse practitioner, physician assistant, certified registered nurse anesthetist, nurse midwife, or pharmacist under Pharmacy and Therapeutics Committee authority may order medications. Orders must be within the ordering practitioner's scope of practice. Medical student orders for medications will not be carried out until countersigned by an appropriate physician.
    d. Patient care orders may be written by house officers who are duly appointed to the UCSD programs of graduate medical education; however, no policy shall be adopted to prohibit orders from being written by a patient's practitioner. A staff member's unwillingness to give full authority for writing orders to members of the house staff shall not in itself be a basis for sanctions relating to staff membership and clinical privileges.
    e. Automatic Medication Stop Orders:
        i. If not specified or limited otherwise by the prescriber, medication orders will have a duration of 180 days.
        ii. If no action is taken by the prescriber, the order will be automatically discontinued after 180 days.
2. Verbal or telephone orders
    a. Verbal or telephone orders may be initiated only by physicians, dentists, podiatrists, clinical psychologists (excluding medications), physician assistants, nurse practitioners, nurse midwives, certified registered nurse anesthetists or pharmacists under Pharmacy and Therapeutics Committee authority. Orders must be within the ordering practitioner's scope of practice.
    b. Such orders may be accepted only by registered nurses, license pharmacists, registered dietitians, and other ancillary staff as designated in Medical Center policy. The individual accepting the order will read back the order as written to the ordering practitioner for verification. The orders shall be signed, dated and timed by the individual receiving them.
    c. Such orders given to a registered nurse or to other ancillary staff as designated in Medical Center policy shall be either stat or for one time only. Verbal orders given to a licensed pharmacist may be accepted for longer periods, or more than one dose, in accordance with Medical Center policy.
    d. All such orders must be signed, dated and timed within 48 hours by the ordering practitioner or other member of the primary healthcare team for the patient. The primary healthcare team is the group of healthcare practitioners on the teaching service assigned the responsibility for the patient's care. The primary healthcare team

may be composed of an attending faculty member with house staff (i.e., residents and/or fellows) and Allied Health Professional Staff as appropriate. The order must be within the signing practitioner's scope of practice.

Surgery/Operating Room

1. 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 PCPRC, in conjunction with Pathology, may develop a gross only listing.
2. Operative Records and Reports
   a. Responsibility for the preparation of the operating room record shall be with the OR charge nurse. This record shall not be altered or substituted after the fact.
   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 s/he has been present and has actively participated in, or directed a portion of the operation. In such instances s/he 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 Records.
   f. In operations requiring two or more teams of surgeons (usually with different skills, e.g., an 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 handwritten immediately after surgery before leaving the operating or procedure area and shall include at minimum elements of the comprehensive operative report. A comprehensive Operative Report shall be completed immediately 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.
3. Serious Adverse Outcomes/Patient Injury
   It shall be the responsibility of the operating surgeon or the anesthesiologist (in addition to the charge nurse in the operating room) to notify Medical Center Administration, through the Chief Medical Officer, Director of Quality, Patient Safety and Risk Management or Chief Operating Officer, immediately whenever a sentinel event or serious untoward development occurs in the course of patient care within the operating room.
4. Availability of Delineation of Privilege (DOP) Forms
   A current list of delineated surgical privileges shall be available online via the UCSD intranet (Attending Physician Privileges). Delineated privileges are also available by calling Medical

Staff Administration. House staff competencies also are available online via the UCSD Intranet (Resident Competencies).

Autopsy

1. Members of the Medical Staff should encourage performance of necropsies.
2. The Medical Staff should pursue necropsy consent in deaths due to uncertain causes including cases waived by the coroner.
3. No autopsy shall be performed without written consent or other method of properly executed consent obtained from the decedent prior to death or any of the following persons: the decedent's legally authorized agent, the surviving spouse or registered domestic partner, a child or parent, a sibling, any other kin or person who has acquired the right to control the disposition of the remains, a public administrator or the coroner or other duly authorized public officer.

Original Records

1. All original records are the property of UCSD Medical Center and may not be taken away 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 the medical center.

Medical Staff Committees

Cancer Committees

Cancer Tumor Board Committee

Membership

- Chair of the Cancer Tumor Registry Committee will be appointed by the Medical Director of the Cancer Center with annual approval by Medical Staff Executive Committee
- Representative, Surgical Oncology
- Representative, Medical Oncology
- Representative Gynecologic Oncology
- Representative, Radiation Oncology
- Representative, Diagnostic Radiology
- Representative, Pathology
- Cancer Registrar (serves as staff to the committee)
- Representative, Hospital Administration
- Representative, Nursing
- Representative, Social Services
- Representative(s) from House Staff
- Representative, Performance Improvement & Patient Safety
- Other disciplines should be included as appropriate, such as Internal Medicine, Family

- Practice, Urology, Thoracic Surgery, Otolaryngology, and Pediatrics

Duties

1. To establish and operate a multidisciplinary Tumor Board, which shall hold regular meetings open to all members of the Medical Staff, House Staff and medical community. The Tumor Board shall meet the standards established by the American College of Surgeons;
2. To make certain cancer conferences include major cancer sites yearly and are primarily patient oriented and prospective;
3. To ensure that consultative services are available to patients with cancer through multidisciplinary physician attendance at conferences;
4. To evaluate quality of care of patients with cancer;
5. To conduct and support performance improvement efforts;
6. To supervise the cancer registry for quality control of abstracting, staging and reporting;
7. To serve as registry physician-advisor(s).

Meetings

The Cancer Tumor Board Committee shall meet at least quarterly.

Reporting Relationship

The Cancer Tumor Board Committee reports to the Cancer Quality Committee which reports to Medical Staff Executive Committee through the Quality Council.

Cancer Quality Committee

Membership

- Chair, appointed annually by the Medical Director of the Cancer Center with annual approval by the Medical Executive Committee
- Representative, Surgical Oncology
- Representative, Medical Oncology
- Representative Gynecologic Oncology
- Representative, Radiation Oncology
- Representative, Diagnostic Radiology Representative, Pathology
- Cancer Registrar (serves as staff to the committee)
- Representative, Hospital Administration
- Representative, Nursing
- Representative, Social Services
- Chair or representative of the Cancer Pharmacy and Therapeutics

Duties

1. Provide leadership and oversight of the quality of services provided at Moores Cancer Center;
2. To evaluate quality of care of patients with cancer;
3. To conduct and support performance improvement and patient safety efforts
4. Ensure that the Joint Commission, California Title 22 and other regulatory requirements for quality of care are met;

Meetings
Cancer Quality Committee will meet monthly, at least ten times per year

Reporting Relationship
Cancer Quality Committee will report at least annually to the Quality Council of the Medical Executive Committee.

Cancer Pharmacy Committee, a Subcommittee of the Cancer Quality Committee and Pharmacy and Therapeutics Committee

Membership
- Chair will be appointed jointly by the Medical Director for Moores Cancer Center and the
- Director of Pharmacy with annual approval by the Medical Executive Committee
- Medical Director for Infusion Center at Moores Cancer Center
- Director of Pharmacy for Moores Cancer Center, who is ex-officio secretary
- A representative of Nursing
- A representative of Medical Center Administration
- Other members of the Medical Staff, Pharmacy or hospital services as appointed by the Chair

Duties
1. Review effectiveness of chemotherapeutic agents for utilization, expenses and clinical outcomes;
2. Provide formulary guidance to the Pharmacy and Therapeutics Committee on chemotherapeutic agents;
3. Work the Medical Director of the Infusion Center and Nursing Administration to optimize operational effectiveness.

Meetings
Cancer Pharmacy Committee will meet monthly, at least 10 times per year.

Reporting Relationship
Cancer Pharmacy Committee is a subcommittee of the Cancer Quality Committee and will report quarterly to the Cancer Quality Committee and also provides reports to Pharmacy and Therapeutics Committee.

Cardiovascular Quality Committee

Membership
- Chair, Medical Director for Cardiovascular Services
- A minimum of four (6) members of the Medical Staff to include representatives from
- Cardiothoracic Surgery, Interventional Cardiology, Cardiology, Electrophysiology, Vascular Surgery and Anesthesiology.
- One representative of the House Staff
- Associate Administrator, Cardiovascular Services
- A minimum of two (2) members of Cardiovascular nursing leadership

- Other members as designated by the committee

Duties
1. Establish and enforce policies and procedures for patient care in the Sulpizio Cardiovascular Center;
2. Oversee the quality and safety of the patient care in the Sulpizio Cardiovascular Center;
3. Provide a forum for monitoring the quality and safety of services, and provide an integrated approach to improve cardiovascular performance;
4. Make recommendations regarding identified issues to the Quality Council and respond to issues of patient care and safety raised by other Medical Staff Committees;

Meetings
The Cardiovascular Quality Committee shall meet at least quarterly.

Reporting Relationship
The Cardiovascular Quality Committee reports to the Medical Staff Executive Committee through the Quality Council.

Utilization Review Committee

Membership
- At least 5 members of the Medical Staff including representatives from the Departments of Surgery, Medicine, Emergency Medicine
- Chair, Technology Assessment committee (may be delegated)
- Medical Staff members as determined by the Chair, MSEC
- Chief Medical Officer
- Medical Director, Perioperative Services, or designee
- Medical Director, Clinical Resource Management
- Medical Director, Hospitalist Medicine Services, or designee
- CRM Program Director
- Quality Officer or designee
- Nursing representative
- Decision support analyst
- Representative, Department of Finance
- Chair will be appointed by the Chair, Medical Staff Executive Committee on an annual basis

Duties
1. Responsible for oversight of utilization of resources related to patient care;
2. Develop and implement institution-wide utilization improvement projects;
3. Review and evaluate data regarding resource utilization;
4. Create focused multidisciplinary teams to develop and implement strategies to improve quality and conserve fiscal resources.
5. Approval and oversight of the Utilization Review Plan

Meetings
The Utilization Review (UR) Committee shall meet monthly.

Reporting Relationship
The Utilization Review Committee reports to the Medical Staff Executive Committee through the Quality Council. The Chair of the Utilization Review Committee is a member of the Quality Council.

Credentials Committee

Membership
Physician membership will reflect the UCSD Medical Center's diversified physician staff, including but not limited to representatives of the major clinical departments. One of the members shall serve as chair and one member shall serve as vice-chair appointed by the Chair, Medical Staff Executive Committee. The chair shall be appointed for three years with the option to extend the appointment three more years. In addition, the Chief Medical Officer, UCSD Medical Center is a full voting member of the committee.

Duties
1. To review and recommend the criteria and forms developed by clinical departments for the delineation of clinical privileges;
2. To review and recommend the proctoring requirements associated with clinical privileges;
3. To oversee in conjunction with the Patient Care Peer Review Committee Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation Processes.
4. To review and evaluate applicant's professional and ethical qualifications for membership on the Medical Staff;
5. To solicit physician specific practitioner profiles including quality, peer review and claims data.
6. To review departmental assessment of practitioner's qualifications in relation to the privileges requested on the delineation of clinical privileges form;
7. To assess and recommend action on information received from all areas including quality, peer review and claims data;
8. To consider and recommend action upon the recommendation of the chair of the individual's department for appointment, reappointment, corrective action, or termination;
9. To recommend to the Medical Staff Executive Committee for approval any actions relating to membership or privileges on the Medical Staff.

Meetings
The Credentials Committee shall meet at least monthly. Medical Staff Administration shall serve as staff to the committee and shall maintain a permanent record of its proceedings.

Reporting Relationship
The Credentials Committee reports monthly to the Medical Staff Executive Committee. The Interdisciplinary Practices Committee is a subcommittee of the Credentials Committee.

Evaluating Quality and Patient Safety Improvement Projects Committee (EQIP)

Membership

- Chief Medical Officer
- Chief Quality and Patient Safety Officer
- Director Quality and Patient Safety Analytics
- DIO for Graduate Medical Education
- Chair Patient Safety Committee
- Director Nursing Quality
- Representative(s) from Information Services
- Representative(s) from Decision Support
- Medical Staff Representatives

Duties

1. Evaluate, approve, support and provide oversight to project proposals to improve quality and patient safety that require institutional resources.
2. Align faculty, trainee and staff project proposals with the institutional quality and safety priorities
3. Facilitate the implementation and evaluation of project proposals

Meetings

Reporting Relationship

The Evaluating Quality and Patient Safety Improvement Projects Committee will serve as a subcommittee of the Quality Council and report to the Quality Council. The Quality Council is a subcommittee of the Medical Staff Executive Committee.

Interdisciplinary Practices Committee, a Subcommittee of Credentials Committee

Membership

- The committee chair must be an Allied Health Professional
- At least two (2) physician members of the Medical Staff
- At least one (1) Physician Assistant
- At least three (3) Nurse Practitioners
- At least one (1) Psychologist
- At least one (1) Certified Registered Nurse Anesthetist
- At least one (1) Certified Nurse Midwife
- Chief Nursing Officer or RN designee

Non-Voting:

- CEO or designee
- The Chair may appoint additional non-voting members

Duties

1. Develop and recommend policies for Allied Health Professional Staff practice including, but not limited to, the appropriate scope of practice and, granting of expanded role privileges to provide for the assessment, planning and direction of the diagnostic and therapeutic care of patients;
2. Review Allied Health Professional Staff applications and credentials and make recommendations to the Credentials Committee for advancement to the Medical Staff Executive Committee for granting and/or revoking such privileges. Applications and requests for granting privileges will be reviewed by a peer. A peer is considered to be a person with equivalent qualifications;
3. Review periodically approved interdisciplinary practice programs, protocols, and policies;
4. Identify functions or procedures that require the formulation and adoption of "standardized procedures" under Section 2725 of the Business and Professions Code;
5. Review and approve standardized procedures covering practice of health professionals in the Allied Health Professional Staff categories.

RN standardized procedures for expanded practice roles will be reviewed and approved by the Advanced Practice Council.

Meetings

The Interdisciplinary Practices committee shall meet monthly.

Reporting Relationship

The Interdisciplinary Practices Committee reports to the Medical Staff Executive Committee through the Credentials Committee.

Critical Care Committee

Membership

- Representatives of the Departments of Anesthesiology, Emergency Medical Services, Medicine, Surgery, Pediatrics
- The Medical Directors of the Medical Intensive Care Unit (MICU), Coronary Care Unit (CCU), Neonatal ICU, Surgical ICU, Burn ICU, and Thornton Hospital ICU.
- The Nurse Manager or the Clinical Nurse Specialist of the Medical ICU, CCU, Neonatal ICU, Surgical ICU, Burn ICU, and Thornton Hospital ICU
- Infection Control Officer
- A representative of Medical Center Administration
- A representative of Nursing Research and Education
- A representative of Pharmacy
- A representative of Respiratory Services
- A representative of Nutrition and Dietetics
- A representative of Medical Social Work
- Two (2) representatives of the House Staff
- Chief Nursing Officer
- Chief Medical Officer

- Chair and Vice Chair of the Critical Care Committee will be appointed by the Chair of the Medical Staff Executive Committee for a 2 year period. Either the Chair of Vice Chair must be a Medical Director of an Intensive Care Unit

Duties

1. To provide a multidisciplinary forum to conduct oversight and coordination of all critical care areas.
2. To conduct and support performance improvement efforts that involve the care delivered in the intensive care unit.
3. To establish and enforce policies and procedures in consultation with other appropriate healthcare professionals and medical center administration.
4. To establish, evaluate, and make recommendations regarding standardized physician's orders and emergency standing orders for critical care areas.
5. To establish and maintain current admission, discharge, and transfer criteria for all units.
6. To assure the necessary staff, services, facilities, and other resources are available to all units.
7. To provide educational programs in the area of critical care for both physicians and nursing personnel.
8. To make recommendations to the Quality Council, as appropriate.
9. Oversee Resuscitation Services through the Code Blue Committee.

Meetings

The Critical Care Committee (CCC) shall meet monthly unless there are no agenda items.

Reporting Relationship

The CCC reports to the Medical Staff Executive Committee through the Quality Council. The Code Blue Committee is a subcommittee of the Critical Care Committee. The Chair of the CCC is a member of the Quality Council.

Code Blue Committee, a Subcommittee of Critical Care

Membership

- Chair, Medical Director for Resuscitation
- Representatives of the Departments of Anesthesiology, Emergency Medical Services, Medicine, Surgery, Pediatrics
- A representative of Pharmacy
- A representative of Respiratory Services
- A representative of Performance Improvement Patient Safety Committee

Duties:

1. To review on an ongoing basis hospital-wide practices with regard to availability of the equipment and supplies for managing codes for all inpatient and ambulatory care areas.
2. To ensure contents of the hospital code blue cart reflect current standard of practice and are standardized for all pertinent patient care areas.
3. To perform quality assessment of all codes at the Medical Center, and oversee performance improvement which may be carried out under the auspices of this committee or jointly by the

committee and the individual clinical service responsible for Cardiopulmonary Resuscitation management (e.g. Neonatology and SICU).
4. To perform the annual review of Medical Center policies related to cardio-respiratory arrest management to ensure they reflect current standard of practice.

Meetings
The Code Blue Committee will meet at least on a bi-monthly basis

Reporting Relationship
The Code Blue Committee is a subcommittee of the Critical Care Committee and reports at least quarterly to the Critical Care Committee.

Infection Control Committee

Membership
- Chair, Medical Director for Infection Prevention, Epidemiology and Control
- At least four (4) members of the Medical Staff to include, but not limited to representatives of the Departments of Surgery, Medicine, Pathology, and the Infection Control Officer.
- Two (2) representatives of the House Staff
- Director of Infection Prevention, Epidemiology and Control
- A representative of Nursing
- A representative of Medical Center Administration
- Representative of the Performance Improvement and Patient Safety department
- A representative from the non-medical units/areas as determined by the Infection Control Committee
- Medical Center Safety Officer, Environmental Health and Safety
- Chair of Antibiotic Utilization Committee

Duties
1. Oversee the development of the organization's annual Infection Prevention and Surveillance Program, including pandemic planning.
2. To review and analyze risk factors that may be associated with infection risk and recommend action to reduce this risk;
3. To review infection surveillance reports and analyze infections within the Medical Center with regard to their epidemic potential and to recommend action to minimize such occurrences;
4. To conduct and support performance improvement efforts in conjunction with the Quality Council;
5. To work with other medical staff committees to improve patient care through infection control.

Meetings
The Infection Control Committee shall meet at least quarterly.

Reporting Relationship

The Infection Control Committee reports to the Medical Staff Executive Committee through the Quality Council. The Chair of the Infection Control Committee is a member of the Quality Council.

Medical Ethics Committee

Membership

- At least three (3) members of the Medical Staff
- Two (2) representatives of the House Staff
- At least one (1) representative of Nursing
- At least one (1) representative of Medical Center Administration
- At least one (1) representative of the Department of Social Work
- Chief Human Relations, Risk and Safety Officer
- A pastoral representative
- Chair of the Ethics Committee will be appointed annually by the Chair, Medical Staff Executive Committee

Committee members should be knowledgeable in the field of biomedical ethics and should be willing and available to carry out the Committee's function, which may include consulting on issues dealing with transplantation, intensive care/life support, neonatal medicine, and other ethically controversial heath care situations.

Duties

1. Oversee the UCSD Medical Center's ethics consultation service whose purpose is to suggest possible approaches or alternatives to ethical dilemmas;
2. Facilitate appropriate communication among the patient, family, and all members of the health care team when performing ethical consultations;
3. Provide a 24-hour on-call Ethics Consultation Team composed of active committee members, which provides advice to patients, families, physicians, and staff pertaining to difficult ethical choices;
4. Assist the health care team, if requested, regarding No Code or Do Not Attempt to Resuscitate orders;
5. Establish guidelines, policies and procedures regarding the withholding or withdrawal of life sustaining treatments;
6. Provide educational programs to committee members, the Medical Center community and the San Diego community pertaining to ethical decision making;
7. Make recommendations regarding ethical issues to the Medical Staff Executive Committee.

Meetings

The Medical Ethics Committee shall meet monthly at least ten times a year.

Reporting Relationship

The Medical Ethics Committee reports to the Medical Staff Executive Committee.

Medical Records Informatics Oversight Committee

Membership

- Chair, Medical Director of Information Services
- Vice Chair, Director of Medical Records
- At least four (4) members of the Medical Staff, including the chair, to represent the physician staff
- Manager, Inpatient Medical Records
- Director, Clinical Information Systems
- Chief Compliance Officer
- Representative, Performance Improvement and Patient Safety department
- Chief Ambulatory Officer or designee to represent ambulatory care
- At least two (2) representatives of Inpatient Nursing Leadership
- One programming Resource from clinical Information Systems
- One (1) representative of the House Staff

Duties

1. Ensure a clinically coherent record that will provide a patient-centered view of care and allow all healthcare practitioners seamless access to the patient's record, regardless of where care is provided.
2. Ensure a safe and secure record that recognizes the fundamental patient right to privacy and confidentiality.
3. Ensure a record that is completed in a timely manner and to assist the Office of the Chief Medical Officer in monitoring timeliness and authentication standards.
4. Ensure a record that is compliant with current medical records standards, state and federal laws, key payor standards, accreditation standards and supports evidence-based care for our patients.
5. Ensure a record that supports our mission as teachers and scientists, while still preserving the privacy of direct patient care, and also creates a record that supports correct documentation of services rendered to ensure appropriate compensation.

Meetings

The committee shall meet monthly; the meetings will be preceded by the agenda meeting to be held between the Medical Director of Information systems and the Director of Medical Records; this meeting shall also serve as a Forms Committee to determine if additional input is required by the full Medical Records Informatics Oversight Committee.

Reporting Relationship

The Medical Records Informatics Oversight Committee reports to the Medical Staff Executive Committee through the Quality Council. The Chair of the Medical Records Informatics Oversight Committee is a member of the Quality Council. The committee will also report directly to the Office of the Chief Medical Officer regarding matters of timeliness and authentication standards for physician providers.

Medical Risk Management Committee

Membership

- At least eight (8) members of the Medical Staff
- Two (2) representatives of the Medical Center Administration

- A representative of Pharmacy
- Two (2) representatives of the House Staff
- A representative of Nursing
- A representative of Infection Control
- Chair and Vice Chair will be appointed for three year terms by the Chair of the Medical Staff Executive Committee

Duties

1. Review the clinical management of patients involved in serious incidents or lawsuits;
2. Recommend policy or procedure improvements intended to minimize or prevent recurrence;
3. Make recommendation to the Risk Management Department regarding medical defense and litigation strategies;
4. Notify the principal(s) and the department chair(s) of issues or concerns raised during deliberations;
5. Make recommendations regarding patient care issues to the Patient Care and peer Review Committee as appropriate;
6. Make recommendations regarding administrative issues to the Medical Staff Executive Committee and CEO, UCSD Medical Center, as appropriate.

Meetings

The Medical Risk Management Committee (MRMC) shall meet at least quarterly to fulfill its function and responsibility. The proceedings of the MRMC shall be privileged pursuant to the California Evidence Code, Section 1158 (Attorney/Client), except to the extent that Section 1157 Medical Staff peer review activities.

Reporting Relationship

The MRMC reports to the Medical Staff Executive Committee. The vice chair of the MRMC is a member of the Patient Care and Peer Review Committee and the chair is a member of the Quality Council. Performance Improvement and quality issues are reported to the Quality Council. Patient safety and significant events are reported to the Patient Safety Committee.

Patient Care and Peer Review Committee

Membership

- Chair is the Vice Chair, Medical Staff Executive Committee
- Vice Chair (appointed from membership)
- The Quality Improvement Representative from each clinical department represented on the Medical Staff Executive Committee (the Division of Family Medicine shall represent the Department of Family and Preventive Medicine).
- Director Blood Bank
- Chief Medical Officer
- Chief Nursing Officer or designee
- Two (2) representatives of the House Staff
- Quality Officer, or delegate
- Vice Chair, Credentials Committee
- Ex-officio members as warranted

Duties

1. The patient Care and Peer Review Committee has oversight responsibility for patient care management.
2. Reviews and approves peer review plans including department specific for UCSD Medical Center medical departments and divisions and receives departmental peer review reports with action plans;
3. Reviews and approves department peer review reports and actions plans, at least quarterly, and refers performance issues requiring action to the Credentials Committee;
4. Oversees physician performance profiling activities and reports results to the Quality Council, Medical Staff Administration, Credentials Committee, and MSEC;
5. Reviews cases with multi-departmental/service issues and systems failures and directs corrective action plans; and
6. Identifies patient care issues that require the attention of the other Medical Staff Committees or other resources within the institution, and communicates their findings and concerns directly with these bodies for appropriate evaluation and corrective action if needed.
7. Monitors corrective actions with reports to the Quality Council or Medical Staff Executive Committee as necessary;
8. Defines and identifies cases appropriate for intensive review or external peer review.
9. Oversees these activities when necessary.

Meetings

The Patient Care and Peer Review Committee (PCPRC) meets monthly. Five (5) members will constitute a quorum.

Reporting Relationships

The PCPRC reports to the Medical Staff Executive Committee through the Quality Council. The Transfusion Committee of the Medical Center, which oversees blood utilization review for the Medical Center, will report at least quarterly to the PCPRC. The chair of the PCRPC is a member of the Quality Council.

Patient Safety Committee

Membership

- Medical Director, Hospitalist Program (or delegate)
- Medical Staff representatives from the departments of Surgery, Medicine, Anesthesia, Radiology, Reproductive Medicine and others as determined by the Chair and the Chair, Medical Staff Executive Committee
- Chief Medical Officer, UCSD Medical Center
- Chief Nursing Officer, UCSD Medical Center
- Medical Director, Perioperative Services
- Member, Pharmacy & Therapeutics Committee

Representatives (1 each) from Departments of Nursing, Clinical Laboratories, Respiratory Therapy, Radiology

- Nurse Manager, Special Procedures
- Two (2) representatives of the House Staff

- Medical Center Safety Officer, Environmental Health and Safety
- Associate Director/Director, Patient Care Services, UCSD Medical Center
- Chief Human Resources, Risk and Safety Officer
- Quality Officer
- Director, Administrative Services
- CEO, UCSD Medical Center

Duties
1. Responsible for medical error and risk reduction activities in the organization using evidence-based medicine;
2. Actively promotes culture of patient safety awareness to patients and employees;
3. Proactively and retrospectively evaluates patient safety and recommends/initiates action;
4. Promotes a non-punitive environment and fosters the analysis of errors, incidents or events by focusing on the processes rather than on the individual;
5. Oversees all significant adverse and sentinel events with action plans;
6. Addresses sentinel event alerts for compliance;
7. Assures compliance to the Joint Commission and other regulatory bodies on Patient Safety Standards.

Meetings
The Patient Safety Committee meets monthly.

Reporting Relationship
The Patient Safety Committee reports to the Medical Staff Executive Committee through the Quality Council. The Significant Event Committee of the Medical Center, which evaluates and directs the response to significant events will report at least quarterly to the Patient Safety Committee.

Perinatal Practices Committee

Membership
At least three (3) members of the Medical Staff to include but no be limited to representatives of:
- Reproductive Medicine, Pediatrics and Anesthesiology
- Two (2) representatives of the House Staff
- Director of Womens and Infants Services
- Nurse Manager of Infant Special Care Unit
- Nurse Manager of Labor and Delivery
- Additional representatives of Nursing, as appropriate
- A representative of Medical Center Administration
- Chair will be appointed annually by the Chair, Medical Staff Executive Committee

Duties
1. Establish and enforce policies and procedures for patient care in the Labor and Delivery Suites and in the antepartum and postpartum areas;
2. Make recommendations regarding medical staff issues to the Patient Care and Peer Review Committee as appropriate

3. Oversee the quality and safety of the patient care in Labor and Delivery Areas, as well as the antepartum and postpartum areas.

Meetings
The Perinatal Practices Committee (PPC) shall meet monthly.

Reporting Relationship
The PPC reports to the Medical Staff Executive Committee through the Quality Council.

Perioperative Services Committee

Membership
- Chair, Medical Director for Perioperative Services
- Non-delegated membership shall include the following:
- A minimum of four (4) members of the Medical Staff to include representatives from: Anesthesiology and the surgical disciplines.
- Two (2) representatives of the House Staff.

Duties
1. Provide a forum for monitoring the quality and safety of services and key utilization indicators, and provide an integrated approach to improve organizational performance;
2. To establish policies and procedures and service standards in consulting with other appropriate health care professionals and administration;
3. To review the effectiveness and efficiency of operating room services;
4. To make recommendations regarding identified issues to the Quality Council and respond to issues of patient care and safety raised by other Medical Staff Committees;
5. Strategic planning of invasive procedure services;
6. To monitor resource management and utilization of invasive procedure services; and
7. Shall formulate rules for the conduct of activities within the operating rooms

Meetings
The Perioperative Services Committee shall meet monthly.

Reporting Relationship
The Perioperative Services Committee reports to the Medical Staff Executive Committee through the Quality Council. The Chair of the Preoperative Committee is a member of the Quality Council.

Pharmacy and Therapeutics Committee

Membership
- Chair, Medical Director for Pharmacy Services
- Representatives required from the Departments of Anesthesiology, Medicine, Neonatology, Neurology, Psychiatry, and Surgery.
- A representative from Medical Oncology.
- Two (2) representatives of the House Staff
- A representative of Nursing

- Director of Pharmacy, who is ex-officio secretary
- A representative of Medical Center Administration
- Director, Drug Information Service
- Chief Nursing Officer, UCSD Medical Center
- Chief Medical Officer, UCSD Medical Center
- Chair Antibiotic Utilization Committee
- Chair Cancer Pharmacy and Therapeutics Committee
- Chair Safe Medication Practices Committee

Duties

1. Develop and review written policies and procedures annually for establishment of safe and effective systems for procurement, storage, labeling, distribution, dispensing and use of drugs;
2. Review and revise regularly the list of drugs and dosage forms available at UCSD Medical Center to provide the most efficacious and economical selection of agents:
3. Serve as an advisory group in matters pertaining to choice of drugs and their dosage forms available at the Medical Center;
4. Revise and publish regularly a formulary of drugs available for use at UCSD Medical Center;
5. Inform regularly the medical and nursing staff of changes in policy and the drug formulary and information on new drug products;
6. Review regularly the policies and procedures of the pharmacy;
7. Review regularly all standing orders in the Medical Center and to review and approve any new standing orders;
8. Review regularly the contents of emergency medication and supplies and to review and approve any proposed changes in the content of these supplies and policies and procedures for maintaining and stocking the supplies;
9. Review drug utilization, and Adverse Drug Reactions and medication errors, provide practice pattern information to the department chairs, and undertake appropriate educational processes and limitations of drug usage to ensure optimal safety, efficacy and economy of drug use;
10. Oversee the activities and duties of the investigational drug pharmacist;
11. Review for information purposes all protocols approved by the human subjects committee;
12. Serve as an advisory group in developing policies relating to the conduct of pharmaceutical manufacturer's representatives, sampling policies and drug displays at the Medical Center.
13. Develop and promote safe medication practices.

Meetings

The Pharmacy and Therapeutics Committee shall meet monthly.

Reporting Relationship

The Pharmacy and Therapeutics Committee reports to the Medical Staff Executive Committee through the Quality Council. The Chair of the Pharmacy and Therapeutics Committee is a member of the Quality Council. Subcommittees include: The Safe Medication Practices Committee and the Antibiotic Utilization Committee.

Antibiotic Utilization Committee, a Subcommittee of Pharmacy and Therapeutics

Membership

- Chair will be appointed jointly by the Director of Pharmacy, Medical Director for Infection Prevention, Epidemiology and Control
- A representative from Pharmacy appointed by the Director of Pharmacy, who is ex-officio secretary
- A representative of Nursing
- A representative of Medical Center Administration
- Other members of the Medical Staff, Pharmacy or hospital services as appointed by the Chair

Duties

1. Review effectiveness of antimicrobial drug utilization, expenses and resources
2. Provide formulary guidance to the Pharmacy and Therapeutics Committee on antimicrobial drugs

Meetings

Antibiotic Utilization Committee will meet at least quarterly

Reporting Relationship

Antibiotic Utilization Committee will report quarterly to Pharmacy and Therapeutics Committee. Antibiotic Utilization will also provide reports to the Infection Control Committee

Safe Medication Practices Committee, a Subcommittee of Pharmacy and Therapeutics

Membership

- Chair appointed by the Director of Pharmacy and the Medical Director for Pharmacy Services
- At least 4 representative from the Medical Staff , including a physician member of the Cancer Pharmacy and Therapeutics Committee
- Two (2) representatives of the House Staff
- A representative of Nursing
- Director of Pharmacy, who is ex-officio secretary
- A representative of Medical Center Administration
- Director, Drug Information Service

Duties

1. Develop and review written policies and procedures annually for establishment of safe and effective systems for procurement, storage, labeling, distribution, dispensing and use of drugs;
2. Guide the Pharmacy and Therapeutics Committee by reviewing the contents of emergency medication and supplies and any proposed changes in the content of these supplies and policies and procedures for maintaining and stocking the supplies;

3. Guide the Pharmacy and Therapeutics Committee by reviewing drug utilization, and Adverse Drug Reactions and medication errors
4. Undertake appropriate educational processes and limitations of drug usage to ensure optimal safety, efficacy and economy of drug use;

Meetings
Safe Medication Practices Committee will meet monthly, at least 10 times per year

Reporting Relationship
Safe Medication Practices Committee will report at least quarterly to the Pharmacy and Therapeutics Committee and also provides reports to the Patient Safety Committee.

Physicians' Well-Being Committee

The Physician Well-Being committee (PWBC) is a standing committee of the Medical Staff and, as such, is afforded confidentiality protection under California Evidence Code 1157. The mission of the Physicians' Well-Being Committee is to promote the well-being of the Medical Center's Attending and House Staff physicians by early intervention in cases of suspected impairment and by facilitation of health promoting practices.

Membership
Members shall be selected for specific expertise and experience and willingness to serve. An effort should be made to appoint members from several specialties including physicians with expertise in addiction medicine, psychiatry, and qualified persons recovering from alcoholism and other chemical dependence.

The membership will consist of at least four (4) members of the attending Medical Staff and up to two (2) representatives of the House Staff. A physician shall not serve on both the Committee on Physician Well Being and any committee that has review or authority over members of the medical staff.

Duration of Service
To provide for continuity and development of expertise, Committee membership is encouraged to continue for three to five years.

Duties
1. Be known by the Medical Center community as the resource where information and concern about the health of an individual physician can be delivered for confidential consideration and evaluation;
2. Provide advice, recommendations and assistance to the physician in question and to the referring source; provide recommendations for the treatment and/or education; provide assistance in obtaining what is recommended; be an advocate for the physician; These resources will be provided in accordance with the committee's goals, prior to and ideally in lieu of, referral to those hospital, medical staff, house staff, academic or governmental committees and agencies which might result in censure of practice and/or licensing problems);

3. Develop a monitoring plan for a physician to comply with terms of a monitoring agreement and initiate additional appropriate actions when a physician fails to complete the required rehabilitation program;
4. Assist physicians with issues of re-entry to the workplace;
5. Educate Committee members, the staff of the Medical Center and the members of the medical and house staff about physician health, well-being and impairment; about appropriate responses to different levels and kinds of distress and impairment; about treatment, recovery and monitoring; about the responsibilities of the medical staff in response to concerns about a physician's health; about the importance of early intervention; and about appropriate resources for prevention, treatment, rehabilitation, monitoring, and re-entry.
6. Assist the impaired practitioner in meeting ethical obligations to assure quality of care and patient safety;
7. Maintain confidentiality unless the committee receives information that demonstrates that the health or impairment of the member may pose a risk of harm to patients or staff, in which case the matter and information will be referred to the Chief of Staff and Chief Medical Officer who will determine whether corrective action is necessary to protect patients.

Meetings
The committee shall meet at least quarterly in accordance with the approved UCSD Guidelines for the Medical Staff Committee on Physician Well Being.

Reporting Relationship
The Physician Well Being committee reports to the Medical Staff Executive Committee at least quarterly.

Resident Physician Council

Membership
The Resident Physician Council (RPC) shall be a Committee composed of two house staff representatives from each residency program sponsored by the University of California, San Diego, School of Medicine, together with ex-officio members as defined elsewhere in the Bylaws with the addition of the chair of Graduate Medical Education. House staff members shall consist of a senior and a junior member from each aforementioned residency program, selected by their peers.

Representation
All members of the RPC shall be afforded a vote. The RPC shall be co-chaired by two RPC house staff members selected by a vote of the RPC. Co-Chairs shall serve for a minimum one year term, beginning each July and ending the following June.

Duties
With the assistance of the Chair of Graduate Medical Education and the ex-officio members, the RPC shall perform the duties listed below.
1. Supervise the performance of all house staff serving on committees of the Medical Staff, which shall include:

a. Requiring regular reports and recommendations from the departments, committees and officers represented by the house staff concerning discharge of assigned functions.
b. Recommending such directives to the Medical Staff Executive Committee as appropriate to assure effective delivery of patient care; and following up regarding implementation of all recommendations.
c. Assist with coordination of the administrative activities of house staff serving in the various committees and departments.

2. The RPC makes recommendations to the MSEC on at least the following:
    a. Adoption of Bylaws and rules germane to the functions of the house staff and the organization;
    b. Feedback regarding the quality assessment and improvement activities of the organization as noted by the house staff;
    c. Nomination of the house staff whom MSEC shall designate to serve on the appropriate Standing Medical Staff Committees other than the RPC;
    d. Feedback regarding opportunities for improvement in patient care in the organizational infrastructure and resources.
    e. Assist with the efforts of the Medical Staff to adopt, as needed, Bylaws, rules, regulations, policies and procedures establishing clinical criteria and standards to oversee and manage quality assurance.
    f. Assist the MSEC and the Medical Staff in defining objectives for establishing and maintaining the continuing improvement of the quality of care rendered in the hospital, and assist in developing programs to achieve these objectives.

Confidentiality
All house staff serving on Medical Staff committees shall report to the RPC within the confidentiality requirements set forth by each committee.
Meetings
The RPC should meet on a monthly basis and shall maintain a permanent record of its proceedings and actions. The RPC may establish, as necessary, ad hoc house staff committees that will fulfill particular functions for a limited time and will report directly to the RPC; represent and act on behalf of the house staff between meetings of the MSEC.

Reporting Relationship
The RPC reports to the Medical Staff Executive Committee at least three times a year.

Quality Council

Membership
- Chief Medical Officer serves as Chair
- Chief of Staff serves as Vice Chair
- Vice Dean for Clinical Affairs
- Chair, Patient Care and Peer Review Committee
- Chair, Clinical Resource Management Committee
- Chair, Medical Records Informatics Oversight Committee
- Chair, Patient Safety Committee

- Chair, Pharmacy and Therapeutics Committee
- Chair, Infection control committee
- Pharmacist in Chief
- Quality Officer
- Director, Nursing Quality
- Director, Regulatory Affairs
- Chief Clinical Officer
- CEO, UCSD Health System
- Medical Staff representatives from Medicine, Surgery and Psychiatry
- Two (2) representatives of the House Staff

Duties

1. Provide strategic direction, leadership, and oversight of the quality of services provided at UCSD Medical Center;
2. Oversee the implementation of the strategic plan including the mission, vision and goals as they relate to the delivery of quality services;
3. Oversee the development of the organization's annual Performance Improvement and Patient Safety plan ensuring effective integration of quality and patient safety activities throughout the organization;
4. Integration of communication and activities of the various medical staff committee efforts which are directed towards performance improvement and patient safety efforts;
1. Ensure that the Joint Commission, California Title 22 and other regulatory requirements for quality of care are met;
2. Communicate to the Medial Staff Executive Committee the spectrum of quality, patient safety and performance improvement activities of the organization including activities of its reporting committees.

Reporting Relationship

The Patient Safety Committee, Patient Care and Peer Review Committee, Infection Control Committee, Pharmacy & Therapeutics Committee, Clinical Resource Management Committee, Perioperative Services Committee, Perinatal Practices, Cancer Committee, Medical Records Informatics Oversight Committee and the Critical Care Committee report to the Quality Council. The Chairs of the Patient Safety and Patient Care and Peer Review Committees are to report to their respective committees' relevant information from the Quality Council. The Quality Council reports to the Medical Staff Executive Committee.

Quality Council Executive Committee serves as a sub-committee of the Quality Council and provides the strategic direction for the Quality Council.

APPENDIX II UCSD GRADUATE MEDICAL EDUCATION SUPERVISION POLICY

OBJECTIVE
In order to maintain high clinical and educational standards and to assure compliance with applicable regulations in these areas, UCSD Medical Center assured 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. UCSD assures that training at all affiliates is in accordance with these principals.

DEFINITION
GME TRAINING PROGRAM: The responsible program within a Department of the School of Medicine that recruits residents, oversees their training and conducts that evaluation process.

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 in accordance with applicable requirements. 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 faculty must determine the 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 the Joint Commission. One of the four components listed below must always be present in the medical record. There are also certain setting outlined in this policy, for which a specific type of documentation is required by accreditation and regulatory agencies:
- 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 medical 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, the RR Requirements must also be met.
- Each GME Training Program will assign a supervision practitioner(s) to be responsible for compliance with this policy at each affiliate.
- There will be a report provided periodically to the organized medical staff and the governing body about the safety and quality of patient care, treatment and services provided by, and the related educational and supervisory needs of, the participants in professional graduated education programs.

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 faculty member will be identifiable for each resident's patient care encounter; any of the four types of documentation listed in Section III is acceptable.
- 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 for the emergency department. The supervising practitioner will be identified in each resident's patient care encounter; any of the four types of documentation listed in Section III is acceptable.

- The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from the emergency documentation is appropriate. Any of the four types of documentation listed in Section III is acceptable.
- Patients scheduled for direct hospital admission are not required to be seen by the supervising practitioner for the emergency department.

Extended Care Sites

- Each new patient admitted to an extended care facility will be seen by the supervising practitioner within 72 hours of admission; the attending must either write an independent progress note or an addendum to the resident note.
- Extended care facility patients will be seen by, or discussed with, the supervising practitioner at such a frequency to ensure that the course of treatment is effective and appropriate. Any of the four types of documentation listed in Section III is acceptable.

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.

For procedures performed at the VA, the level of staff involvement will be reported to the VA Central Office via the Surgical Quarterly Report.

Non-Operating Room Procedures

- Routine bedside and clinic procedures include skin biopsies, central and peripheral lines, lumbar punctures, centeses, incision and drainage. Any of the four types of documentation listed in Section III is acceptable.
- 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. Any of the four types of documentation listed in Section III is acceptable.

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. If the specific requirements of the pre-operative notes are included, the admission note (or addendum) may also serve as the pre-operative note.
- 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. Any of the four types of documentation of supervision listed in Section III is acceptable.
- 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 counter-signature of the consultative note written by the resident.

APPENDIX III UCSD RESIDENT/FELLOW POSITION DESCRIPTION

The goal of the graduate medical education training program is to (a) provide trainees (interns, residents, and fellows) with an extensive experience in the art and science of medicine in order to achieve excellence in the diagnosis, care, and treatment of patients and (b) to establish trainee's eligibility to participate in the relevant ABMS Specialty Board examination. To achieve this goal, the trainee agrees to do the following for the duration of his/her graduate medical education training at UCSD Medical Center:

1. Develop and participate in a personal program of self-study and professional growth with guidance from the Medical School's teaching staff.
2. Under the supervision of the Medical School's teaching staff, participate in safe, effective and compassionate patient care, consistent with the trainee's level of education and experience.
3. Participate fully in the educational activities of the residency/fellowship program and assume responsibility for participation in the teaching of more junior physicians, of medical students and students in allied health professions.
4. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures and policies of the institution.
5. Participate in the standing committees of the Medical Staff and institutional committees, as assigned by the program director; especially those that relate to patient care review activities.
6. Develop an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical education and the practice of medicine. Learn cost containment measures in the provision of patient care.
7. Perform all duties in accordance with the established practices, procedures and policies of the institution, its programs, clinical departments and other institutions to which the resident/fellow is assigned.
8. Strict adherence to the moonlighting policies of UCSD and to the program in which the resident/fellow is appointed.
9. Comply with the duty hour policies of UCSD and the program in which the resident/fellow is appointed.
10. Adhere to the program's call schedule and schedule of assignment.
11. Document patient care in the medical record in a timely fashion as per Medical Staff policy.
12. Adhere to the ACGME Institutional Requirements and to the ACGME-RRC Program Requirements for the specialty in which the resident/fellow is in training.
13. Participate in the evaluation of the training program and its faculty.
14. Comply with the licensure requirements of the State of California, and the laws of the State and Federal Governments.
15. Adhere to the policies defined in the UCSDMC document entitles, Guidelines for Managing Impaired Residents and the UCSD House Officer Policy and Procedure Document.

APPENDIX IV PATIENT RIGHTS

Documentation of Participation in Health Care Decision Making
Given that the process by which care and treatment decisions are made should elicit, respect, and incorporate patient's preferences, and that this process is based on a partnership with the physician and other health care professionals to facilitate informed decision making by the patients or his/her designated representative(s), the Medical Staff of the UCSD Medical Center established the following policy with regard to the documentation of patient care decision:

At the initiation of in-patient or outpatient care at UCSD Medical Center and on admission to or discharge from an intensive care unit, physicians their discussions with patients and/or their surrogates with regard to:

1. The contemplated course(s) of care;
2. Consideration of alternatives and the patient's and provider's jointly chosen course of treatment;
3. The patient's understanding and agreement with his or her participation and assistance in the treatment;
4. Changes in the care plan;
5. Do not Resuscitate status;
6. Advanced Directive status; and
7. Pain management considerations, if any.

This policy that applies to all patients, is effective immediately, and is to be followed in conjunction with the Medical Staff policy on Informed Consent (Appendix V to these Bylaws).

APPENDIX V POLICY ON INFORMED CONSENT

UCSD Medical Center recognizes that every person having the ultimate responsibility for decisions respecting his or her health care, or the health care of others, has the right to determine whether to submit to medical or surgical care but has less knowledge of recommended procedures than do physicians, members of the Allied Health Professional staff (AHP) and nurses who perform invasive procedures.

Thus, except in emergencies, patients are entitled to receive, in terms of language they can understand, as much information about any proposed treatment or procedure as needed in order to participate actively in decision regarding health care, and to consent to or refuse a course of treatment (See Attached MCP 339.1E, Consent for Anesthesia, Surgery, Special Diagnostic, or Therapeutic Procedures). Such information includes:

1. The nature of the proposed treatment
2. The risks, benefits, side effects, and complications (including potential problems related to recuperation);
3. The likelihood that the proposed treatment will achieve its intended goals;
4. Any alternatives to the treatment, including refusal of treatment and its risks and benefits;
5. The risks, complications and expected benefits or effects of rehabilitation associated with the treatment; and
6. When indicated, any limitations on the limitation on the confidentiality of information learned from or about the patient.

Accordingly, for all procedures that require informed consent (as identified in the attached Medical Center Policy on Informed Consent) the following is established as policy at the Hospital and Clinics of the UCSD Medical Center:

The physician member of the treating team, Allied Health Professional or licensed practitioner credentialed to provide the procedure or service must either inform the patient with respect to recommended treatment or procedure, or ascertain that such information has been given to the patient before commencing the treatment or procedure.

Material information is that which a reasonable physician or licensed practitioner knows or should know and would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject a recommended procedure, and includes information of the risk to the patient of refusing treatment.

There shall be appropriate documentation of the information given, as follows:

1. The provider who had the informed consent discussion with the patient, and/or the patient's surrogate decision maker, will make an entry in the progress record, at the time of discussion or as soon as possible thereafter, attesting that the procedure, potential risks and complications, risks associated with refusal or treatment, and alternative methods of treatment have been explained to the patient, and he or she has consented to the specific

procedure. The provider who had the informed consent discussion with the patient should note in the progress record whether the patient's family was present during the discussion with the patient.

2. The provider performing the procedure or the anesthesiologist will ascertain that the patient or patient's representative has signed an appropriate consent form.
3. If the patient declines to discuss or receive information about the potential risks, complications and alternative treatment, after being offered the opportunity to do so, such declination shall be noted in the progress record.

If the patient or surrogate decision maker refuses the proposed treatment or procedure, a detailed note should be written in the Progress Record, and should include at least the following: A statement that the patient refused treatment despite a discussion of risks and benefits, reason(s) given by the patient or representative for refusal, identification of others, if any, who were present during the discussion.

APPENDIX VI PRIVILEGES FOR ALLIED HEALTH PROFESSIONAL STAFF

General Provisions

This document is intended to provide a delineation of the qualifications, status, clinical duties and responsibilities of specifies professional personnel whose patient care activities require that their appointment and authority for specified services be processed through usual medical staff channels. At UCSD Medical Center, the Interdisciplinary Practices Committee has recommended and the Medical Staff Executive Committee has approved five (5) major categories of Allied Health Professional Staff. These include nurse anesthetist, nurse-midwife, nurse practitioner, physician assistant, and psychologist.

Allied Health Professional Staff credentials are reviewed by the Interdisciplinary Practices Committee, which in turn recommends individual practitioner, expanded role activities to the Medical Staff Executive Committee and the Governing Body. The Governing Body as represented by the CEO, UCSD Medical Center, grants final approval.

Applicants to the Allied Health Professional Staff shall be made on a form approved by the IPC. The application shall be signed by the applicant and submitted to Medical Staff Administration. To be complete, it shall include:

1. Statement of acknowledgment of receipt and agreement to comply with the Bylaws, Rules and Regulations;
2. Explicit acknowledgment of that section of the Bylaws which provides for release and immunity from civil liability of the Allied Health Professional Staff with respect to the performance of its quality improvement/peer review functions
3. Licensure and authority to furnish/prescribe medications, if applicable, in the state of California;
4. Information on any malpractice or professional liability actions involving the applicant during the last seven years, including a consent to the release of information by the applicant's malpractice insurance carrier(s); and as applicable, to include a copy of the judgment entered and a copy of the final settlement entered. Medical Staff Administration will verify information that is provided.
5. Completion of Delineation of Privileges or Standardized Protocols with evidence of ability to perform privileges, job description requested.
6. Current CPR certification;
7. Names and addresses of three (3) references who can certify to the applicant's professional competency on the basis of personal knowledge, and who can serve as a character witness. Medical Staff Administration (MSA) may solicit written recommendations from the names provided;
8. Consent by the applicant to the inspection of records and documents pertinent to his/her licensure, specific training experience, current competency and health status;
9. Employment history for the past seven years which shall be verified by MSA;
10. 2" x 2" photo, and
11. Application fee.

Reappointment to the Allied Health Professional Staff shall be sent to prior to the expiration of their current appointment. A reappointment form will be sent to the applicant to complete, to include:

1. Statement of acknowledgment of receipt and agreement to comply with the Bylaws, Rules and Regulations;
2. Explicit acknowledgment of that section of the Bylaws which provides for release and immunity from civil liability of the Allied Health Professional Staff with respect to the performance of its quality improvement/peer review functions (see Article XVI);
3. Licensure and furnishing/transmittal of medications licensure;
4. Information on malpractice or professional liability actions involving the applicant since he completion of the last application form;
5. Updated delineation of privileges or standardized protocols;
6. Names of two (2) references who can certify to the applicant's current professional competency on the basis of personal knowledge. MSA shall solicit written recommendations from the names provided;
7. Current ART or BART certification;
8. Current evaluation of the member's professional competency as determined by the department chair or designee; and
9. Application fee.

Expanded role privileges for Allied Health Professional Staff members may be limited or modified or terminated by the department chair, program director, Medical Director or CEO, UCSD Medical Center, on the following grounds:

1. Noncompliance with Medical Staff Bylaws, Rules and Regulations, or the regulations of the clinical department;
2. Violation of specific rules of the Medical Center;
3. Misconduct;
4. Care below applicable standards;
5. Personality dysfunction.

Expanded role privileges may be summarily suspended by the department chair, program director, Medical Director or CEO, UCSD Medical Center, whenever necessary to protect life or welfare of patients.

Expanded role privileges shall be automatically suspended when the practitioner's license and/or certificate to practice expires, is revoked, suspended, restricted or placed on probation.

A due process hearing mechanism for an aggrieved practitioner will be through the formal mechanism in place for the particular classification, e.g., nurse practitioners, in accordance with the provisions of the CNA Agreement. In any situation in which a formal mechanism is not already in place, the aggrieved practitioner shall have the right to challenge an action taken by the department chair, program director, Medical Director, or CEO, UCSD Medical Center, which would limit or modify or terminate his/her expanded role privileges (except when automatically suspended due to expiration, revocation, suspension, restriction, or probation of a license/certificate to practice) by filing a written grievance with the Medical Staff Executive Committee within 15 days of the action. Upon receipt of the grievance the Medical Staff

Executive Committee shall either itself or through an ad hoc committee (selected by the Chair, Medical Staff Executive Committee) conduct an investigation that affords the aggrieved an opportunity for a hearing concerning the grievance. Before the hearing, the aggrieved shall be informed of the general nature of the circumstances giving rise to the action, and the aggrieved may present relevant information at the hearing. A record of the hearing shall be made. A decision shall be rendered by the Medical Staff Executive Committee on the action either as a result of its investigation or on the recommendation of the ad hoc committee. The Governing Body shall affirm the decision if it is supported by substantial evidence. The decision of the governing Body shall be final.

Corrective action and due process related to issues of employment shall be conducted in accordance with applicable policies of the University, the Medical Center, and contractual agreements.

Nurse-Midwife

Qualifications

1. Graduation from a master's level educational program accredited by the American College of
2. Nurse-Midwives, Division of Accreditation, or equivalent comprising of two (2) years or more of post-Registered Nurse Education with Certificate of Nurse Midwife (CNM) certification by the state of California.
3. Successful completion of the certification examination given by the American College of Nurse-Midwives, Division of Competency Assessment.
4. Licensure in the State of California as a registered nurse under the Nurse Practice Act.
5. Licensure by the State of California to practice nurse-midwifery.

Status

1. Full-time/part-time employee of UCSD, located/funded either by campus or UCSD Medical Center.
2. With or without appointment to the faculty of the UCSD School of Medicine.
3. Those nurse-midwives whose primary employers have a contractual relationship or affiliate agreements with the UCSD Healthcare Network.

Clinical Duties

Supervision:

All tasks are to be performed by a certified nurse-midwife under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics. The physical presence of the supervising physician is not required at the time the nurse-midwife is engaged in practice.

All complications as outlined in the protocol require consultation or referral to a physician.

The supervisory relationship between the physician and nurse-midwife shall be formalized in writing and shall include, but not be limited to:

1. Responsibility to each other.
2. Communication arrangements.
3. Arrangements for alternate consultation when the physician may be unavailable.

4. Arrangements for a hospital referral and an alternate supervision physician accessible to the Nurse midwife's area of practice.

Clinical Duties:
The nurse-midwife and nurse practitioner UCSD employee shall function within medically approved guidelines set forth in the Medical Center and Interdisciplinary Practices Committee Approved document entitled, "Standing Orders, Policies, procedures and Protocols for Use by Certified Nurse-Midwives and Registered Nurse Practitioners."

In general terms, the nurse-midwife is authorized to attend cases of normal childbirth and shall provide prenatal, intrapartal, postpartal, and interconceptional care including family-planning for the mother and immediate care for the newborn.

Responsibilities
1. May serve on medical staff committees.
2. Shall serve as instructors in the educational programs of the Medical Center as appropriate.
3. Shall provide the proper quality of professional care in the Medical Center.

Certified Registered Nurse Anesthetist

Qualifications
1. Graduation from an accredited nursing program and licensure in the State of California as a Registered Nurse with designations as a Nurse Anesthetist.
2. Completion of a Certified Registered Nurse Anesthetist program, generally consisting of a minimum of two years clinical and didactic training with completion of the National Certification Examination and/ or current Re-Certification.

Status
Full time/part-time employee of UCSD funded without appointment to the faculty of the UCSD Medical Center School of Medicine.

Clinical Duties
The following clinical duties are performed under direct supervision of board certified or board eligible anesthesiologist.
1. Reviews laboratory x-ray and electrocardiogram reports and recognizes common abnormalities. Performs those parts of history and physical examination necessary for anesthetic preoperative evaluation and makes an assessment therefore, and records and presents pertinent data in a manner meaningful to the anesthesiology.
2. Within medically established guidelines, develops a plan of anesthetic management for assigned patients, ensuring that necessary supplies and equipment are available, and that the anesthesia machines are properly functioning.
3. Ascertains condition of patient prior to and during surgery by reviewing laboratory results, obtaining and recording vital signs. Administers pre-operative medication when ordered by staff anesthesiologist.

4. Maintains current expertise in the placement and care of indwelling venous and arterial catheters, fluid and electrolyte therapy, blood and blood product transfusion, direct laryngoscopy, and endotracheal intubation (both oral and nasal).
5. Administers anesthetics by inhalation, IV, and regional methods. Monitors anesthetic level and inform anesthesiologist and/or operating surgeon of significant change in physical condition. Takes any necessary remedial action including administration of medication and/or oxygen. Performs post-operative follow-up in the recovery room. May evaluate the post-anesthetic course management, and within medically established guidelines, recommends courses of action aimed at correcting any complications.
6. Is able to institute emergency respiratory therapy including mask, endotracheal and mechanical ventilation of the patient as necessary. Will draw arterial blood and analyze acid base data to assist in assuring effectiveness of the patient's ventilatory capacity or mechanical ventilation.
7. Maintains cognizance of legal aspects of anesthesia, including informed and implied consent, liability and responsibility. Undergoes continual education updating to maintain skills in physiology, pharmacology, anesthetic agents and gases, vaporization, uptake and distribution of agents and drugs.
8. Assists others in learning basic areas of expertise, including cardiopulmonary resuscitation, fluid therapy and physiological monitoring.
9. Participates in developing procedures for infection control, ordering of supplies, workflow and restocking of anesthesia drugs and other supplies in the anesthesia workroom. May participate in research protocols and performance improvement studies.

Responsibilities
1. May serve on medical staff committees.
2. Shall serve as instructors in the educational programs of the Medical Center as appropriate.
3. Shall provide the proper quality of professional care in the Medical Center.

Nurse Practitioner

Qualifications
The nurse practitioner is a registered nurse with additional preparation and skill in physical diagnosis, psychosocial assessment and management of health/illness needs in primary health care.

Categories of specialization include, but are not limited to, adult nurse practitioner, pediatric nurse practitioner, neonatal nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner.

The following qualifications apply to nurse practitioners:
1. Current licensure in the State of California as a registered nurse under the Nurse Practice Act, and one (1) of the following:
    a. Successful completion of a program of study which conforms to Board Standards; or
    b. Certification by a national or state organization whose standards are equivalent to those set forth in Section 1484 of the Rules and Regulations, Title 16, California Administrative Code, Chapter 12, Registered Nursing; or

c. A nurse who has not completed a nurse practitioner program which meets Board Standards must submit to the Board the following documents:
    i. Documentation of remediation of areas of deficiency in course content and/or clinical experience, and
    ii. Verification by a nurse practitioner and by a physician who meet the requirements for faculty members specified in Section 1484 (c), of clinical competence in the delivery of primary care.
d. Effective January 1, 2016, all new hire nurse practitioners will meet the certification requirements as specified in 1.b. above.

2. Indication of the registered nurse license issued or renewed by the Board, that the person is qualified to use the title "Nurse Practitioner".
3. Certificate issued by the Board evidencing that person is qualified to use the title "Nurse Practitioner."

Status
Full-time/part-time employee of the University of California at San Diego, located/funded either by the campus or Medical Center; with or without appointment to the faculty of the UCSD School of Medicine.

Clinical Duties under Licensed Physician
The following clinical duties are performed under a licensed physician who is approved by the State of California:
1. The physician must be a member in good standing of the UCSDMC attending medical staff;
2. A physician shall be available in person or by electronic communication at all times when the nurse practitioner is caring for patients;
3. A physician shall delegate to a nurse practitioner only those task and procedures consistent with the physician specially or usual and customary practice and with the patients' health and condition;
4. A physician shall observe or review evidence of the nurse practitioner's performance of all task and procedures to be delegated to the nurse practitioner until assured of competency;
5. A nurse practitioner and the physician shall establish in writing, guidelines for the nurse practitioner, which conforms to the department/division, approved standardized protocols and the scope of the nurse practitioner's license.

Clinical Duties:
The nurse practitioner shall provide comprehensive health care services for patients and shall formulate an appropriate treatment plan. The practitioner shall provide health teaching and health maintenance for well and ill persons. He/she may act as clinical preceptor for students of health care disciplines and may participate in research and performance improvement studies.

Basic health care services provided to patients include but are not limited to:
- Health histories and physical examinations
- Treatment of minor illnesses such as flu, colds, sprains, infections, and others
- Care for patients with stabilized chronic illnesses such as diabetes, heart disease, emphysema, hypertension and others

- Health counseling and teaching
- Pap smears and routine female exams
- Well baby exams
- Diet and exercise counseling
- Immunizations
- Referrals.

Furnishing Medications/Devices
The Nurse Practitioner may furnish drugs and/or devices to a patient under the Nursing Practice Act, Business & Professions Code Section 2836.1. The Nurse Practitioner must have obtained a furnishing number from the Board of Registering Nursing. This number must be included on the transmittal order form for all drugs and/or devices and other legal requirements followed. Drugs and/or devices include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act, Division 10. The drugs and/or devices are furnished by a Nurse Practitioner according to standardized procedures or protocols developed by the Nurse Practitioner and supervising physician under any of the following circumstances:

- When furnishing incidental to the provision of family planning services;
- When furnishing incidental to the provision of routine health care or prenatal care;
- When rendered to essentially health persons.

Furnishing Controlled Substances
Scheduled III controlled substances, as defined in Section 11056 of the health and Safety Code, are furnished in accordance with a patient-specific protocol contained within the standardized procedure and approved by the physician. This protocol may state any other limitations as agreed upon by the Nurse Practitioner and the physician.

At UCSD Medical Center, nurse practitioners are authorized to practice in accordance with the specific provisions of the Medical Center and Interdisciplinary Practices Committee approved standardized procedures and protocols. For example, all family nurse practitioners shall function in accordance with the "Policy and Procedures for Use by Certified Family Nurse Practitioners in the UCSD Family Medicine Center."

Standardized policies and procedures shall address the issues of specific requirements, education, training and experience, evaluation, supervision/consultation, circumstances for immediate physician consultation, setting, location, patient record keeping and periodic review.

Responsibilities
1. May serve on medical staff committees.
2. Shall serve as teachers in the educational programs of the Medical Center as appropriate.
3. Shall provide the proper quality of professional care in the Medical Center.

Physician Assistant – Certified (PA-C)

Qualifications
The California Physician assistant Examining Committee (PAEC) of the Medical Board of

California (MBC) is legally authorized to license physician assistants. The following general qualifications apply to PAs.

1. Successful completion of a course of instruction acceptable to PAEC/MBC, which includes graduation from a PA program, approved by the State of California or a medical school located in the United States.
2. Successful completion of a certification examination administered by the National Commission of Certification of Physician Assistants.
3. Certification by the California Physician assistant Examining Committee to perform direct patient care services under the supervision of a physician (s) who is approved by the Board to supervise such an assistant. Certification is renewed biennially.
4. Interim approval to function as a PA granted by the State of California to candidates who have graduated from an approved program and are waiting to take the certification exam.

Status

Full-time/part-time employee of the University of California at San Diego, located/funded either at campus or the UCSD Medical Center.

Supervision:

All tasks are to be performed by a PA under the supervision of a licensed physician who is approved by the State.

1. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.
2. A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.
3. A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.
4. The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.
5. A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms (a copy of such documentation shall be presented to the IPC during initial and biennial committee review):
    a. Examination of the patient by a supervising physician the same day as care is given by the PA;
    b. Countersignature and dating of all medical records written by the PA within thirty (30) days that the care was given by the PA; where "medical record" is defined as an inpatient, procedural or outpatient encounter with a patient and a signature is provided at the encounter level.
    c. The supervising physician may adopt protocols to govern the performance of a PA for some or all tasks. The minimum content for a protocol shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the

patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician or adopted from texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The Attending Physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the Physician Assistant functioning under protocols within thirty (30) days. The 5% sample submitted for Attending Physician co-signature are designated by the attending and may include:

i. Patients requiring hospital admission or ER referral
ii. Patients who undergo invasive procedures performed by the Physician Assistant
iii. Patients with identified new allergies
iv. Patients prescribed narcotic medications
v. New patient visits
vi. Any other patients identified by the Physician Assistant according to the Physician Assistant's experience and training that should be forwarded for Physician review.

d. Other mechanisms approved in advance by the PAEC.

6. In the case of a physician assistant operating under interim approval, the supervising physician shall review, sign and date the medical record of all patients cared for by that physician assistant within seven (7) days if the physician was on the premises when the physician assistant diagnosed or treated the patient. If the physician was not on the premises at that time, he/she shall review, sign and date such medical records within 48 hours of the time the medical services were provided.
7. Except in a life-threatening situation, a physician assistant shall perform surgery requiring other than a local anesthesia only under the direct and immediate supervision of an approved physician.
8. The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his/her supervision.

Clinical Duties

A physician assistant may only provide those medical services that he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that PA.

A physician assistant shall consult with a physician regarding any task, procedure or diagnostic problem that the physician assistant determined exceeds his/her level of competence or shall refer such cases to a physician.

The following list of tasks is not intended to be restrictive or all-inclusive, but indicative of the complexity and types of tasks and services that may be performed. PA's may be permitted to perform additional tasks, except those expressly excluded, in which adequate training and proficiency can be demonstrated to the Board's satisfaction.

The Interdisciplinary Practices Committee will individually review and approve specific privileges for PA's practicing at UCSD Medical Center.

A physician assistant may:

1. Take an appropriate history; perform and appropriate physical examination and make an assessment there from, and record and present pertinent data in a manner meaningful to the physician.
2. Perform and/or assist in the performance of routine laboratory and screening procedures delegated by the supervising physician when the procedures to be performed are consistent with the physician's specialty or usual and customary practice, and with the patient's health and condition.
3. Perform and/or assist in the performance of therapeutic procedures delegated by the supervising physician where the procedures to be performed are consistent with the physician's specialty or usual and customary practice, and with the patient's health and condition.
4. Recognize and evaluate situations that call for immediate attention of the physician and institute, when necessary, treatment procedures essential for the life of the patient.
5. Instruct and counsel patients regarding matters pertaining to their physical and mental health, such as diets, social habits, family planning, normal growth and development, aging, and understanding of and long term management of their disease.
6. Assist the physician by arranging admissions, by taking complete histories and performing physical examinations, by completing forms and charts pertinent to the patient's medical record, by providing services to patients requiring continuing care, including patients at home. This assistance also includes the review of treatment and therapy plans, the ordering of routine diagnostic laboratory tests and procedures and routine diagnostic radiological services, such as bone and chest x-rays, the ordering of therapeutic diets, physical therapy treatments, occupational therapy treatments and respiratory care services, and by evaluating patients and performing the procedures and tasks specified in subsections (1), (2), and (3) above and acting as first or second assistant in surgery under the supervision of an approved supervising physician.
7. Facilitate the physician's referral of patients to the appropriate health facilities, agencies, and resources of the community.
8. Administer medication to a patient, or transmit orally, or in writing on a patient's record, a prescription from his/her supervising physician to a person who may lawfully furnish such medication or medical device. The supervising physician's prescription, transmitted by the PA, for any patient cared for by the PA, shall be based either on a patient specific order by the supervising physician or on written protocol which specifies all criteria for the use of a specific drug or transmit a prescription for a drug other than that specified in the protocol, without a patient-specific order from a supervising physician. At the direction and under the supervision of a physician supervisor, a PA may hand to a patient of the supervising physician a properly labeled prescription drug prepackaged by a physician, a manufacturer,

as defined in the Pharmacy Law, or a pharmacist. In any case, the medical record of any patient cared for by a PA for whom the physician's prescription has been transmitted or carried out shall be reviewed and countersigned and dated by a supervising physician within seven (7) days. A PA may not administer, provide or transmit a prescription for controlled substances in Schedules II through V inclusive without patient-specific authority by a supervising physician.

9. A physician assistant may be trained to perform medical services, which exceed his/her areas of competency, in the physical presence of an approved supervising physician who is directly in attendance and assisting the PA in the performance of the procedure.

Responsibilities

1. May serve on medical staff committees.
2. Shall serve as teachers in the educational programs of the Medical Center as appropriate.

RULES & REGULATIONS – APPROVALS

APPROVED BY:	DATE:	REVISED:
▪ UCSD Medical Staff Executive Committee	12/19/2006	04/24/07; 07/19/07; 12/20/07; 6/19/08; 7/17/08; 05/21/09; 05/20/10; 08/19/10, 03/17/11, 08/09/11, 10/20/11, 12/15/11
▪ UCSD Medical Staff	02/2720/07	
▪ CEO, UCSD Medical Center	02/27/2007	04/24/07; 07/19/07; 12/20/07; 06/19/08; 07/17/08; 05/21/09; 05/20/10;
▪ UCSD Medical Staff Executive Committee	08/17/2017	08/19/10, 03/17/11, 08/09/2011, 10/20/11, 12/15/11; 6/30/12; 11/15/12;
▪ EGB, UCSD Medical Center	09/05/2017	7/18/13; 10/22/13; 03/05/2014; 3/20/2014, 09/05/2017