

**NEUROSURGERY CLINICAL SERVICE  
RULES AND REGULATIONS**

**2016**

**NEUROSURGERY CLINICAL SERVICE  
RULES AND REGULATIONS  
TABLE OF CONTENTS**

I.	NEUROSURGERY CLINICAL SERVICE ORGANIZATION.....	2
A.	SCOPE OF SERVICE .....	2
B.	MEMBERSHIP REQUIREMENTS.....	2
C.	ORGANIZATION and STAFFING OF NEUROSURGERY CLINICAL SERVICE.....	2
II.	CREDENTIALING .....	4
A.	NEW APPOINTMENTS .....	4
B.	REAPPOINTMENTS .....	4
C.	PRACTITIONER PERFORMANCE PROFILES .....	4
D.	AFFILIATED PROFESSIONALS .....	5
E.	STAFF CATEGORIES.....	5
III.	DELINEATION OF PRIVILEGES .....	5
A.	DEVELOPMENT OF PRIVILEGE CRITERIA .....	5
B.	ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM.....	5
C.	CLINICAL PRIVILEGES AND MODIFICATIONS/CHANGES TO CLINICAL PRIVILEGES .....	5
D.	TEMPORARY PRIVILEGES .....	6
IV.	PROCTORING AND MONITORING.....	6
A.	REQUIREMENTS.....	6
B.	ADDITIONAL PRIVILEGES.....	6
C.	REMOVAL OF PRIVILEGES.....	6
V.	EDUCATION OF MEDICAL STAFF .....	6
VI.	NEUROSURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION (REFER TO CHN WEBSITE FOR HOUSESTAFF COMPETENCIES LINK.).....	7
A.	ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITY OF THE HOUSE STAFF .....	8
B.	RESIDENT EVALUATION PROCESS .....	8
C.	PATIENT CARE ORDERS .....	9
VII.	NEUROSURGERY CLINICAL SERVICE CONSULTATION CRITERIA.....	9
VIII.	DISCIPLINARY ACTION.....	9
IX.	PERFORMANCE IMPROVEMENT PATIENT SAFETY (PIPS) AND UTILIZATION MANAGEMENT.....	9
A.	GOALS AND OBJECTIVES .....	9
B.	MEDICAL RECORDS .....	10
C.	INFORMED CONSENT .....	10
D.	CLINICAL INDICATORS.....	11
E.	CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES .....	11
F.	MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES .....	11
G.	MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE.....	11
X.	MEETING REQUIREMENTS.....	12
XI.	ADOPTION AND ADMENDMENT.....	12

**NEUROSURGERY CLINICAL SERVICE  
RULES AND REGULATIONS  
TABLE OF CONTENTS (Continued)**

APPENDIX A NEUROSURGERY PRIVILEGE REQUEST FORM ..... 13  
APPENDIX B NEUROSURGERY PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) PLAN ..... 16  
APPENDIX C NEUROSURGERY HOUSESTAFF MANUAL ..... 18  
APPENDIX D CLINICAL SERVICE CHIEF OF NEUROSURGERY SERVICE JOB DESCRIPTION..... 19

## **I. NEUROSURGERY CLINICAL SERVICE ORGANIZATION**

### **A. SCOPE OF SERVICE**

The Neurosurgery Service at San Francisco General Hospital is an integral part of the Department of Neurological Surgery at The University of California, San Francisco. The Service serves a broad community of patients and their physicians through the maintenance and continuing development of capacity for the management of surgical disorders of the nervous system with a special emphasis on Neurotrauma and Neurocritical care. While problems associated with acute and severe illness and injury are addressed daily, the range of conditions treated includes chronic and degenerative diseases of the brain, spine, and peripheral nerves. Excellence in patient care is dependent on vigorous interaction with neurological, radiological and other expert SFGH colleagues.

The Rules and Regulations of the Neurosurgery Clinical Service correspond to the standards and requirements set forth in the SFGH Medical Staff Bylaws, Rules and Regulations.

Standards of professional clinical practice are those applicable to all full- and part-time faculty members of the Department of Neurological Surgery of the University of California, San Francisco.

### **B. MEMBERSHIP REQUIREMENTS**

Membership on the Medical Staff of San Francisco General Hospital is a privilege that shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth in SFGH Medical Staff Bylaws, Rules and Regulations.

1. Board Eligible or Board Certified by ABMS Neurological Surgery (may be waived at the recommendation of the Chief of Neurosurgery)
2. Current California medical licensure
3. Current DEA certification
4. CPR/ACLS/BCLS/ATLS is encouraged

### **C. ORGANIZATION and STAFFING OF NEUROSURGERY CLINICAL SERVICE**

The members of the Neurosurgery Clinical Service are:

Chief of Service

Members of the Attending Neurosurgical Staff

#### **1. Chief of Service**

Responsibilities (Refer to Appendix D for job description):

- a. Overall direction of the clinical, teaching, and research activities of the Neurosurgery Clinical Service.
- b. Review and recommendation of all new appointments, request for privileges, and reappointments.
- c. Appointment of the remaining officers of the neurosurgery clinical service and of committee members.

- d. Financial affairs of the Neurosurgery Clinical Service.
- e. Attendance at the Medical Executive Committee, the Chiefs of Service meetings, and other meetings as called from time to time by the Executive Administrator or the Chief of Staff.
- f. Disciplinary actions as necessary, as set forth in the SFGH Medical Staff and Rules and Regulations.

### **Attending Physician Responsibilities**

Responsibilities include:

- a. Overall direction of clinical care is the responsibility of the attending staff of the Neurosurgery Clinical Service. In order to discharge that responsibility, close supervision and active participation in decision-making is required.
- b. All neurosurgical procedures performed in the operating theater will be supervised by an attending neurosurgeon who is physically present during the case. Most procedures can be started by the Neurosurgery Chief Resident without the direct physical supervision of a Neurosurgical Attending provided he/she has previously discussed patient preoperative assessment, surgical approach, and patient positioning with the responsible Neurosurgical Attending. When the Chief Resident performs any procedure for the first time, the responsible attending must be in the room from the beginning. Particularly complex procedures or instances where the Attending and Chief Resident are unfamiliar with each other will also require attending supervision from the beginning of the case.
- c. Under certain conditions, it will be necessary for the Chief Resident to start a procedure prior to the physical presence of an Attending. This situation applies mainly to emergency neurosurgical procedures for trauma occurring after regular working hours. The vast majority of these procedures are straightforward and there should be no difficulty for a Chief Resident begin these on his/her own after discussing the case with an Attending Neurosurgeon. Nevertheless, the physical presence of an attending is required during the critical portion of the operation.
- d. All elective cases require that the Attending Neurosurgeon be in-house while the patient is in the operating room (OR) and he/she be physically present in the OR during the important aspects of the procedure. For some procedures, such as lumbar discectomy or stereotactic brain biopsy, the actual physical involvement of the attending neurosurgeon may be minimal. Nevertheless, direct supervision by an attending neurosurgeon who is physically in the operating theater is also required during the more important aspects of these procedures.
- e. The degree to which a neurosurgical attending actively participates in a surgical procedure will be in proportion to its complexity. As such, a greater degree of attending participation is expected for extra- or

intracranial vascular surgery, complex tumor surgery or for spinal procedures involving complex instrumentation.

- g. Procedures performed outside the operating theater may sometimes be performed without the direct physical supervision of an Attending Neurosurgeon. These include placement of a HALO cervicothoracic orthosis, insertion of intraparenchymal or intraventricular intracranial pressure monitors, advanced neuromonitors (brain tissue oxygen, cerebral blood flow, microdialysis), insertion of routine intravascular monitoring lines (e.g., central venous pressure lines, pulmonary capillary wedge pressure lines, arterial lines, or jugular venous saturation monitoring lines), and tapping of ventricular access (Ommaya) or ventriculoperitoneal shunt reservoirs. In addition, closure of non-complicated, post-traumatic wounds (both in the operating theater and outside) may be performed in an unsupervised fashion by the neurosurgical chief resident when performed as a service to the trauma team or emergency department.

## **II. CREDENTIALING**

### **A. NEW APPOINTMENTS**

The process of application for membership to the Medical Staff of SFGH through the Neurosurgery Clinical Service is in accordance with SFGH Medical Staff Article II, *Medical Staff Membership*, Rules and Regulations as well as these Clinical Service Rules and Regulations.

### **B. REAPPOINTMENTS**

The process of reappointment to the Medical Staff of SFGH through the Neurosurgery Clinical Service is in accordance with SFGH Medical Staff Bylaws, Rules and Regulations.

#### **1. Modification of Clinical Service**

Changes in patterns of practice within the Neurosurgery Service, whether occasioned by clinical or fiscal or other constraints or whether by expansion of service through new competence or new facilities, require discussion and approval by the Service. This specifically includes new operative or other technical procedures and approaches.

#### **2. Staff Status Change**

The process for Staff Status Change for members of the Neurosurgery Services is in accordance with SFGH Medical Staff Bylaws, Rules and Regulations.

#### **3. Modification/Changes to Privileges**

The process for Modification/Change to Privileges for members of the Neurosurgery Service is in accordance with SFGH Medical Staff Bylaws, Rules and Regulations.

### **C. PRACTITIONER PERFORMANCE PROFILES**

The attending neurosurgeons of the Neurosurgery Service include full-time University employees and non-compensated members of the UCSF Neurosurgery Department's clinical faculty. In other cases they must be board eligible or board certified in neurological surgery and must meet the standards, and abide by the regulations of the

University of California School of Medicine. All patient care matters pertaining to attending physicians, individually or as a group, are addressed as they arise, in regular Neurosurgery Service meetings. Specific events, including incident reports and occurrences with potential or actual legal implications, are reviewed in association with the UCSF Risk Management Office at SFGH.

**D. AFFILIATED PROFESSIONALS**

The process of appointment and reappointment of the Affiliated Professionals to SFGH through the Neurosurgery Clinical Service is in accordance with SFGH Medical Staff Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations.

**E. STAFF CATEGORIES**

The Neurosurgery Clinical Service fall into the same staff categories which are described in Article III- *Categories of the Medical Staff* of the SFGH Medical Staff Bylaws, Rules and Regulations.

**III. DELINEATION OF PRIVILEGES**

**A. DEVELOPMENT OF PRIVILEGE CRITERIA**

Neurosurgery Clinical Service privileges are developed in accordance with SFGH Medical Staff Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations. Refer to Appendix A.

**B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM**

The Neurosurgery Clinical Service Privilege Request Form shall be reviewed annually

**C. CLINICAL PRIVILEGES AND MODIFICATIONS/CHANGES TO CLINICAL PRIVILEGES**

Neurosurgery Clinical Service privileges shall be authorized in accordance with the SFGH Medical Staff Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of the Neurosurgery Clinical Service.

Privileges to practice in the Neurosurgery Clinical Service will be commensurate with clinical training and documentation of an acceptable standard of clinical practice.

Privileges are delineated by consensus of the active members of the Neurosurgery Clinical Service and are recommended for approval by the Chief of Neurosurgery, subject to the recommended approval of the Credentials Committee of the Medical Staff and the Governing Body.

Individual privileges are subject to review and revision at an initial appointment, throughout the period of proctoring, at the time of reappointment, at the time as judged necessary by the Chief of Service, or at any time recommended by two thirds of the Service's active staff.

**D. TEMPORARY PRIVILEGES**

Temporary Privileges shall be authorized in accordance with the SFGH Medical Staff Bylaws:-

**IV. PROCTORING AND MONITORING**

**A. REQUIREMENTS**

Monitoring (proctoring) requirements for the Neurosurgery Clinical Service shall be the responsibility of the Chief of the Service. Such requirements shall include, as a minimum, the successful management by each proctored physician of six (6) clinical cases, including surgical therapy and all pre- and post-operative care and the interval to final outcome. Assessment is based on review of all pertinent records including inpatient and outpatient documents, incorporating critical care, operative, and pathologic data. All areas of concern or uncertainty in performance assessment will be addressed by such further review of additional cases as the Chief of Service determines to be required for such assurance, and the areas of performance meeting such additional examination necessary will be discussed with the proctored physician.

Additionally, continuous review of clinical cases through detailed morbidity and mortality analyses, identifying in each case the responsible attending physician, provides an ongoing process of monitoring of all Neurosurgery Service attending physicians, and includes documentation of all analyses and discussions on a regular basis. All sources of data are used in identification of problems, risks and practice trends.

**B. ADDITIONAL PRIVILEGES**

Requests for additional privileges for the Neurosurgery Clinical Service shall be in accordance with SFGH Medical Staff Bylaws.

**C. REMOVAL OF PRIVILEGES**

Requests for removal of privileges for the Neurosurgery Clinical Service shall be in accordance with SFGH Medical Staff Bylaws.

**V. EDUCATION OF MEDICAL STAFF**

Education is considered a prime function of the Neurosurgery Service of San Francisco General Hospital as an academic component of the Department of Neurological Surgery of the University of California, San Francisco. It is not simply a necessary by-product of clinical activity. The process of education applies to all medical persons whether within school of postgraduate training, or board certified and beyond. Daily rounds include residents, fellows, interns (PGY-1), attending physicians, clinical nurse specialists, and students, as well as associated staff including representatives of speech pathology, physical therapy, and social services, and other participants. Discussion of each case permits involvement and input by each of these persons as various aspects are addressed. Specific examples include detailed critical care/advanced physiology discussions with Critical Care and Neuro-vascular specialists on the one hand, and discussion of efficient and effective patient placement in rehabilitation or other programs on the other. Prior to or during daily clinical rounds review of all new and otherwise pertinent radiographic data is conducted with discussion of a number of relevant clinical and scientific points.



Education also includes a weekly neuroradiology conference attended by neurosurgical, neurological and radiologic faculty and housestaff members, and by medical students. Regular focused conferences include spine, trauma, and neurology/neurosurgery meetings in which topics are reviewed after preparation, often incorporating bibliographic sources. In addition, medical students meet on Wednesday and Friday mornings for organized patient-centered discussion with a designated neurosurgical attending physician from full-time to clinical faculty. The Neurosurgery Service contributes to the education of neurosurgeons, neurologists, and other specialists, including primary care physicians, through both formal and informal exchange of ideas and experience. Members of the clinical faculty are encouraged to spend day-long intervals of time with staff and housestaff on the Service, contributing to their own learning and enhancement of advanced skills in diagnosis and therapy. The SFGH Neurosurgery faculty participates on a weekly (or more frequent) basis in UCSF Neurosurgical rounds, Neuro-radiological rounds, and research progress meetings. When possible they also participate in other special conferences including pediatric neurosurgery, vascular surgery, and neuropathology sessions. Medical students are invited to observe neurosurgical operations and participate under supervision in case management in the intensive care units, the wards and the outpatient clinic. They are actively encouraged to learn through association with physicians who do likewise.

**VI. NEUROSURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION** (*Refer to CHN Website for Housestaff Competencies link.*)

The members of the housestaff participating in the activities of the SFGH Neurosurgery Service vary somewhat in number and level of experience, but usually include two PGY-1 physicians and one intermediate level UCSF Neurosurgical resident serving as Chief Resident. All function under the continuing, daily supervision of qualified attending neurosurgeons who are ultimately responsible for all aspects of the safety and welfare of every patient. The interns referred to are usually, but not always, members of the SFGH general or specialty surgical services' housestaff. They may be supplemented by a more senior resident from any surgical specialty.

San Francisco General Hospital offers an important complex of experiences for the neurosurgical resident assigned. Through relative autonomy and progressing responsibility he or she develops diagnostic, operative, physiologic and pharmacologic, and other essential skills, especially in relation to acute, severe illness or injury. The Neurosurgery Service is mindful of the need for constant supervision of every resident during the process of rapid development of clinical competence and confidence, and acts accordingly through in-person direction of every operative procedure and every clinical case during daily, and often more frequent, focused rounds. It is the policy of the Neurosurgery Service that every patient admission, every consultation, and every significant clinical change in hospitalized patients is discussed by the neurosurgical resident with the responsible faculty neurosurgeon. A small number of procedures may be performed by a resident after attending approval. These are limited to placement of intracranial pressure monitors, advanced neuromonitors, access lines and lumbar drains, as examples. With such practical exceptions no neurosurgical procedures are conducted without the physical presence of an attending neurosurgeon. This invariable rule applies to night-time emergencies with the same force as an elective day-time operation. On alternate weekends and on some other occasions a neurosurgical resident assigned elsewhere in the UC program covers for the SFGH chief resident. All of the same policies continue to apply.

The goal of the Neurosurgery Service with respect to resident training has two objectives, each fully consistent with the other when properly organized and vigorously pursued; the safe, effective, and compassionate care of patients, and the development to the maximum extent possible of resident competence.

Attending faculty shall supervise house staff in such a way that house staff assumes progressively increasing responsibility for patient care according to their level of training ability and experience.

**A. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITY OF THE HOUSE STAFF**

**1. Role of Resident Within the Service**

The service consists of one Chief Resident and three interns (PGY 1). The interns shall field all primary calls regarding in-house patients and take first call for consults and emergency room admissions. In addition, the interns shall write all admission orders, transfer orders and dictate discharge and transfer summaries for the service in addition to pre-rounding on service patients and consults prior to morning rounds. Interns are expected to consult frequently with the Chief Resident with any and all patient-care issues. Furthermore, the interns are required to immediately contact the Chief resident regarding all consults and emergency room admissions.

The Chief Resident shall take primary responsibility for the running of the clinical service. This includes supervision of the interns, maintenance of the surgical schedule, scheduling cases, and participating in all neurosurgical operations. The Chief Resident is expected to consult frequently with the responsible Attending with any and all patient-care issues. Furthermore, the Chief Resident shall contact the responsible attending regarding all neurosurgical consults and emergency room admissions upon completion of the initial evaluation. In addition, he/she shall discuss all surgical cases with the responsible attending prior to making the final surgical decision.

**2. House Staff Supervision**

Supervision of the house staff shall be the responsibility of the service attending as well as the Chief of Service. The service attending shall round with the house staff on a daily basis allowing the Chief Resident to run rounds and to formulate the patient care-plan. However, the service attending has the responsibility to modify such plan as he/she may deem appropriate while discussing the change in an instructional manner. Surgical supervision shall be as stated in sections I.C.3.a-f.

Progressive patient-care involvement and independence of action shall be left at the discretion of the supervising attending and the Chief of Service.

**B. RESIDENT EVALUATION PROCESS**

Informal evaluation shall be done on a daily basis with emphasis placed on house-staff and medical student instruction. Formal evaluation shall be done on a monthly basis for interns via the UCSF computerized evaluation system. The Chief Resident shall be evaluated at the end of his/her rotation (4-6 months) via the UCSF Department of Neurosurgery resident evaluation form. These are submitted to the Residency Program Director of Neurosurgery. Formal feedback to the interns is done through the UCSF Department of Surgery. Formal feedback to the Chief Resident is done through the office of the Residency Program Director of the UCSF Department of Neurosurgery. Informal feedback is done via face-to-face discussion between the Chief of Service and the Chief Resident or intern.

**C. PATIENT CARE ORDERS**

At the beginning of their rotation, all residents and interns shall be given a copy of both the Neurosurgery House Staff Manual and Guidelines for the Critical Care Management of Severe Head Injury which address guidelines for patient care, orders, and neurological and neurosurgical assessment. Proper order writing and patient care issues will be re-enforced on daily rounds and conferences. Housestaff are expected to independently write orders for step-down unit and regular ward patients under general patient-care guidelines discussed on daily rounds. All new orders or changes in patient-care plan for ICU patients must be discussed with the Chief Resident. He/she shall then discuss these with the attending prior to their implementation.

**VII. NEUROSURGERY CLINICAL SERVICE CONSULTATION CRITERIA**

The Neurosurgery Service provides consultation on both urgent and routine bases on behalf of any requesting service. Such requests frequently originate in the Emergency Department, ICU, Operating Room or other acute care sites. The importance of prompt response is recognized by a policy that requests for consultation will be answered immediately, in cases described as unstable, changing, or unclear, and as soon as practicable in all other cases, including relatively minor or stable conditions. In this sense, no consultation is considered “routine” or unimportant. In the case of severe or undiagnosed problems the resident immediately discusses the case with the responsible attending neurosurgeon, at any hour, and in any matter of doubt about diagnosis or therapy the attending neurosurgeon personally sees the patient immediately. The attending neurosurgeon is called for discussion and approval at some time during the consultation process in every case. The Neurosurgery Service also serves as an information resource for physicians calling from acute care facilities.

**VIII. DISCIPLINARY ACTION**

The San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations will govern all disciplinary action involving members of the SFGH Neurosurgery Clinical Service.

**IX. PERFORMANCE IMPROVEMENT PATIENT SAFETY (PIPS) AND UTILIZATION MANAGEMENT**

**A. GOALS AND OBJECTIVES**

1. To insure appropriate care and safety of all patients receiving care in the department
2. To minimize morbidity and mortality as well as to avoid unnecessary days of inpatient care.
3. The Chief of Service is responsible for ensuring solutions to quality care issues. As necessary, assistance is invited from other departments, the PIPS Committee or the appropriate administrative committee or organization.
4. The Neurosurgery Clinical Service is committed to the highest possible standard of clinical practice. The Neurosurgery Performance Improvement and Patient Safety program is detailed in the document, Performance Improvement and Patient Safety Plan, Attachment B.

## **B. MEDICAL RECORDS**

1. The members of the Neurosurgery Clinical Service are committed to the maintenance of complete, accurate and timely medical records. The requirements as set forth in the SFGH Medical Staff Bylaws, Rules and Regulations define the minimum standards for medical records in Neurosurgery.
2. **Operative Records**  
Dictated operative reports will contain all of the following, at a minimum:
  - a) preoperative diagnosis
  - b) postoperative diagnosis
  - c) operative procedures performed
  - d) operating team
  - e) major findings
  - f) succinct description of the operation performed, such that an individual trained in the procedure would understand the techniques employed.
  - g) complications
  - h) estimate of blood loss
  - i) listing of specimens sent

Dictated operative reports are required for all major and minor operative procedures performed in the operating suite.
3. **Discharge Summaries**  
Dictated discharge summaries will contain a succinct description of the reasons for hospitalization, the course of treatment, complications of treatment, condition on discharge and plans for continuous care post-hospitalization. Dictated discharge summaries will be completed on all patients in the hospital for more than 48 hours. Patients hospitalized less than 48 hours may have a handwritten or dictated discharge summary at the discretion of the treating resident or attending physician.

## **C. INFORMED CONSENT**

1. All decisions for treatment should involve the active participation of the patient, and should be made after appropriate discussions of risks, benefits, and alternatives.
2. Documentation of "Informed Consent" on Medical Staff-approved forms is required for all surgical procedures performed in the operating room.
3. Documentation of patient consent will be provided by a signed Operative Consent Form as well as by a Preoperative Note in the progress notes by the operating surgeon detailing:
  - a) The goal of the procedure to be performed.
  - b) Alternative therapies
  - c) Complications that may be reasonably anticipated or associated with the procedure
  - d) The likelihood of success with the procedure

**D. CLINICAL INDICATORS**

Clinical Indicators, including head trauma hospital admissions requirements, are addressed in the monthly comprehensive Morbidity and Mortality reviews conducted by the UCSF Neurosurgery Department and with separate analysis of all aspects of patient care at each of the four teaching hospitals specifically including SFGH at each monthly conference.

**E. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES**

The attending neurosurgeons of the Neurosurgery Service include full-time University employees and non-compensated members of the UCSF Neurosurgery Department's clinical faculty. In other cases they must be board eligible or board certified in neurological surgery and must meet the standards, and abide by the regulations of the University of California School of Medicine. Specific events, including incident reports and occurrences with potential or actual legal implications are reviewed in association with the UCSF Risk Management Office at SFGH.

**F. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES**

All aspects of patient care including outpatient, in-hospital, consultative, diagnostic, and operative management matters are discussed and reviewed on a continuing basis. Daily bedside, weekly in neurosurgery meetings (whenever indicated) and monthly in relation to all morbidity, death and outcome issues.

**G. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE**

**1. Physicians**

Attending physician performance is assessed as a part of the mechanism noted on a continuing basis. In addition, active participation in Neurosurgery Service meetings, medical records maintenance, other administrative activities and productions, interaction with non-clinical staff members are expected.

**2. Housestaff**

The performance of the housestaff assigned to the Neurosurgical Service is monitored by daily observations in rounds and in all clinical activities. Evaluation includes completion of performance assessment forms, with additional comments, submitted to the UCSF School of Medicine.

**3. Affiliated Professionals**

The work of research nurses and research associates engaged in clinical trials and scientific efforts is assessed on an ongoing basis. As currently planned such staff will include a clinical nurse specialist who will coordinate the many daily clinical activities of the Neurosurgery Service.

**4. SFGH Employees other than Affiliated Professionals**

The performance of non-clinical employees is assessed by the Administrative Analyst, in coordination with the Chief of Service, with submission of summaries to the management services officer responsible for service-wide administration.

**X. MEETING REQUIREMENTS**

In accordance with SFGH Medical Staff Bylaws 7.2.I, All Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings and the annual Medical Staff Meeting.

The Neurosurgery Clinical Services shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

As defined in the SFGH Medical Staff Bylaws, Article VII, 7.2.G., a quorum is constituted by at least three (3) voting members of the Active Staff for the purpose of conducting business.

**XI. ADOPTION AND ADMENDMENT**

The Neurosurgery Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the Neurosurgery Service annually at a quarterly held Neurosurgery Clinical Service Meeting.

## APPENDIX A NEUROSURGERY PRIVILEGE REQUEST FORM

### Privileges for San Francisco General Hospital

Requested    Approved

Applicant: Please initial the privileges you are requesting in the Requested column.

Service Chief: Please initial the privileges you are approving in the Approved column.

#### 20 NEUROSURGERY

##### 20.00 NEUROSURGERY PRIVILEGES

MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Neurological Surgery.

##### 20.10 CRANIOTOMY OR CRANIECTOMY - BURR HOLES

20.11 Aneurysms, Arteriovenous malformations

20.12 Tumors: primary/secondary, Intra/extra-axial, intraventricular, supra/infratentorial

20.13 Hematomas, Infection

20.14 Congenital Anomalies

20.15 Cranial Nerve Decompression

20.16 Intracranial Infections

20.17 Transnasal Surgery for Tumors, CSF leak, Infection

20.18 Shunt Procedures

##### 20.20 SPINAL

20.21 Laminectomy or laminotomy for disc infection, stenosis, trauma, tumor, vascular anomaly

20.22 Anterior vertebral approach with or without fusion

20.23 Anterior Cervical Instrumentation

20.24 Posterior Cervical Instrumentation

20.25 Anterior Thoracolumbar Instrumentation

20.26 Posterior Thoracolumbar Instrumentation

##### 20.30 PERIPHERAL NERVE: Peripheral Nerve Neurolyses, Decompression, Repair

##### 20.40 TRACHEOSTOMY

##### 20.50 INTRACRANIAL & EXTRACRANIAL REVASCULARIZATION

MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Neurological Surgery. Based on demonstrated competence, with documentation of focused experience.

SCOPE: Includes all Extracranial Vascular Procedures and Microvascular Anastomosis

##### 20.60 FUNCTIONAL & STEREOTACTIC SURGERY

MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Neurological Surgery. Based on demonstrated competence, with documentation of focused experience.

20.61 Stereotactic cranial or spinal recording, stimulation or ablative procedures

20.62 Stereotactic Biopsy or Irradiation

20.63 Percutaneous or Open Spinal Ablative Procedures

20.64 Implantation of spinal or peripheral nerve stimulation devices

20.65 Ventricular and spinal fluid studies

20.66 Intraoperative Angiography

20.67 Intracranial Pressure Monitoring

##### 20.70 CENTRAL VENOUS ACCESS PROCEDURES

MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Neurological Surgery. Based on

demonstrated competence, with documentation of focused experience.

SCOPE: Insertion of central venous access lines, Swan Ganz Catheters, Triple Lumen Catheters, Jugular Venous Saturation Monitoring

**20.80 NEUROSONOLOGY**

MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Neurological Surgery including formal training in the basic principles and clinical application of Neurosonology; or a minimum of 40 hours of Category I Training in courses approved by the ACGME and documentation of supervised interpretation of a minimum of 100 Neurosonology Studies. Verification of a passing score by the American Society of Neuroimaging (ASN) Neurosonology Examination.

20.81 Perform Ultrasound examination for the diagnosis and management of cerebrovascular disease and head injury

20.82 Interpretation of studies

**20.90 ACUTE TRAUMA SURGERY**

20 NEUROSURGERY

20.90 Acute Trauma Surgery

SCOPE: On-call trauma coverage for the comprehensive neurosurgical management of the acutely injured trauma patient.

CRITERIA: 1. Completion of ACGME-approved residency with Board certification/eligibility in Neurological Surgery. 2. Availability, clinical performance and continuing medical education consistent with current standards for neurosurgeons surgeons at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgeons.

**30.00 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY**

MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Neurological Surgery. Current X-Ray/Fluoroscopy Certificate.

I hereby request clinical privileges as indicated above.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
date

FOR DEPARTMENTAL USE:

\_\_\_\_\_ Proctors have been assigned for the newly granted privileges.

\_\_\_\_\_ Proctoring requirements have been satisfied.

\_\_\_\_\_ Medications requiring DEA certification may be prescribed by this provider.

\_\_\_\_\_ Medications requiring DEA certification will not be prescribed by this provider.

\_\_\_\_\_ CPR certification is required.

\_\_\_\_\_ CPR certification is not required.



*Zuckerberg San Francisco General Hospital  
1001 Potrero Avenue  
San Francisco, CA 94110*

APPROVED BY:

\_\_\_\_\_  
Division Chief

\_\_\_\_\_  
date

\_\_\_\_\_  
Service Chief

\_\_\_\_\_  
date

## **APPENDIX B NEUROSURGERY PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) PLAN**

### **I. Goals and Objectives**

- A. To assure that all patients receive appropriate and timely care with respect to their diagnostic and therapy, including surgical treatment where appropriate.
- B. To minimize to the fullest extent possible both morbidity and mortality.
- C. To prevent unnecessary in-patient days.

### **II. Responsibility**

The Chief of the Neurosurgery Service has the overall responsibility for the program. Initiation, implementation, and follow-up of patient care evaluation activities may be delegated to another staff member.

### **III. Components of the Performance Improvement and Patient Safety (PIPS)**

- A. The quality and appropriateness of care on the Neurosurgery Service area assessed by the following:
  - 1. Morbidity and mortality review
  - 2. Complications review including incidence of infections
  - 3. Surgical case review without specimens
  - 4. Housestaff evaluations
  - 5. Chart reviews
  - 6. Attending staff reappointment review
  - 7. Clinical Service monthly meetings which include patient care
  - 8. Incident reports and risk-management cases related to the clinical practice are responded to promptly since they are almost always based on complications of clinical events already documented in the minutes of the monthly Morbidity and Mortality Review. Search of the clinical records for additional details may also be necessary. This documentation is the mechanism by which adverse patterns and trends may be identified, in which case the following remedial actions are implemented:
    - a) In-service education and training program,
    - b) New revised policies and procedures
    - c) Staffing changes or equipment changes

### **IV. Reporting**

Evidence of all Neurosurgery Service performance improvement and patient safety activities will be maintained in the Service and reported during monthly Neurosurgery Service staff meetings. Minutes of the meetings will be forwarded to the QM office monthly.

### **V. Correction**

The Chief of the Neurosurgery Service will be responsible for assuring the correction of interservice/committee patient-care issues. Assistance from the Q&UM Office will be requested when certain problems cross service/committee boundaries and/or when the Service is unable to correct the problem.

### **VI. Peer Review**

Appraisal of Service and individual patterns of patient care as determined by reviews and evaluations conducted by the Neurosurgery Service, e.g., complication rates, housestaff reviews, and hospital committees/programs (e.g., Performance Improvement & Patient Safety, Infection Control), will be used by the Chief of the Service in the medical staff reappointment process and delineation of privileges. Patterns of care will be discussed during the monthly service meeting.

**VII. Admission Policy for Patients with Head Trauma**

Head-injury patients with either of the following:

- a. New abnormality on CT scan of the head, or
- b. Abnormal neurological exam not entirely attributable to intoxication or other obvious process, with negative CT

Will be admitted by the Chief Resident unless a neurosurgical-attending physician who has examined the patient and reviewed the scan writes a note that discharge is safe.

**VIII. Service Policy: Level-One Trauma Designation**

The Neurosurgery Service at the San Francisco General Hospital supports the American College of Surgeons trauma designation criteria and procedures and maintains its service in compliance with Level-One Trauma criteria.

A housestaff member of the Neurosurgery Service is in-house 24 hours a day to respond immediately to the Emergency Clinical Service for cases involving trauma to the nervous system. A senior neurosurgical resident is immediately available from outside the hospital for additional consultation and for all cases requiring surgery. Minor cases such as wound debridement and scalp laceration repair do not require attending coverage.

The Neurosurgery Service is organized separately from the Trauma Service, but coordinates its activities closely with the Trauma Service. The Neurosurgery Service participates routinely in Trauma Quality Improvement proceedings and maintains its own independent Performance Improvement and Patient Safety Program.

Neurosurgery actively participates with a variety of other services at SFGH through weekly joint conferences with Neurology and with Neuro-radiology, and monthly multidisciplinary conferences regarding trauma care at SFGH. Faculty members of the Neurosurgery Service routinely teach principles of neuro-trauma care to other services within the Hospital.

*Zuckerberg San Francisco General Hospital  
1001 Potrero Avenue  
San Francisco, CA 94110*

**APPENDIX C    NEUROSURGERY HOUSESTAFF MANUAL  
MAINTAINED IN NEUROSURGERY ADMIN OFFICE BUILDING 1, ROOM 101**

## **APPENDIX D CLINICAL SERVICE CHIEF OF NEUROSURGERY SERVICE JOB DESCRIPTION**

### **Chief of Neurosurgery Clinical Service**

#### **Position Summary:**

The Chief of Neurosurgery Clinical Service directs and coordinates the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of San Francisco General Hospital (SFGH) and the Department of Public Health (DPH). The Chief also insures that the Service's functions are integrated with those of other clinical departments and with the Hospital as a whole.

#### **Reporting Relationships:**

The Chief of Neurosurgery Clinical Service reports directly to the Associate Dean and the University of California, San Francisco (UCSF) Department Chair. The Chief is reviewed not less than every four years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Associate Dean, the UCSF Department Chair, and the SFGH Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.

#### **Position Qualifications:**

The Chief of Neurosurgery Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at SFGH.

#### **Major Responsibilities:**

The major responsibilities of the Chief of Neurosurgery Clinical Service include the following:

Providing the necessary vision and leadership to effectively motivate and direct the Service in developing and achieving goals and objectives that are congruous with the values, mission, and strategic plan of SFGH and the DPH;

In collaboration with the Executive Administrator and other SFGH leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement, reviewing and approving Service policies and procedures, identifying new clinical services that need to be implemented, and supporting clinical services provided by the Department;

In collaboration with the Executive Administrator and other SFGH leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of Service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and

Performing all other duties and functions spelled out in the SFGH Medical Staff Bylaws.