

**THE PRISCILLA CHAN AND MARK ZUCKERBERG
SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER**

**MEDICAL STAFF
Rules and Regulations**

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1. Admission and Attendance Policies

- A. Patients shall be admitted only upon the order and under the care of a Member of the Medical Staff (Member) of the Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG or Hospital) who is lawfully authorized to diagnose, prescribe and treat patients. The patient's condition and provisional diagnosis shall be established at time of admission by the Member who admits the patient. The Member must be responsible for the care of any medical problems that may arise during the course of a patient's Hospital stay. Other members of the Medical Staff may evaluate and record portions of the history and physical, which pertain to his/her scope of licensure and privileging.
- B. Patients in Skilled Nursing Facility (SNF) beds must have an evaluation of his/her mental and physical condition within seventy-two (72) hours of admission. If the patient's condition has not significantly changed or if significant changes have occurred and are recorded at the time of admission, a durable legible original or reproduction of a history and physical, obtained by a Member, completed five (5) days before readmission or admission and recorded in the Medical Record is acceptable.
- C. Except in an emergency, patients shall be admitted to the Hospital only after a provisional diagnosis has been provided. In the case of emergency, the provisional diagnosis shall be provided as soon as possible after admission.
- D. The responsible Member, or his/her designee, who believes that a patient may pose an imminent risk to staff or other patients due to a history of violent behavior, shall be responsible for providing that information to the charge nurse and other staff as necessary.
- E. Each inpatient shall be seen daily by a Member or his/her designee, and a note shall be placed in the medical record. This note shall reflect the involvement of the Member in the patient's care. Either this Member, or a designated Member of the Medical Staff, shall be available on a call twenty-four (24) hours per day to meet the needs of the patient. This provision shall not apply to patients in the GCRC admitted for the purpose of a research study.

- F. Each patient in a SNF bed shall be seen by a Member at least once during a thirty (30) day period and in accordance with the patient's needs. This Member shall designate an alternative Member to contact for regular or emergency care when the admitting Member is not available.
- G. When a patient is transferred from one Clinical Service (Service) to another Clinical Service, all of the following must occur:
 - i. Medical Staff Members on both the transferring and the receiving Services approve the transfer and agree upon the ongoing role, if applicable, of the transferring Service.
 - ii. A transfer note describing the patient's condition completed by the transferring service shall accompany the patient to the receiving Service.
 - iii. A Member of record for the receiving Service shall be identified.
 - iv. All orders shall be rewritten upon transfer to the receiving Service.
- H. The Patient Rights and Responsibilities, as detailed in the Hospital Administrative Policy and Procedure No. 16.04, shall be observed by all Members of the Medical Staff.
- I. All research involving human subjects shall be subject to the policies and regulations of the University's Committee on Human Research.

2. Medical Histories and Physical Examinations ("H&P"s)

- A. H&P's shall be performed and documented by a Member of the Medical Staff or by an Affiliated Professional pursuant to a Standardized Procedure.
Components include:
 - i. Chief complaint/reason for admission
 - ii. History of present illness
 - iii. Past medical history/surgical history
 - iv. Current medications
 - v. Allergies/adverse drug reactions
 - vi. Review of systems (as pertinent)
 - vii. Physical examination (as pertinent)
 - viii. Diagnostics (if relevant)
 - ix. Assessment
 - x. Plan

For non-inpatient services, a directed history and physical examination shall include those components listed above as relevant and indicated by the clinical setting and nature of the visit.

- B. For surgical patients, the assessment shall be as follows:
- i. Acute Hospital Admission: The patient's H&P, nursing assessment, and other screening assessments are completed within the first twenty-four (24) hours after admission, and prior to surgery or a procedure requiring anesthesia services. H&P's performed within thirty (30) days prior to admission as an inpatient must be in the medical record and updated within the first twenty-four (24) hours after admission.
 - ii. Surgical or other invasive diagnostic or therapeutic procedures, including both "come and go" and "come and stay" surgeries: The H&P shall be performed within thirty (30) days prior to the procedure and be present in the medical record. An interval updated H&P must be done and recorded in the chart after registration or admission and within 24 hours prior to surgery for a procedure requiring anesthesia services. An interval update records any changes since the last H&P was performed.
 - iii. Procedures performed under moderate sedation: The H&P shall be performed within the preceding thirty (30) days, with an interval update if the H&P was performed more than twenty-four (24) hours prior to the procedure.
 - iv. Oral and maxillofacial surgery: Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U. S. Office of Education and have been determined by the Medical Staff to be competent to do so, may perform a history and physical examination and determine the ability of patients, who have been admitted for oral/maxillofacial surgery and who have no other relevant medical problems, to undergo the surgical procedures the oral and maxillofacial surgeon proposes to perform. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the Medical Staff must conduct or directly supervise the admitting history and physical examination, except the portion related to oral and maxillofacial

surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oral and maxillofacial surgeon's lawful scope of practice.

3. Consent

Each Clinical Service will monitor compliance with the Hospital informed consent policy. Procedures requiring consent shall be performed only upon signed informed consent, which contains evidence that the risks, benefits and alternative treatments have been explained and understood by the patient. It is the responsibility of the Member to ensure that the signed consent form and documentation of the informed consent discussion is contained in the medical record. For Oral and Maxillofacial Surgery, Medical Staff members of the Oral and Maxillofacial Surgery are responsible to ensure that the signed consent form and documentation of the informed consent discussion is contained in the medical record. Emergency procedures may be performed when signed consent has not been obtained if, in the opinion of the Member, serious harm would befall the patient if the procedure were not performed. The need for the emergency procedure shall be documented in the medical record.

4. Consultations/Communications

- A. In order to insure informed and timely management of patients and to utilize the variety of special expertise at the Hospital, consultations are encouraged. Consultations shall be obtained whenever the consultation might reasonably be expected to assist in the patient's continuing care as provided by the applicable Clinical Service Rules and Regulations.
- B. When in-patient consultation is requested, the patient should be seen within twenty-four (24) hours by the consulting Member. A satisfactory consultation includes examination of the patient and the medical record. An urgent request for consultation should be honored within six (6) hours. Request for emergency consultation should be honored promptly. A brief note consisting of the consulting Member's assessment and plan should be entered into the medical record at the completion of the consultation. A complete consulting Member's report should be in the medical record within forty-eight (48) hours. All consultations must be in writing and signed by the consulting Member.

5. Surgeries

- A. All operations shall be fully described by the operating physician or oral surgeon and operative reports shall be dictated, electronically entered into the electronic health record or written on a standardized, approved form immediately, before the patient is transferred to the next level of care, following completion of surgery. The reports shall contain a description of the findings, operative procedures performed, specimen(s) removed, if any, any complications/adverse events, the preoperative and postoperative diagnosis, and the name of the primary surgeon and assistant(s). ~~All reports shall be signed by the responsible licensed physician within five (5) calendar days.~~ If entry of the operative report into to the medical record is delayed, is dictated, a brief operative summary note must be written in the patient's chart immediately after surgery. When standard forms that have been approved by the Medical Records Committee exist, his/her completion of those forms can be substituted for a dictation of the operative procedure. All reports shall be signed by the responsible licensed physician within five (5) calendar days.
- B. When an inpatient undergoes surgery, cancellation of all standing orders, is automatic and new orders shall be written after surgery is completed. A DNR order may be held in abeyance during and immediately following an invasive procedure (generally, those requiring informed consent) at the discretion of the physician performing the procedure and/or the anesthesiologist. The possibility of resuscitating a patient under these circumstances shall be discussed with the patient or his/her surrogate discussion-maker as part of the informed consent process.
- C. Tissues removed at operation shall be sent to the Hospital pathologist, who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis and he/she shall sign the report for inclusion in the patient's chart.

6. Medical Records

- A. Overview
- i. All patients admitted for care in the inpatient and outpatient settings must have a complete medical record. All encounters where care is provided must

be documented.

B. Inpatient Medical Records

i. Admissions

- a. For all admissions to the inpatient units, a complete history and physical examination shall be performed and documented within the first twenty-four (24) hours after admission.

ii. The inpatient medical record will include the following:

- a. Initial diagnostic/clinical impression and plan;
- b. Reports (such as consultation, clinical laboratory, diagnostic studies, radiology reports etc);
- c. Medical and/or surgical treatment; Pathologist's findings;
- d. Daily progress notes; and
- e. Discharge summary which briefly recapitulates the reason for hospitalization, significant findings, procedures performed, treatment rendered, final diagnosis, patient's condition on discharge, medications to be taken at discharge, plans for outpatient follow-up and discharge instructions as pertinent.

iii. Anesthesia/Operative Procedures

- a. If a patient undergoes anesthesia or operative procedures, the anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation.
- b. A post-anesthetic follow-up note shall be written in the patient's chart by an anesthesiologist within 48 hours of the patient's procedure.
- c. Operative reports must be completed ~~within five (5) calendar days of the patient's discharge and are considered part of the medical record~~ immediately, after surgery, prior to transfer to the next level of care, see, Section 5, above.

- d. A record will be considered incomplete if it is missing the anesthesia and/or operative report.
- iv. Antibiotic Orders
 - a. All inpatient orders for antibiotics (oral, intra-muscular or intravenous), without specific limitations as to dosage, must be written on the antibiotic order sheet which specifies renewal frequency.
- v. Verbal Orders
 - a. Verbal orders are only appropriate in an emergency situation or for pain management or in situations in which a delay may adversely affect the patient.
 - b. All verbal orders, including telephone and face-to-face orders, will be signed within forty-eight (48) hours by the licensed independent practitioner who gave the order. Verbal orders for SNF patients must be signed within five (5) days .The signature of the Attending physician who was responsible for the care of the patient at the time that the order was given is acceptable if the practitioner is not available.
- vi. Inpatient medical records shall be completed promptly and authenticated or signed by the relevant physician, nurse practitioner, physician assistant, clinical psychologist, dentist or podiatrist within five (5) calendar days following the patient's discharge.

C. Skilled Nursing Facility Medical Records

- i. Admissions: For all Skilled Nursing Facility (SNF) admissions, an evaluation of his/her mental and physical condition shall be documented within seventy-two (72) hours of admission.
- ii. The medical record will also include the following:
 - a. Initial diagnostic impression and plan, reports (such as consultation, clinical laboratory, diagnostic studies, radiology reports, and other), medical and/or surgical treatment and Pathologist's findings;

- b. Progress notes at least every thirty days; and
 - c. Discharge summary which briefly recapitulates the reason for hospitalization, significant findings, procedures performed, treatment rendered, final diagnosis, patient's condition on discharge, medications to be taken at discharge and discharge instructions as pertinent.
 - iii. Antibiotic Orders
 - a. All skilled nursing orders for antibiotics (oral, intra-muscular or intravenous), without specific limitations as to dosage, must be written on the antibiotic order sheet which specifies renewal frequency.
 - iv. Medical records shall be completed promptly and authenticated or signed by the relevant physician, nurse practitioner, physician assistant, clinical psychologist, dentist or podiatrist within five (5) calendar days following the patient's discharge.
- D. Outpatient Medical Records
 - i. In addition to the appropriate history and physical examination, the outpatient medical record will include the following:
 - a. Problem list: a summary list of significant past and present diagnoses and health problems;
 - b. A list of current medications;
 - c. A recording of significant allergies and drug sensitivities;
 - d. Complete assessment that outlines the diagnosis(es) and clinical impression (and possible differential diagnoses) as well as the plan which should include the treatment and diagnostic plan as appropriate.
 - ii. Medical records shall be completed promptly and authenticated or signed by a physician, clinical psychologist, dentist, or podiatrist or nurse practitioner within five (5) calendar days of the patient's visit.
- E. Oversight of Medical Records

- i. The Chief of the Clinical Service shall be responsible for all aspects of medical records pertaining to his/her service, including the following:
 - a. Adherence to guidelines for inpatient, SNF, and outpatient medical records;
 - b. Completeness of the medical record; and
 - c. Timely record completion.
 - ii. The Chief of the Clinical Service will be held responsible for the completion of clinical service patients' medical records that have not been completed in a timely manner, as defined above, by their medical staff.
 - iii. The Chief of Staff or the relevant Chief of Service may suspend the Privileges of Medical Staff members or the Standardized Procedures of Affiliate Staff members for failure to complete records within the timelines outlined for each clinical area.
- F. Practitioner Responsibilities
- i. All medical record entries shall be legible.
 - ii. The physician, nurse practitioner, physician assistant, clinical psychologist, dentist or podiatrist dictation notes for the medical record shall be personally signed or electronically authenticated.
 - iii. In addition to the practitioner's signature, the entry shall include the practitioner's unique identifier number, and the entry shall be timed and dated.
 - iv. All records shall be completed in a timely manner in accordance with the timelines outlined for each clinical area.
 - v. Medical Record Authentication
 - vi. All medical records must be authenticated by members of the Medical Staff or Affiliated Medical staff. This includes review and attestation to the medical records completed by trainees.

- a. All students and House Staff writing in the medical record will indicate his/her year in training and unique identifier number, date and time. An order may be written by a medical student after conferring with a supervising physician who will counter-sign the order.
 - b. Notes written by medical students should be countersigned by a physician within twenty-four (24) hours.
- vii. The method of authentication must be one of the following.
 - a. Handwritten signature with legible unique identifier numberdenotation, date, and time;
 - b. Electronic signature authorization;
- viii. Electronic Authentication
 - a. When authentication is by electronic signature authorization or digital signature, the following characteristics must be included: identification of the author by first and last name, professional degree, unique identifier number, and date and time of authentication;
 - b. An authentication statement must include current CMS-approved language, e.g., “Electronically signed by _____”;
 - c. A member of the Medical Staff shall not allow anyone else to use his/her electronic signature;
 - d. The Associate Chief Medical Health Informatics Officer will certify that Medical Staff members using the Hospital’s electronic health record will have a unique and confidential code to generate the electronic signature.
- G. The Chief of a Clinical Service that maintains an independent electronic medical information system is responsible for ensuring that each individual Medical Staff member has his/her own code to generate the electronic signature and that the codes and passwords are confidential.
- H. Medical Records, Definition, Ownership and Control

- i. Medical records are legal documents and are the property of the Zuckerberg San Francisco General Hospital and are under the custody of the Health Information Services Department.
- ii. Medical records contain valuable and confidential information and are to be safeguarded against loss, defacement, tampering, or use by unauthorized persons. Nothing shall be removed or deleted from a medical record, and no irrelevant or facetious notations may be made in them.
- iii. Medical records are to be in the Health Information Services Department or at the site of patient care service. Medical records may be used outside the Health Information Services Department for specific occasions, such as conferences and meetings. Persons with records checked out to them must always have them immediately available for patient care. Records are not to leave the Zuckerberg San Francisco General Hospital campuses except pursuant to a court order, subpoena, or statute.
- iv. Medical records may be borrowed only by authorized borrowers, who must adhere strictly to established Zuckerberg San Francisco General Hospital administrative policies for request and return of records to Health Information Services at the end of the day.
- v. Medical records of inpatients must be available for pick-up by Health Information Services Department immediately following discharge.
- vi. Medical records requested by clinics must be returned on the day of the visit.
- vii. The following are criteria for research review:
 - a. Approval must be obtained from the UCSF Committee on Human Research and completion and approval of the ZSFG Protocol Application if the researcher plans to contact the patient directly.
 - b. Record must be reviewed in the Health Information Services Department.
 - c. No more than twenty-five (25) records at a time may be requested.

- d. Distribution and access of medical records for patient care and utilization review shall have priority over use for study and research.

- I. Special Circumstances for Organ Donation

- i. The requirements for the medical record of the donors of organs or tissue shall be the same as for any inpatient.
 - ii. When the donor organ or tissue is obtained from a brain dead patient, the medical record shall include the date and time of brain death, documentation by and identification of the physician who determined the death, the method of transfer and machine maintenance of the patient for organ or tissue donation, and documentation of the renewal of the organ or tissue.
 - iii. When a cadaveric organ or cadaveric tissue is removed for purposes of donation, the removal is documented in the donor's medical record.

7. Clinical Service Rules and Regulations

Each Clinical Service shall formulate its own rules and regulations and proctoring protocol for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall be consistent with these Bylaws, the general rules and procedures of the Medical Staff and other policies of the Hospital, shall be reviewed annually by the Chief of the Clinical Service and revised as appropriate and shall include at a minimum:

- A. Scope of Service;
- B. Development and annual review of Criteria of Delineation of Privileges;
- C. Annual review of privilege forms;
- D. Method for reviewing applications for appointment, reappointment, increase in privileges, modifications of clinical service and/or staff status, and granting of privileges;
- E. Proctoring requirements including exceptions;
- F. Clinical indicators and elements of individual practitioner's performance profiles;
- G. Methods for monitoring and evaluation of the appropriateness of patient care provided within the clinical service;
- H. Methods for monitoring and evaluating the professional performance of all individuals who have delineated clinical privileges in the clinical service (regardless of clinical service assignment);

- I. Reporting individual practitioner's monitoring and evaluation results to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;
- J. Frequency and format of clinical service meetings; and
- K. Rules and regulations pertaining to House Staff supervision and oversight.

8. House Staff

- A. Medical Staff Members shall supervise House Staff in such a way that House Staff assume progressively increasing responsibility for patient care according to his/her level of training, ability and experience.
- B. Guidelines pertaining to House Staff supervision and oversight are set forth in the Rules and Regulations of each Clinical Service. Such departmental Rules and Regulations shall include:
- C. Written descriptions of the role, responsibilities, and patient care activities of the House Staff;
- D. Identification of the mechanisms by which the House Staff members' supervisors and the graduate education program director make decisions about each House Staff members' progressive involvement and independence in specific patient care activities; and
- E. The delineation of House Staff members who may write patient care orders, the circumstances under which he/she may do so, and what entries, if any, must be countersigned by a member of the Medical Staff.
- F. Pursuant to California Business and Professions Code 2065 and 22 California Code of Regulations Section 70705, unlicensed resident trainees may write orders without obtaining a countersignature if they are graduates of an approved medical school, are registered with the Division of Licensing of the California Medical Board, and are engaged in the University's postgraduate training program.
- G. If patient care is provided by residents, interns and medical students, such care shall be in accordance with the provisions of an approved program and under

the supervision of a Medical Staff member with appropriate clinical privileges.

9. Outpatient Medical Screening/Emergency Medical Treatment and Labor Act (EMTALA)

- A. An appropriate screening exam shall be provided to all persons who present themselves to the Hospital Emergency Department, Psychiatric Emergency Service, and designated urgent care centers in the hospital and who request, or have a request made on his/her behalf, for examination or treatment of a medical condition. Where there is no verbal request, the request will nevertheless be considered to exist if a prudent layperson observer would conclude, based on the person's appearance or behavior, that the person needs emergency examination or treatment. In such an event, the Hospital shall not seek authorization from an individual's insurance company until a medical screening examination has been provided and any necessary stabilizing treatment has been initiated. The patient will not be transferred to another facility unless the patient's condition is stabilized or it is in the patient's best interest to be transferred due to the hospital's inability to provide the needed services or level of care.
- B. The medical screening exam must be performed by a Physician Member of the Medical Staff or by a Nurse Practitioner, Physician Assistant, or Certified Nurse Midwife pursuant to a standardized procedure.
- C. In the event that a request is made for emergency care in the Hospital department off the Hospital's main campus, such as Community Primary Care Services Clinic, EMTALA does not apply. The clinic shall provide whatever assistance is within its capability and shall call the local emergency medical service to take the individual to an emergency department.

10. Discharge and Transfer of Patients

- A. The records of all acute care patients who have been hospitalized for longer than forty-eight (48) hours require a discharge summary, which must be dictated or otherwise recorded within five (5) days of discharge. The discharge summary should recapitulate concisely the reason for admission, pertinent features of the course in the Hospital, relevant laboratory,

electrocardiographic and x-ray findings, treatment rendered and procedures performed, the condition of patient on discharge, and the instructions provided to the patient and/or family or institution in relation to diet, exercise, activity, rehabilitation, follow-up care and medications. Transfer summaries are required for patients who are to be placed in skilled nursing facilities and should be dictated at the earliest time prior to patient transfer. All summaries shall be signed and dated by the responsible Medical Staff Member.

- B. The Clinical Service transferring a patient from an acute care unit to an extended care or acute care unit shall be responsible for assuring continuing care of the patient with adequate documentation in the medical record.
- C. A patient shall not be discharged or transferred from an acute care unit to an acute or extended care facility without a written order from the treating Medical Staff Member. A patient discharge plan (PDP form) shall be completed at the time of Hospital discharge, or transfer to an acute care facility. A discharge note shall be written in the medical record which includes the discharge diagnosis, recommendations for further care, including scheduled outpatient clinic appointments, limitations of activity, if any, dietary restrictions if any, and discharge medications. Whenever possible, patient discharges shall be arranged before nine (9) A.M., in keeping with Hospital policy.
- D. No patient shall be discharged to another health care facility unless arrangements have been made in advance for admission to that facility and the person legally responsible for the patient has been notified, or attempts have been made to notify such person over a twenty-four (24) hour period. Discharge shall not be carried out if, in the opinion of the patient's treating Medical Staff Member, such discharge would endanger the patient.

11. Deaths and Autopsies

- A. The Physician Member or designee shall certify the time of death and notify the next of kin.
- B. Every member of the Medical Staff is expected to be actively interested in securing autopsies, particularly when a quality assurance, legal, or educational issue exists. No autopsy shall be performed without legal consent. All

autopsies shall be performed by the Hospital pathologist as prescribed by the State of California. The Medical Examiner shall be notified in appropriate cases as defined by statute and hospital policy.

- C. The Medical Staff Member, shall be notified when and where an autopsy on his/her patient is being performed.
- D. Responsible efforts shall be made to identify potential organ and tissue donors and to cooperate in the procurement of anatomical gifts. All organ and tissue donations shall be coordinated through the Donor Network West (DNW). Only those recovery teams which have been approved by and referred from the DNW will be permitted to recover organs and tissues.

12. General

- A. All research involving human subjects shall comply with the policies and regulations of the University's Committee of Human Research.
- B. Medical Staff members and the Affiliated Professionals shall abide by the Hospital-wide administrative policy regarding Restraint and Seclusion.
- C. Medical Staff members and the Affiliated Professionals shall abide by the Hospital-wide administrative policy regarding the administration of moderate or deep sedation.
- D. Positions requiring x-ray supervisor and operator certification in accordance with Division 20, Chapter 7.4, Sections 25668(e) and 25699 of the California Health and Safety Code, shall maintain a current license.
- E. Both UCSF and San Francisco General Hospital have adopted policies prohibiting sexual harassment. The Medical Staff acknowledges and affirms these policies.
- F. Members of the Medical Staff shall comply with the DPH Notice of Privacy Practices, the Hospital policies and procedures regarding patient privacy and the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) and shall abide by the following;
 - i. Protected health information shall only be accessed, discussed or divulged as required for the performance of job duties;

- ii. User IDs and/or passwords shall only be disclosed to Hospital Information System staff;
- iii. Members shall not log into Hospital information system or authenticate entries with the user ID or password of another; and.
- iv. Members shall only install software on Hospital computers that have been appropriately licensed and authorized by Hospital Information System staff.
- v. Members agree that violation of this section regarding the privacy and security of Protected Health Information may result in corrective action as set forth in Articles VI and VII of these Bylaws.

13. Adoption and Amendment

These Rules and Regulations may be amended or repealed, in whole or in part, as prescribed in Article XIII of the Medical Staff Bylaws.