ORTHOPEDIC SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
2015
# Orthopedic Surgery Clinical Service

## Rules and Regulations

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I. ORTHOPEDIC SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The Orthopedic Surgery Service at San Francisco General Hospital is organized along two axes: tertiary orthopedic trauma care and general orthopedics. The orthopedic trauma service involves the treatment of complex injuries, such as pelvic and acetabular fractures, spinal fractures and dislocations, high-grade open fractures and complex soft tissue injuries. The management of these complex injuries is comprehensive and greatly enhanced by the fellowship trained subspecialists on the orthopaedic surgery service, including fellowship trained orthopaedic surgeons in trauma, sports, spine, arthroplasty, foot and ankle, and hand, as well as board-certified/board eligible specialists in rehabilitation and podiatry. The general Orthopedic surgery services offered are comprehensive and of the highest quality. They cover all orthopedic sub-specialties except oncology and pediatrics.

As a member of the Orthopedic Surgery Service, the board-certified physiatrist is also the Medical Director of the Rehabilitation Service for SFGH. The service also has a fully equipped orthotics and prosthetics group with experts in prosthetics and orthotics.

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of San Francisco General Hospital is a privilege which 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 and accompanying manuals as well as these Clinical Service Rules and Regulations.

C. ORGANIZATION OF ORTHOPEDIC SURGERY CLINICAL SERVICE

Currently the Clinical Service of Orthopedic Surgery at San Francisco General Hospital is staffed by 9 orthopedic surgeons with 50% or more time effort (Drs. Coughlin, Kandemir, Matityahu, Miclau, McClellan, Pekmezci, Meinberg, Morshed, Marmor, and Strauss), two trauma fellows (Clinical Instructors and Active SFGH Medical Staff Members), two full-time podiatrist (Drs. Dini, Werner), 2 full-time physiatrists (Drs. Pascual and Nagao), and 1 part-time physiatrist (Dr. Tran). Hand coverage is one full-time orthopaedic hand surgeon (Dr. Strauss) and 4 volunteer hand surgeons (Drs. Richards, Cardon, and Green). Pediatric clinic is staffed by 1 part-time staff member (Dr. Delgado). There are several volunteer surgeons who assist in the clinics and ORs (Drs. Jergesen, Rosenblatt, Glick, and Fong). The attending physicians and podiatrists are responsible for daily attending rounds on both services, assuring quality patient care, resident education, and dictation of attending notes on all patients every day. Call coverage is by the 9 trauma attendings (with the exception of Dr. Rosenblatt, who covers approximately 1 call per month).

The administrative tasks at SFGH are solely covered by the core attending physicians. SFGH is a major public hospital with the complex problems of indigent care as well as the more routine problems of hospital management. The core staff is responsible for running the outpatient clinics, orthopedic wards and operating rooms as well as addressing the utilization and service issues. In addition, there are 13 hospital
committees, which require orthopedic staff participation, all of which are the responsibility of the full-time staff.

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of SFGH through the Orthopedic Surgery Clinical Service is in accordance with SFGH Bylaws Medical Staff Membership, Rules and Regulations, as well as these Clinical Service Rules and Regulations.

Criteria

1. Board Certified or Eligible by the American Board of Orthopedic Surgery, the American Board of Physical Medicine and Rehabilitation, or the American Board of Podiatric Surgery. Applicants not board-certified must document recent training and experience by providing a narrative of their clinical activities during the preceding two (2) years. They must also demonstrate current competence to the Chief of Service.

2. Current California Medical or Podiatric Licensure

3. Current DEA Certificate


B. REAPPOINTMENTS

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

1. Practitioners Performance Profiles

Practitioner’s performance profiles are determined and monitored in two fashions. Outpatient encounters are monitored by the hospital outpatient clinic services, and statistics are available by ICD9 and CPT codes. Inpatient services, including emergency room consultations, are monitored and counted according to different categories. Complications of all nature are also compiled on a monthly basis and are kept on file by the Service as well as in the Medical Staff Services Office.

2. Modification of Clinical Service

A request by a practitioner for a modification of clinical services is first reviewed by the Chief of Service in light of the generally accepted requirements (formal and practical) of the appropriate state and national associations/organizations. If the Chief of Service judges that the requested modification is reasonable, it is then discussed at a faculty meeting. If the general consensus of the faculty is favorable for such a modification, it is submitted by the Chief of the Clinical Service to the SFGH Credentials Committee for review and recommendation.

3. Staff Status Change

The process for Staff Status Change for members of the Orthopedic Surgery Services is in accordance with SFGH Bylaws, Rules and Regulations and accompanying manuals.
4. Modification/Changes to Privileges
   The process for Modification/Change to Privileges for members of the Orthopedic
   Surgery Clinical Services is in accordance with SFGH Bylaws, Rules and
   Regulations and accompanying manuals.

C. AFFILIATED PROFESSIONALS
   The process of appointment and reappointment of the Affiliated Professionals to SFGH
   through the Orthopedic Surgery Clinical Service is in accordance with SFGH Bylaws,
   Rules and Regulations and accompanying manuals as well as these Clinical Service Rules
   and Regulations.

D. STAFF CATEGORIES
   The Orthopedic Surgery Clinical Service fall into the same staff categories which are
   described in Article III – Categories of the Medical Staff of the SFGH Bylaws, Rules and
   Regulations and accompanying manuals.

III. DELINEATION OF PRIVILEGES (Refer to Attachment A)

A. DEVELOPMENT OF PRIVILEGE CRITERIA
   Orthopedic Surgery Clinical Service privileges is developed in accordance with SFGH
   Medical Staff Bylaws, Article V: Clinical Privileges, Rules and Regulations and
   accompanying manuals.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM
   The Orthopedic Surgery Clinical Service Privilege Request Form shall be reviewed
   annually.

C. CLINICAL PRIVILEGES
   Orthopedic Surgery Clinical Service privileges shall be authorized in accordance with the
   SFGH Medical Staff Bylaws, Article V: Clinical Privileges, Rules and Regulations and
   accompanying manuals.
   All requests for clinical privileges will be evaluated and approved by the Chief of
   Orthopedic Surgery Clinical Service.

   The process for modification/change to the privileges for members of the Orthopedic
   Surgery Service is in accordance with the SFGH Medical Staff Bylaws, Rules and
   Regulations and accompanying manuals.

D. TEMPORARY PRIVILEGES
   Temporary Privileges shall be authorized in accordance with the SFGH Medical Staff
   Bylaws, Article V: Clinical Privileges

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS
   Proctoring requirements for physicians who perform surgery on the Orthopedic Surgery
   Clinical Service require that the Chief of Service, or designee, observe five (5) of the
applicant's major surgical cases. Proctoring requirements for physicians who treat clinic outpatients require that the Chief of Service, or designee, observes the practitioner in three (5) outpatient clinic settings, and retrospective reviews of the care provided to fifteen (15) outpatients.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Orthopedic Surgery Clinical Service shall be in accordance with SFGH Bylaws, Rules and Regulations and accompanying manuals.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Orthopedic Surgery Clinical Service shall be in accordance with SFGH Bylaws, Rules and Regulations and accompanying manuals.

V. EDUCATION

The Orthopedic Surgery Service at SFGH offers high quality educational activities at the graduate and undergraduate levels. It is one of the main teaching sites for the UCSF orthopedic surgery residency program. The service is also an important teaching site for the Department of Emergency Medicine. Furthermore, residents from the Department of Family Medicine, Internal Medicine, and the Department of Pediatrics occasionally rotate through the orthopedic outpatient clinics.

At the graduate level, the service is also the main teaching site for third-year UCSF medical students. It also offers rotations for UCSF fourth-year medical students. During the academic year, between 5-10 UCSF medical students and about 5-10 non-UCSF fourth-year medical students rotate through the service.

VI. ORTHOPEDIC SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. SUPERVISION

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

B. EDUCATIONAL ACTIVITIES

Currently, there are eight orthopedic residents on rotation at SFGH, two residents from every Orthopaedic year PGY-5 through -2 at all times. There are also a varying number of interns (1-3) at any point in time. There are two fellows on the Orthopaedic Surgery Service. These trainees are divided into 2 teams and are providing emergency room coverage.

Resident teaching at SFGH occurs in three ways:

- interactive didactic sessions with faculty
- hands-on teaching in the operating room, clinic and rounds
- resident involvement in research projects.

Regular didactic sessions include:
- daily on-call case review
- weekly case conference attending by the residents, the full and part time staff, which includes post-operative trauma case review
- weekly pre-operative case review
- weekly Grand Rounds at UCSF
- weekly specialty conference (foot and ankle, Morbidity and Mortality)
- weekly trauma conference (didactic, journal club, bioskills exercises)

Regular research meetings are held with the full-time attending physicians, the research personnel, and the involved residents and medical students.

Medical students currently rotate at SFGH through Surgical Specialties 110 (1 week) and 4 week optional electives.

C. EDUCATIONAL GOALS

Rotation on the Orthopedic Surgery Service at San Francisco General Hospital is primarily designed to provide the orthopedic resident an in-depth experience in operative and non-operative management of orthopedic traumatology and general orthopaedic surgery. Emphasis is placed on the treatment of polytrauma victims as well as those with isolated injuries. In addition, a significant exposure to general and other subspecialty orthopaedic conditions based on outpatient clinical problems, including spine, sports, arthroplasty, foot and ankle, pediatrics, and hand surgery are available. Thorough participation in ongoing clinics, programs, lectures, conferences, supervised patient care and in-depth surgical experience provide orthopedic residents with sufficient experience to manage a wide range of diseases and afflictions of the musculoskeletal system.

D. GUIDELINES

All orthopedic residents are responsible for the day-to-day management of patients admitted to the Orthopedic Service at San Francisco General Hospital. Although the staff physician carries ultimate responsibility for patient care, it is expected that the fellow and all residents will be intimately involved in patient care on an ongoing basis, making daily rounds and providing an ongoing continuum of care for inpatients. Decisions regarding admission and complications should be reported immediately to the staff physician. Residents will not operate independently unless under unusual circumstances, i.e., emergency situations, and if so directed by the staff physician. History and physical examinations on new patient admissions are expected to be carried out, generally by the junior resident, but they should be evaluated carefully and reviewed in detail by the chief resident on the service. The chief resident, likewise, is responsible for examining the patient and taking a relevant history, and should be available to assist the junior resident in directing the appropriate work-up, writing of specific orders as necessary and requesting specific consults unless otherwise outlined by the staff physician.

It is stressed that the chief resident is ultimately responsible for the day-to care of patient management under the direction of the staff physicians. Should the first-year resident or the junior resident not be familiar with the plan of patient care or treatment protocols, it is the chief resident’s responsibility to oversee these matters and to educate the junior resident as necessary. A smooth functioning, competent surgical team is dependent upon the chief resident’s interest, organizational skills, efficiency, knowledge and ability to communicate. The surgical teams will be assisted thorough the work of the nurse practitioners on the Orthopaedic Surgical Service. The orthopedic interns and residents
are responsible for working closely with them to provide care to the patients on the service.

E. DUTIES OF RESIDENTS (Specific Responsibilities):
Also refer to House Staff Competencies Link on CHN Intranet Site

1. Patient Care Responsibilities
Orthopedic residents are expected to make patient rounds at least once a day. It is anticipated and expected that all residents on the service would make rounds in the early morning prior to going to the morning conferences. All patients should be seen, charts should be reviewed, orders written, dressings changed, consultations requested and x-rays reviewed as necessary. The nurses should be advised of any problems or orders, which need to be carried out expeditiously. Rounds for problem patients should be made again at the end of the day, postoperative checks should be made on all patients and postoperative notes should be placed on the chart before the residents department for the evening. All postoperative x-rays should be reviewed and notations made in the chart of the appropriate findings. The status of the implants should be noted, or in the case of total hip arthroplasty, for instance, a notation should be made that the x-rays reveal that the hip implant is in satisfactory position and remains reduced. A neurological-vascular check should be a standard part of the postoperative evaluation and a notation should be made in the chart that this has been examined, evaluated and is normal or not. Any abnormalities should be reported to the staff physician immediately. A note must be written in the chart each day. The chief resident or designee should write an initial evaluation note after the junior resident’s history and physical exam. All patients scheduled for operative procedures must have a preoperative note, which includes the patient’s diagnosis, alternatives of treatment and documents the patient’s informed consent. Patient Discharge Planning (PDP) forms are to be completed the evening before the patient’s anticipated discharge. All discharge summaries must be completed within 24 hours of the patient’s discharge and preferably done the day the patient is discharged while the chart is still on the station.

5. Clinic Responsibilities
All residents are expected to be present on time for clinic sessions. Clinic staff will discuss with the resident how he wishes to run his or her particular clinic. In general, residents are expected to carry out thorough history and physical examinations directed toward the patient’s orthopedic problem. The staff physician assigned to the clinic is available for consultation and instruction at all times while the clinic is operating. Particularly interesting or difficult problems are excellent material for presentation at the weekly conference. Residents will dictate on the clinic patients they see and be in compliance with the standard billing practices.

The emergency room resident is responsible for being present in their team’s activities, and leave for consults when paged. Coverage of the emergency room during these times is as assigned on the call schedule.

6. Surgical Responsibilities
Residents assigned to specific operative cases are expected to check that the required paperwork, including history and physical (including interval history and physical) and consent, and that proper site marking has occurred. If the patient has questions
regarding the procedure and would like to confer with the attending staff, the resident will inform the attending staff member. The resident is expected to confer with the attending staff regarding details of the procedure, including specifics about the operation, appropriate implants, and positioning. The resident is expected to arrive in the operating suite promptly at the time the patient is brought into the room in order to assist the anesthesiologist as necessary and facilitate positioning of the patient, arranging x-rays, double checking instruments packs, time outs, etc. It is essential, that have a thorough knowledge of anatomy along with the procedure plan for the specific operation and a knowledge of alternative surgical techniques for the management of that specific problem. Orthopedic residents not well versed in the relevant literature or the anatomy of the exposure to be performed or the planned procedure are unlikely to be given active involvement in the surgical case and, at best, would have a compromised educational experience. The extent of a resident’s involvement in a specific operative procedure is in a great part dependent not only on the resident’s natural ability, surgical knowledge and skill, but also on their interest, desire, and preparation.

7. **Conference Responsibilities**

As an important part of the educational curriculum, conferences on specific topics are held daily, along with grand rounds each Wednesday at UCSF. These conferences are planned months in advance and they have been carefully thought out by staff and senior residents as to the educational content as it relates to the overall educational curriculum. Residents are expected to attend these conferences and to come prepared to discuss the subject matter and to provide a healthy exchange of ideas and questions that would maximize everyone’s educational experience. Case presentations at the weekly orthopedic conference are essential for discussing and analyzing current treatment rationale. If the junior resident is presenting cases, he/she should discuss the presentation with the chief resident prior to the conference, review briefly the relevant literature and to have a working knowledge of the treatment, complications and results to be expected. The chief resident should have a more detailed knowledge of the material and problem, and be prepared to discuss more extensively the current concepts of the problem being presented along with its current accepted treatment and complications of treatment.

**VII. ORTHOPEDIC SURGERY CLINICAL SERVICE CONSULTATION CRITERIA**

The Orthopedic Surgery Service answers consultations from many different sources. For emergency room consultations, patients are should be seen in accordance to the Emergency Department Diversion Reduction Initiative, which outlines that patients in the ED should be seen with a goal to respond to pages within 15 minutes, initially assess the patients within 30 minutes of the initial page, and disposition from the ED within 2 hours.

**VIII. DISCIPLINARY ACTION**

The San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations will govern all disciplinary action involving members of the SFGH Orthopedic Surgery Clinical Service.
IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT

A. RESPONSIBILITY

The Chief of the Orthopedic Clinical Service, or his/her designee, is responsible for ensuring solutions to quality care issues. As necessary, assistance is invited from other departments, the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization.

To ensure appropriate care and safety of all patients receiving care in the department, it is understood that this care is provided chiefly in the emergency room, the operating room, the inpatient nursing units and the clinics.

To minimize morbidity and mortality as well as to avoid unnecessary days of inpatient care, contributes to the efficient delivery of patient services.

B. REPORTING

Performance Improvement/Patient Safety (PIPS) and Utilization Management activity records will be maintained by the Orthopedic Clinical Service. Further, minutes will be sent to the Medical Staff Service Department and will include PIPS and Utilization Management information.
C. CLINICAL INDICATORS
The following clinical indicators are among those closely followed:
- Open fractures
- Antibiotic prophylaxis in patients
- Nosocomial infection rate by surgical categories (i.e., clean, contaminated, infected, and open fractures)
- Readmission rate following ORIF of fractures
- Professional behavior (i.e. Unusual occurrence reports
- Deaths

D. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES
The practitioner performance profiles are monitored by the outpatient clinic and inpatient statistics as well as by the monthly M&M Review Board.

E. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES
Monitoring and evaluation of appropriateness of patient care services is done on a daily basis. Each morning at 7:00AM, service attendings and all housestaff meet to discuss all emergency room consultations and admissions from the previous 24 hours, including their diagnostic evaluations, treatment plans (surgical and conservative) and discharge plans. Following these conferences, pre-operative and post-operative cases will be reviewed on Mondays and Tuesdays. Once a week with each service, all inpatients are formally reviewed with representatives from Physical Therapy, Social Services, and Rehabilitation Services.

F. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE
1. Physicians/Affiliated Professionals
   All of the professional staff, except for the housestaff, are evaluated by the Chief of Service and the Chairman of the Department on an annually. The faculty are evaluated by the residents and fellows regularly during the academic year according to UCSF Department of Orthopaedic Surgery policy.

2. Housestaff
   Each resident is evaluated twice during their rotation. Once, in the middle of his/her rotation, where constructive comments can be made following a performance evaluation, and again at the end of the rotation. At these meetings, suggestions can be made by the attending staff to give some direction to the resident for his/her self-improvement. At the end of the rotation, a formal evaluation by the entire faculty is performed for each resident. The findings are summarized on the appropriate form and forwarded to the Chairman of the Department. These results are discussed semi-annually at the Department Chief of Service meeting.

X. MEETING REQUIREMENTS
In accordance with SFGH Medical Staff Bylaws, 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 Orthopedic Surgery faculty shall meet monthly. Discussions will include monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

XI. ADOPTION AND AMENDMENT

The Orthopedic Surgery Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the Orthopedic Surgery faculty annually during a faculty meeting.

XII. PATIENT INFORMATION

All patient-related health information will be treated with the upmost confidentiality, in accordance to the Health Insurance Portability and Accountability Act (HIPPA) guidelines.
ATTACHMENT A– ORTHOPEDIC SURGERY PRIVILEGES

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.

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**OrthoSurg**  ORTHOPAEDIC SURGERY 2010  
(MEC 08/10)

FOR ALL PRIVILEGES: All complication rates, including problem transfusions, deaths,  
unusual occurrence reports, patient complaints, and sentinel events, as well as Department  
quality indicators, will be monitored semiannually.

28.00 GENERAL PRIVILEGES

Core privileges directed at the treatment of disorders and injuries of the neck, back,  
thorax, pelvis, upper extremities, and lower extremities, include the following  
treatments (other than those outlined for supplemental privileges):

- PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by  
  the American Board of Orthopedic Surgery.
- PROCTORING: 5 observed operative procedures and 15 retrospective reviews of  
  operative procedures.
- REAPPOINTMENT: 20 operative procedures in the previous two years.

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A. Amputation, traumatic and elective  
B. Application of skeletal traction  
C. Arthrodesis  
D. Arthroscopic surgery  
E. Arthrotomy  
F. Back and neck pain; chronic and acute  
G. Biopsy of the musculoskeletal system  
H. Bone graft  
  I. Contusion, sprains, and strains  
  J. External fixation of fractures  
K. Fractures and dislocations, open or closed  
L. Infection (surgical and medical treatment)  
M. Injections (Joint, Bursa, trigger point, tendon sheaths)  
N. Internal fixation of fractures  
O. Ligament reconstruction  
P. Ostectomy  
Q. Osteotomy  
R. Repair of lacerations  
S. Revision of total hip and knee surgeries  
T. Skin grafts  
U. Spinal surgery (other than supplemental privileges)  
V. Sports medicine and related injuries  
W. Tenotomy and myotomy
Privileges for San Francisco General Hospital

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<td>X. Total joint surgery</td>
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<td>Y. Tumor surgery</td>
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<td>Z. Wound debridement</td>
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<tr>
<td>aa. Management of orthopedic conditions for patients in SNF Units</td>
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<td>bb. Major tumor resection</td>
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28.05 OUTPATIENT PRIVILEGES
Outpatient clinic privileges directed at the evaluation and diagnosis of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Orthopedic Surgery.
PROCTORING: 5 observed visits and 15 retrospective reviews visits
REAPPOINTMENT: 20 visits in the previous two years.

28.10 SPECIAL PRIVILEGES: SPINAL SURGERY
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Orthopaedic Surgery and has completed fellowship training in spinal surgery or possesses equivalent experience.
PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Orthopaedic Surgery or designee.
REAPPOINTMENT: 20 procedures in the previous two years.
Patient management includes the areas specified below:

A. Complex anterior and posterior cervical, thoracic, and lumbar spinal surgery
B. Open reduction and internal fixation of spine fractures
C. Intra-discal chemonucleolysis
D. Percutaneous disk excision

28.20 SPECIAL PRIVILEGES: HAND AND MICROVASCULAR SURGERY
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery or American Board of Plastic Surgery and has completed fellowship training in hand and microvascular surgery or possesses equivalent experience.
PROCTORING: Review of 5 operative procedures and 15 retrospective reviews of procedures
REAPPOINTMENT: 20 operative procedures in the previous two years.

A. Microsurgery and replacement, replantation of limbs and parts, including adjacent and free tissue transfer.
B. Complex Hand Surgery and Replantation of Limbs and Parts
C. Use of operating microscope, repair blood vessel/nerve, digit replantation
D. Free muscle/skin flap microvascular anastamosis

28.30 GENERAL PODIATRIC PRIVILEGES
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00.
PROCTORING: 5 observed cases and 15 retrospective reviews of procedures.
REAPPOINTMENT: 20 cases in the previous two years.
Simple outpatient procedures including:
Privileges for San Francisco General Hospital

Requested  Approved

A. Nail avulsion
B. Chemical Martisectomies
C. Biopsy and debridement of cutaneous lesions, and simple infection process relative to nails and skin.

28.40 SURGICAL PODIATRIC PRIVILEGES

28.41 Category I: Podiatric Surgery
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00.
PROCTORING: 5 observed cases and 15 retrospective reviews of procedures (Category I).
REAPPOINTMENT: 20 cases in the previous two years.

A. Treatment of cutaneous lesions
B. Removal of foreign bodies
C. Removal of superficial debridements

28.42 Category II: Podiatric Surgery
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00.
PROCTORING: 5 observed procedures and 15 retrospective reviews of procedures (Category 2).
REAPPOINTMENT: 20 procedures in the previous two years (Category 2).

A. Excision of soft tissue lesions
B. Intermetatarsal neuromas
C. Bunionectomies
D. Capsulotomies
E. Tenotomies
F. Removal of foreign bodies of the forefoot
G. Amputation
H. Osseous procedures of the forefoot including sesamoidectomy
I. Fusion of interphalangeal joints
J. Osteotomies

29.00 PHYSICAL MEDICINE & REHABILITATION

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.
PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.
REAPPOINTMENT: 20 procedures in the previous two years.

Performs basic procedures within the usual and customary scope of physical medicine and rehabilitation, including but not limited to diagnosis, management, treatment, and preventive care for adult and pediatric patients.

A. Intra-articular joint injection
B. Intra-articular joint aspiration
Privileges for  San Francisco General Hospital

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C. Joint bursa aspiration
D. Joint bursa injection
E. Tendon sheath injection
F. Trigger/Tender point injection
G. Ganglion aspiration
H. Nerve block
I. Chemical neurolysis
J. Neuromuscular junction block
K. Autologous blood tendon injection
L. Lumbar puncture
M. Intrathecal pump management

### 29.10 SPINAL INJECTION TECHNIQUES

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

REAPPOINTMENT: 20 procedures in the previous two years.

Procedures include:

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A. Transforaminal epidural injection (selected nerve root block)
B. Interlaminar epidural injection
C. Facet joint injection
D. Facet nerve block
E. Discography
F. Epidurolysis
G. Sympathetic nerve block
H. Sacroiliac joint injection
I. Epidural blood patch
J. Radiofrequency nerve ablation

### 29.20 SPINAL TECHNIQUES: SPECIAL PROCEDURES

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

REAPPOINTMENT: 20 procedures in the previous two years.

Procedures include:

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A. Spinal cord stimulation
B. Percutaneous vertebroplasty/kyphoplasty
C. Implanted drug delivery for pain or spasticity
D. Intradiscal electrothermal therapy
Privileges for San Francisco General Hospital

29.30 CLINICAL NEUROPHYSIOLOGY
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation. Additional training in Neurophysiological techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

REAPPOINTMENT: 20 procedures in the previous two years.

Procedures include:

A. Electromyography
B. Nerve conduction study
C. Somatosensory evoked potential assessment
D. Electromyography/nerve conduction guided
E. Guided nerve block
F. Electromyography/nerve conduction guided junction nerve block

29.40 EVOKED POTENTIAL TESTING
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in American Board of Physical Medicine and Rehabilitation. Additional training in Neurophysiological techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required.

PROCTORING: Review of 5 procedures and 15 retrospective reviews of procedures

REAPPOINTMENT: 20 operative procedures in the previous two years

30.00 ACUTE TRAUMA SURGERY
SCOPE: On-call trauma coverage for the comprehensive orthopedic management of the acutely injured trauma patient.

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

PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures.

REAPPOINTMENT: 20 operative procedures in the previous two years

31.00 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of orthopedic Surgery, Plastic Surgery, Podiatric Surgery, or the American Board of Physical Medicine & Rehabilitation, or a member of the Clinical Services prior to 10/17/00. A current x-Ray/Fluoroscopy Certificate is required.

PROCTORING: Presentation of valid California Fluoroscopy certificate

REAPPOINTMENT: Presentation of a valid California Fluoroscopy certificate.
Privileges for San Francisco General Hospital

32.00 PROCEDURAL SEDATION

PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Orthopedics or a member of the Clinical Service prior to 10/17/00, and has completed at least one of the following:
- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year in the preceding 2 years or,
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association

PROCTORING: Review of 5 cases (completed training within the last 5 years)

REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and has completed at least one of the following:
- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year for the preceding 2 years or,
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association

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.

APPROVED BY:

______________________________ date __________
Division Chief

______________________________ date __________
Service Chief

PRINTED 6/24/2013
ATTACHMENT B– ORTHOPEDIC SURGERY POLICIES AND PROCEDURES

A. EMERGENCY ROOM COVERAGE

1. Respond IMMEDIATELY for ER consultation.
2. Confirm:
   a. that your name and beeper number are listed correctly on the call schedule
   b. that your beeper is working.
3. The resident assigned to the ER on days should be available from 7:00 a.m. until 7:00 a.m. the following day.
4. The resident on call on holidays covers the ER during the day and night.
5. PATIENT TREATMENT REGISTER:
   a. All outpatients must be recorded on the “Patient Case Log” by the Orthopedic Emergency Room Resident. Record name, MR number, phone, address, diagnosis, treatment and clinic appointment date. Patients must have complete registry information placed on the information sheet.
   b. All admissions with orthopedic problems (whether admitted to Ortho or not) must also be recorded specifying assigned SFGH ward and admitting service if other than Ortho.
   c. The Ortho Service administrative staff and nurse practitioners will obtain the list each morning and use it for service records.
   d. Acute conditions (fractures, dislocations, infections, etc.) shall not be given e-referral appointments.
6. EMERGENCY TREATMENT POLICIES:
   a. Consult immediately with Chief Resident regarding any potential surgical case.
   b. Unless you are certain of diagnosis and treatment, consult Chief Resident prior to making disposition plans.
   c. The on-call junior resident should notify the Chief Resident immediately of all admissions to their service. The Chief Resident should notify the attending on call of all admissions to their service or cases scheduled.
   d. Residents should save all records, particularly the yellow copies of the consult forms (originals are to be left on the chart) to review the following morning in fracture rounds with the attending who was on call. All consultations (ER & inpatient) must be reviewed by an attending prior to the on-call resident leaving the hospital post-call (no later than 11am the following day).
   e. When in doubt, the junior resident should not hesitate to ask the Chief Resident to personally see the patient and/or the imaging studies (e.g., compression fractures of spine, patients unable to walk or care for themselves safely in casts, potential compartment syndromes, “disposition problems” whose diagnoses are orthopedic, etc.).
   f. ER RECORDS: An ORTHO consult note must be written for each patient seen using the standard template form. The records should include medications given and procedures done for patients admitted to hospital or sent home with follow-up instructions (including clinic follow-up). For admissions, the attending of record must review the consult and see the patient within 24 hours of admission, and complete an attending attestation form.
g. Orthopaedic Surgery residents are responsible for the consultations in the ER.
h. Orthopedics & Neurosurgery should be called for consults according to the spine call schedule.
i. Orthopaedics & Plastics should be called for consults according to the hand call schedule.

7. Avoid “curbside” consultation—it is usually not optimal for the patient.

B. EMERGENCY ADMISSIONS

1. EMERGENCY ORTHOPEDIC ADMISSIONS
a. Emergency admissions are assigned to the service on call for that day, with the following exceptions:
   1) Patients requiring emergency surgery will be cared for by the team performing the operation.
   2) Re-admissions for the same problem will return to their previous team.

b. Complete ER admission paperwork, including admission orders and a complete history and physical examination.

c. Direct admissions/transfers from other hospitals are welcome and encouraged. They must be approved first by an attending who will arrange the transfer with the SFGH eligibility/transfer coordinator (if inpatient to inpatient transfer) or the ED attending (if ED to ED transfer). Make note of patient diagnosis, reason for transfer, type of bed required (ICU, step-down, etc.) and optimal timing for surgery.

2. ADMISSIONS TO OTHER SERVICES
There must be:

a. A note in the medical record clearly defining the patient’s orthopedic problems and treatment, provided or recommended, and a legible signature with beeper number. Times and dates are required on all notes and orders.

b. Clear written indication of which orthopedic team is involved with name of the chief resident and his/her beeper number.

c. Verbal communication with the responsible senior or chief resident of the admitting service to ensure proper communication and discussion of medical plans.

d. Patient admissions and transfers should adhere to the general guidelines established between the various services (including trauma and medicine).

e. While on another service, such “consult patients” will be followed at least daily by the appropriate orthopedic team.

f. Children with orthopaedic problems requiring hospitalization will be admitted to the Pediatric Ward (6A) under the primary care of the Pediatric Service who must be notified immediately about any admission (must see in ER). Ortho interns may assist with the care of such patients, but need not do work-ups and ward care as these are provided by the Pediatric house staff.
C. **NIGHT AND WEEKEND COVERAGE**

1. The assigned junior resident and intern must stay in the hospital.
2. When a new junior resident assumes night/weekend call, the chief resident must also remain in the hospital to provide immediate back up. This may be discontinued only by mutual agreement of the chief resident and service chief.
3. Before leaving for the day, interns will sign out their patients with the intern and/or nurse practitioner on duty.
4. Night call is the responsibility of that person on the call schedule. If the scheduled resident on call needs to be off for some reason, it is their responsibility to make sure that the time is covered by another house officer of the same level who agrees to cover. The chief residents must approve of a switch in night call. Other team members, orthopaedic surgery administrator, telephone operator and ER must be notified of any deviation from the printed schedule.
5. Do not “hassle” the administrative assistant about the call schedule. Questions regarding the call schedule should be directed to the Chief of Service.

D. **VACATION**

1. Vacations should be scheduled 6 weeks in advance, and should be done through the protocol established through the UCSF Department of Orthopaedic Surgery residency, which includes approval from the services chief resident, chief of service, and residency coordinator. Vacations consist of 5 consecutive working days, and cannot exceed that time during the rotation.
2. Residents can request vacation at SFGH in accordance with the Department of Orthopaedic Residency requirements. Vacation will be granted and placed on the calendar on a first-come-first-served basis. The rotations at SFGH allow for only one resident to be gone at a time. Exceptions will be considered for very important educational events or personal issues, and must be approved by both service chief residents and the faculty from the service that will be affected by the leave. If this exceptional leave is granted, the residents must be a senior and junior from different teams. Leave generally will not be granted for the first week of any rotation, during the Christmas Holiday or New Year’s (when coverage teams are formed, allowing for every team member to have an equal number of designated, non-vacation days off), or the first/last weeks of the academic year.

E. **ORTHOPEDIC TEAM ROUNDS**

1. Each chief resident will round with his/her team on all his or her patients daily, prior to fracture rounds (with the exception of Wednesdays when the residents should attend Grand Rounds and the rounding is performed by the in-house residents on call, the NPs, and the fellows). Patient visits must include an opportunity for the patient to discuss his/her care with team members. Patients should know their assigned team, the name of their chief resident, attending and at least one other M.D. on the team.
2. A patient’s perception of his physician as “insensitive” is a frequent precursor of a lawsuit! Always acknowledge the patient prior to examination or bedside discussion of his problems. Listen to the patient and take an interest in their personal life, concerns, and well-being whenever it is possible.
3. Rounds must begin early enough so the chief resident can see and assess each patient.
4. **WEEKENDS AND HOLIDAYS**, the service the residents will be responsible to make rounds on patients from both teams, do necessary ward work, write notes and report problems to the team on duty. The residents will subsequently conduct rounds with the attending on call.

5. **ATTENDING MULTIDISCIPLINARY WARD ROUNDS**, followed by a review of all inpatient x-rays, will be held weekly by each team, Blue on Monday at 8:00 a.m. and Gold on Tuesday at 8:00 a.m. Prior to these rounds, patients will have been seen on regular work rounds and wounds prepared for examination.

**F. WARD PROCEDURES**

1. **MEDICAL RECORDS:**
   a. A history and physical will be written for each patient on admission by the intern or junior housestaff who will write orders after consulting with a senior resident.
   b. There must be a resident note for each patient confirming pertinent history, physical examination, lab and x-ray findings, and given clearly recorded diagnoses and plans.
   c. Any procedure (case change, closed reduction, etc.) must be recorded in the patient’s record along with physical finds, post-reduction x-rays, etc. and a note dictated on Provations as necessary.
   d. Progress notes by the residents should be written daily on each patient, and dated and signed legibly. Electronic progress notes should be written by the fellow or an attending on the service daily.
   e. There should be an interval history/preoperative note written in the chart less than 24 hours before any elective procedure. This should include but not limited to the patient diagnosis, surgical indications, significant laboratory values, significant co-morbidities, and planned procedure.

2. **ORDERS**
   a. All orders will be written completely, including time and date, and signed. All admission and postoperative orders **must be written** on the standing order forms.
   b. Verbal or phone orders must be countersigned within 24 hours.
   c. Narcotics, anticoagulants and IV fluid orders will be carried out for up to 72 hours when they will stop automatically unless renewed.
   d. **GIVE ADEQUATE PAIN MEDICATION!** Pre-medicate before a painful procedure. Do not hesitate to consult the Pain Management Service.
   e. All medication orders must be renewed every 7 days.
   f. All orders are automatically stopped at the time of surgery and on inter-service transfer. They therefore must be re-written in these cases.
   g. X-rays and lab studies must be ordered in the chart as well as requested on appropriate forms. Practitioners should not order unnecessary (routine) blood work or x-rays.
   h. All instructions for the cast technician or braces must be recorded in the chart, just as any other order.

3. **DISCHARGE RECORDS**
   a. The chief resident is responsible for the correctness of recorded discharge diagnoses.
b. Complete, specific, final orthopedic diagnoses must be on the Patient Discharge Form (pink right margin) and on dictated summary.

c. A brief (preferably one page only) dictated discharge summary will be done for each patient. This must record at least the patient’s diagnoses, including date of injury, operations performed with dates, problems encountered, if any, and plans for further care and follow-up. (See section below on Laguna Honda transfers).

d. If a patient is transferred to another hospital or physician, a telephone conversation must occur between the receiving orthopedist and a senior orthopedic team member to discuss the patient’s diagnoses, condition, treatment undertaken and transfer arrangements. This conversation, including name, address and phone number of receiving orthopedist must be recorded in a progress note. A dictated summary and pertinent x-rays or their copies should accompany patients so transferred.

G. DISCHARGE PLANNING

1. Patient’s needs for discharge planning at the time of admission should be anticipated. If a patient is not certain to be discharged ambulatory and independent, consult the social worker and/or discharge nurse coordinator as soon as possible.

2. Remember to allow for needed gait training or other physical therapy before planned time of discharge. Schedule this in advance, not at the last minute.

3. Inform patients as soon as possible about a planned discharge dates, and keep them informed of any changes.

4. Visiting nurse services may permit discharge home where visiting PT may also be arranged.

5. Laguna Honda Hospital (county facility) has a limited number of acute rehabilitation beds (see below). They also have chronic care beds with a long waiting list.

6. Laguna Honda Hospital staff will screen all prospective patients for their rehabilitation ward before accepting them for admission. Patients must need rehabilitation services, must be willing and able to participate, and must have an appropriate plan for discharge from LHH.

7. The social worker will arrange LHH rehabilitation evaluation for a patient upon request of the Orthopedic team.

8. The SFGH orthopedic Service has a weekly follow-up clinic at LHH every on Tuesdays am, alternating between the two services. One attending and the appropriate junior resident staff these clinics.

9. If a patient is accepted for transfer to the LHH rehabilitation ward, a discharge summary must be dictated the day before transfer. It must include the following:
   a) Which team (Blue or Gold) will follow the patient.
   b) Explicit physical therapy and activity orders, including weight bearing status.
   c) Notation of any x-rays desired to be done prior to the first Tuesday LHH clinic in which the patient will be seen.

H. COMPLETION OF MEDICAL RECORDS

1. A dictated discharge summary and a written discharge front sheet should be completed before the patient is discharged.
2. Operative notes must be dictated within 24 hours of the surgical procedure and must be signed by the attending within 3 days. Any und dictated or unsigned delinquent note will result in suspension of surgical privileges.

3. Clinic visits should be seen with an attending when possible. Clinic notes should be dictated as follows: non-licensed residents must see the patient with the attendings and dictate with the attendings name in the note; licensed residents should dictate under their name (with “Dr. Statistical” as attending if they do not see the patient with an attending and dictate in the attendings name if seen with an attending; and attendings should dictate their own name in the notes. Medical students are not allow to write notes. All clinic notes should be signed within a week.

3. Hospital privileges may be suspended for any physician who fails to complete charts or Dictate notes within the designated time. The und dictated charts will be reviewed weekly and notes needing countersignature will be brought to the Department by Medical Records for signature.

I. INFECTION PREVENTION

1. All needle sticks and body fluid contamination must be reported as soon as feasible. First, file incident report at time of contamination. Second, report to CMOSH or ER for appropriate testing and counseling. Third, obtain appropriate patient blood/serologic testing.

2. HANDWASHING and good dressing techniques are the keys to preventing transfer of pathogenic bacteria from patient to patient.

3. Use gloves for all wounds, all dressings and when touching any linen’s, gowns or clothing that may be soiled with blood or body fluids. Wash your hands after touching each patient even if you were wearing gloves. See “Infection Control and Body Substance Precaution orientation Booklet.”

4. Patients with planned or recent clean surgical procedures must not be admitted to rooms that also house patients with infected, draining wounds.

J. PRESSURE SORES & CONTRACTURES

1. Immobilized patients may develop pressure sores, contractures and other problems. Patients who cannot relive focal pressure by moving in bed, or who have insensible skin, are most at risk. For other, mobility aids will increase morale.

2. Unless sitting, trunk flexion, or loading of arms, is contraindicated. An overhead frame and trapeze should routinely be provided.

3. Pressures sores typically develop on the sacrum, lateral buttocks and heels. Rolling the patient every two hours, maintaining dry clean sheets and use of additional padding (e.g., foam egg crate mattress pad) over the firm hospital mattress are standard. Additionally, a pillow placed longitudinally under the calf (not under the knee) with the heel hanging over the end will prevent heel pressure sores.

4. Patients in traction usually can be turned 30 degrees side-to-side, but if they cannot be turned enough to unload their sacrum, prompt use of an air bed before pressures develop is effective. Such beds are available after approval by the Plastic Surgery Service. If none are in the hospital, they can be rented and delivered immediately.

K. PLASTER
1. Do not pull plastic covered pillows or any other plastic material next to setting plaster. If patient c/o burning, **REMOVE** case or splint immediately.

2. Circumferential casts, and even splints, can cause excessive pressure on a limb, especially a recently injured one with increasing swelling. Make sure that enough padding is applied to allow the case to be split without skin trauma.

3. Cast univalving or bivalving should be done the full-length of the case, dividing padding as well as plaster. The case must then be spread to loosen it.

4. Interns should check with the resident before opening a cast. Do not open a cast directly over a traumatic or operative wound.

5. Casts should generally be sawed open **OUTSIDE** the OR to minimize airborne dust.

6. Major cast work (spica, body jacket, etc.) should be planned and scheduled in accordance to with the Chief Resident and ortho technician the preceding day.

7. Inpatient cast work must not be done in the ER or the clinic. If prompt x-ray control or anesthesia is required, such plaster work is best done in the OR.

8. Cast technician duties: Collect treatment equipment, set up traction, apply overhead frames, apply routine casts and splints, assist with casts and cast braces.

9. Maintain reasonable cleanliness in the Cast Room.

10. Stamp and fill out cast room slips for all procedures done and equipment handed out (crutches, braces, etc.). Billing slips are required to obtain insurance payments for the hospital.

11. Plastic cast material is available in limited amounts for patients with appropriate indications.

12. Return all orthopedic equipment to the area from which it is borrowed. If something is missing or broken, inform the cast technician.

L. TRACTION SUPPLIES

1. Traction supplies (rope, splints, fleece slings, weight bags, overhead frames and pulleys, etc.) are stored on 3B. The 3B cast technician is responsible for keeping this material clean and orderly.

2. Traction equipment should be removed from beds when no longer needed. The ortho technician makes regular rounds for this purpose. Overhead frames and trapezes remain on ortho beds, however (Do not apply excessive tape to splints. It is difficult to remove!).

M. ORTHOTICS AND PROSTHETICS

1. All over-the-counter inpatient equipment (i.e. braces, immobilizers, etc.) should be ordered through the Orthotics and Prosthetics service. Care must be taken to ensure that the brace is the right size and length to fit the patient.

2. Proper orders or requisition forms must be completed, including the patient’s name, medical record number, diagnosis (including side of injury), and correct brace type.

N. SURGERY

Phone: 8134
Supervisor: Patty Nichols, R.N.

O. PREOPERATIVE PREPARATION
1. Consultation with attending is required before any patient is taken to surgery.

2. Scheduling (Emergency and Elective)
   a. All cases should be scheduled by the appropriate chief resident. The attendings should be informed when scheduling any case.
   b. Scheduling forms (SFGH and Ortho) must be completed for all cases.
   c. Monday and Thursday are Gold OR days. Tuesday and Wednesday are Blue OR days. Friday is both an OR Gold and Blue day.
   d. Elective operating schedules must be given to the OR head nurse by 48 hours prior to surgery for the elective room, 12:00 noon the day before for 9th Room Cases, and 6:00 am the day of surgery for 8th Room Cases.
   e. Non-urgent cases “added on” after that time will be scheduled in sequence by the OR as space and personnel permit.
   f. Emergency cases must be scheduled through the attending or service chief resident.
   g. The consent form must be obtained prior to booking and the booked case must match the booking form.

3. Resident-specific responsibilities:
   a. Residents will perform pre-operative notes on night prior to surgery for inpatients.
   b. Residents will see all first cases prior to morning conference (6:45 a.m.) and verify that all required paperwork is complete and the patient is site marked. The site marking must be done by a provider that is licensed, and will be available for the time-out, and is capable of starting the procedure. The responsible resident will also perform the site markings, and confirm the paperwork is complete for all subsequent cases.
   c. Residents will check with the attending pre-operatively to ensure that the surgical plan, including necessary instrumentation and positioning, is understood. The resident will go to the OR prior to induction to ensure that the proper instrumentation is available.
   d. Chief resident will act as the contact person for the OR that day and identify themselves with the OR prior to 7am on weekdays. When possible, they will write the names of the attendings, fellows, and residents who will be scrubbing in on the case each day.
   e. The Chief Resident for each team (Gold/Blue) will assign resident teams to each case and list the assigned residents on the weekly case list presented at the weekly conference. The case lists will also list the responsible attendings for each elective case. Every effort will be made to maintain the identified teams. A copy of the case list will be provided electronically (via secured e-mail) to the OR front desk after conference.

4. Attending-specific responsibilities:
   a. Attending surgeon will complete or co-sign the surgery booking form, or the case will not be scheduled by the operating room. These sheets will be accurate and legible, and include all required instrumentation and desired positioning.
   b. Attending surgeon should check the room prior to induction to verify that the proper implants are available for elective cases. For emergency cases, the attending will provide verbal confirmation.
   c. The OR Attending of the day (the on-call attending or his designee) will be available to cover any emergency or trauma cases in OR 8, and be available for board management or patient-related questions.
d. Attending surgeons will see the patient pre-operatively and post-operatively (no later than POD #1). They will perform the site monitoring and complete the paperwork if it is not already done. The patient will not be placed in the room until the attending sees the patient for elective cases. The attending will be available to go to the OR when paged by the circulator that the patient is in the room.
e. Attending surgeon will discuss case of the patient with the patient’s family post-operatively (if they are available).

3. Informed Consent
   a. DISCLOSURE
      Discussion of the procedure with the patient by the physician who will perform or supervise the procedure. Use hospital translator if necessary. Disclosure must include:

      - Nature and goal of procedure
      - Likelihood of achieving goal
      - Reasonable alternatives, both medical and surgical
      - Risks that are serious and/or common

      After disclosure, whether or not the patient agrees, the physician must summarize the discussion in the medical record.

   b. WRITTEN CONSENT FORM
      - AFTER disclosure
      - Complete ALL spaces (including date and time)
      - Signed by patient (or legally appointed conservator)
      - Signature witnessed by another M.D. or SFGH employee
      - Translator must sign
      - Special rules for minors (see Hospital Policy Manual)

4. INCOMPETENT PATIENT
   Check or family or legal guardian (conservator)
   a. EMERGENCY: If delay or non-treatment post significant risk to life, limb or serious deterioration of the patient’s condition, note this and patient’s non-lucidity in the record as justification for proceeding.
   b. NON-EMERGENCY:
      1. Obtain probate court order (slow--call Risk Management, x5125 or pager 997-9660, to initiate).
      2. Alternative: If treatment cannot reasonably be delayed, one member of the medical staff must document in the medical record:
         a) nature of risk from delay of treatment, and
         b) advantages of proposed procedure.

5. Preoperative evaluation and note which must include indications for surgery as well as a list of potential likely complications. This will be written by the resident most involved with the procedure whenever possible.

6. Appropriate Anesthesia consultations should be obtained early enough to permit optimal patient preparation and to prevent last minute cancellation by Anesthesia because of an “incompletely evaluated patient.”

7. Early Anesthesia consultations are routine for patients with complicated medical problems, including those with cardio-respiratory, hepatic, renal, or diabetic problems, as well as Jehovah’s Witnesses.
8. All elective patients scheduled through the clinic should be referred to the anesthesia pre-operative clinic.
9. Preoperative planning must consider requirements for equipment, especially implants. Elective cases scheduled in the clinic must have the equipment required signed or initialed by the attending surgeon.
10. The operating resident will review the patient, including x-rays, with the OR attending so that both may be involved in preoperative planning. The operating resident must know the anatomy, the surgical approach, the operative procedure, the indications and alternative methods of treatment.
11. Pre-operative notes should be written on inpatients the night prior to surgery.
12. Routine lab studies (CBS, UA, EKG, LFT’s, Lytes, Creatinine, clotting studies, etc.) as indicated. Blood should usually be typed and held, or cross-matched if transfusion is anticipated. X-rays must be in the OR before the case is begun.
13. Essential instruments and implants must be selected and sterilized. You must know where equipment is kept, as the night shift nurses are often unfamiliar with orthopedic equipment. Routine cases will be picked by OR nurse.
14. Cast materials must be ready and outside the operating room until wound closure.
15. PREPARATION
   a. Shave (in OR) only when and where hair will impede closure. Clipping should be performed when possible.
   b. If skin is intact, use iodophor prep (Prepadine, Betadine, Ioprep, etc.) which can be painted directly on open wound. Skin must be completely dry if adhesive drape is to stick reliably.
   c. Drape according to standard sterile draping techniques.
15. PROTECTION FOR SURGEONS
   a. All surgeons must wear goggles, glasses, or face shield for every case.
   b. Double gloves must be worn for every case.
   c. For cases with significant blood loss, each surgeon must wear:
      1) Double shoe covers
      2) Knee high disposable boots
      3) Gowns with reinforced sleeves and front panel
      4) Extra sleeves
   d. The pulse lavage must be used with its splash shield. If none is available, the pulse lavage is not to be used. Irrigate with bulb syringe.
   e. Stackhouse surgical helmet systems are available for use on all high-risk cases. When scheduling cases, tell OR you want to use the Stackhouse system.
   b. When operating on high-risk patients, the members of the surgical team should wear Kevlar gloves.
17. Prophylactic antibiotics are used for all clean surgical procedures when implant materials used:
   - 1 gram Kefzol IV with induction of anesthesia
   - 1 gram Kefzol IV in PAR
   Check for allergy and consult with chief resident if needed.
18. OPEN FRACTURE ANTIBIOTIC ROUTINE
   Grade III open fractures:
   - add gentamicin i.v. 1mg per kh q 8 urs if renal fuction is normal
   If gross dirt contamination:
   - add penicillin 2,000,000 units q 6 hours
START IN ER, AS SOON AS POSSIBLE, 1 gram Kefzol IV Q 6 hours for 48 hours. Then STOP.

At time of DPC, use prophylactic routine (#16).

19. Be in the OR by 7:30 a.m. If a member of the surgical team is not in the room, the procedure cannot start.

20. The patient must be site marked prior to surgery by a licensed practitioner who is capable of starting the case and will be present at the beginning of the case.

21. All hair and street clothing must be covered. A self-laundered scrub cap can be used if covered up by a clean, disposable cap. Use hood, not cap alone to cover all hair if exposed (a sweatband helps with sweat).

22. If you leave OR in greens, wear a long gown closed in the front. A short white jacket does not prevent contamination of the front of your greens. When in doubt, change your greens should be changed before beginning another case in those cases that have been on contaminated or infected wounds or if the greens were worn outside of the operating room area. Greens should never leave the hospital campus (can be worn between hospital and Building 9).

23. The operating resident for the next case should stay in the assigned operating room between cases to expedite room turnover. Patients in the pre-operative area should be checked by the surgical team for completion of paperwork, site marking, and desire to have additional questions answered prior to surgery in order to ensure no delay for the start of the next case. The surgical team in the OR in which the patient is expected to enter will be notified by the holding area staff for patients with incomplete requirements so that this can be dealt with in order to avoid delays in room turn-over.

23. Masks should be changed between every case.

24. Shoe covers must be worn in the OR at all times. If you leave the OR, remove your shoe covers and replace them upon return to the OR.

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For general anesthesia, monitored anesthesia care (MAC), and local with sedation

<table>
<thead>
<tr>
<th>Age</th>
<th>NO FOOD*</th>
<th>CLEAR LIQUIDS ONLY**</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
<td>NO FOOD*</td>
<td>CLEAR LIQUIDS ONLY**</td>
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<td>----------------------------</td>
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<tr>
<td>Less than 6 months</td>
<td>4 hours before procedure</td>
<td>2 hours</td>
</tr>
<tr>
<td>7 months to age 12</td>
<td>After midnight</td>
<td>2 hours</td>
</tr>
<tr>
<td>Age 13 and adjust</td>
<td>After midnight</td>
<td>4 hours</td>
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<tr>
<td>Any age</td>
<td>4 hours</td>
<td>Ad lib</td>
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<tr>
<td></td>
<td>(recommended light meal only)</td>
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</tr>
</tbody>
</table>

* No food includes dairy products, infant formula, any unclear liquid, gum
** Clear liquids include water, filtered apply juice, cranberry juice, breast milk
P. DICTATIONS

**OPERATIVE REPORTS**

1. Must be dictated within 24 hours on the Provations system
2. All new fellows, residents, and interns who are unfamiliar with the system should be trained within the first week of their starting on the service.
3. At the time of surgery the surgical team should identify the resident responsible for the surgical dictation. The surgical resident responsible for the dictation should be identified on the operative note.
4. Attendings should submit the yellow copies to the Orthopaedic Department for billing purposes and monitoring the dictations.

**DISCHARGE SUMMARY:**

**FORMAT:**

1) Reason for admission - discharge diagnosis
2) Significant findings (only pertinent or positive)
   a. Physical findings
   b. Lab results
   c. X-ray findings
   d. Other test performed
3) Brief hospital course
   a. Treatment rendered or procedures
   b. Response to treatment
4) Final diagnosis
5) Disposition of patient (to home, etc.)
6) Condition on discharge (i.e., for patients admitted with fever, state “patient afebrile”)
7) Discharge medications
8) Follow-up plans/tests pending
9) Any special diet
10) Special instructions for physical activity

Q. X-RAYS AND FLUOROSCOPY POST OPERATIVE X-RAYS

1. If indicated, obtain films in OR before breaking sterile shield or discontinuing anesthesia. X-rays are not permitted in the PACU unless required for immediate monitoring.
2. Only those orthopaedic practitioners with California fluoroscopy supervisors licenses may operate a fluoroscopy unit.
3. Prior to the use of fluoroscopy, the operator must announce that this equipment will be used and must ensure that those exposed to potential radiation are protected with shielding, including the operator, the patient, and ancillary personnel.

R. CLINIC RULES

1. Arrive when the clinic starts.
2. All patient visits, including new patient visits, should be dictated on the hospital system according to the posted dictation instructions (initial consultation, final visits/discharge notes, and follow-up visits).
3. All Orthopedic Clinic records must remain there. If you must have it, a copy can be made through the clinic.
4. If x-rays or cast removal is planned for next visit, indicate it on the Clinic Progress Record so those nurses may arrange this before you see the patient.
5. Most routine x-rays are done in the Ortho Clinic. Try to order these early.
6. Clinic has priority. Do not leave for ward work, etc.
7. If you must leave for an emergency, tell chief resident and nurse that you are leaving and why.
8. Obtain written consent for appropriate procedures, such as hardware removal, etc.

S. ADMISSIONS FROM CLINIC

1. The nurse will assist with arrangements for admission.
2. The Chief Resident and appropriate service attending should be notified of these admissions immediately.

T. EMERGENCY ADMISSIONS

1. Do not hold patient in clinic for work-up that can be done later on the ward.
2. Patient will be interviewed by eligibility workers and taken to ward.

U. ELECTIVE (FUTURE) ADMISSIONS

1. Schedule through chief resident and attending.
2. Diagnosis, reason for hospitalization, procedure with CPT number (Clinic nurse will help), estimated length of stay, date of admission, date of surgery, ward, admitting M.D., attending M.D. signature.
3. The TAR must be completed as early as possible for pre-admission financial approval if applicable.
4. Patient is then interviewed by eligibility worker.
5. The patient should be sent to the pre-operative clinic.

V. COME–AND-GO SURGERY IN SURGICENTER

1. TAR patients as soon as possible.
2. M.D./R.N. must schedule with Surgi Center at least 3 days in advance.
3. Local anesthesia: Labs only if indicated. Need written H&P, disclosure and consent.
4. General anesthesia: Same work-up and documentation as for Come and Stay.

W. CLINIC DISCHARGE CRITERIA

1. The patient has a musculoskeletal condition that could be addressed with surgery, but after Orthopaedic Surgical Consultation, the patient is not a surgical candidate or the patient decides she/he does not want surgery.
2. The patient has a musculoskeletal condition that does not need or no longer requires further follow-up with an Orthopaedic Surgeon.
3. For patients who are discharged via this mechanism, a discharge note will be available in the LCR clearly explaining why the patient is currently not a good surgical candidate and when to reconsider referring the patient back for surgical evaluation. Additionally, recommendations will be made for appropriate non-surgical management.
X. INFECTIONS

Infections involving joints or bone should be admitted or consulted by Orthopaedic surgery unless a significant medical or extensive surgical condition exists, in accordance to the medicine-orthopaedic surgical guidelines.

Y. ORTHOPEDIC PEDIATRIC ADMISSIONS

1. The orthopedic intern and resident work up the musculoskeletal exam of the patient.
2. Pediatric patients are admitted to the pediatric service with Ortho providing the consultation.
3. Orthopaedic surgery service sees the patients daily, leaving a note on the patient and addressing any musculoskeletal issues.
4. Specific Service Responsibilities: Elective Surgeries, Emergency Admissions, Emergency Surgeries, and Transfers
   
   **Pediatrics:**
   a. Serve as service of record with a Pediatric attending as the attending of record
   b. Perform admission H&P and discharge summary/H&P
   c. Handle all medical orders including, but not limited to:
      i. Diet (special restrictions)
      ii. Medications, including pain medication
      iii. Nursing Checks (specific parameters if applicable, etc.)
   d. Write discharge orders and prescriptions
   e. Assist with placement, if necessary
   f. Communicate with PCP

   **Orthopedics:**
   a. Serve as the consulting service with an Orthopedic attending serving as the consultant attending
   b. Write initial consultation note, including specific recommendations for:
      i. PT and level of activity
      ii. Additional nursing care needed for the specific type of injury
      (i.e neurovascular checks, etc.)
      iii. Specific orthopedic orders/requirements (i.e. limb elevation, icing, etc).
   c. Directly communicate the management plan and treatment recommendations to the pediatric service upon admission and on a daily basis, at a minimum
   d. Obtain consent, explain surgical procedures, and describe anticipated outcomes
   e. Be available to answer questions from the pediatrics service on a 24/7 basis and to answer the family’s questions on a daily basis
   f. Round and write daily notes in the medical record, including new orthopedic recommendations.
   g. For elective cases, assure pre-op medical H&P has been performed prior to admission.
   h. Collaborate with the discharge planning process, including appropriate discharge date, discharge management plans, and orthopedic clinic follow-up.

Z. ORTHOPEDIC FAMILY INPATIENT SERVICE ADMISSIONS

1. Ortho patients with acute medical issues while on the in-patient Ortho Service will first be staffed by inpatient Med Consult Service. For any straight-forward
medical problems, the Med Consult Service will continue to provide management help with Ortho serving as the primary care team of record. However if deemed appropriate, there will be a very low threshold for transfer to the 3rd FIS team for any patients with complex medical needs.

2. Each morning, the FIS Hospitalist will receive any new overnight transfers from the overnight hospitalist or Medicine teams. Later in the morning, the FIS Hospitalist will quickly round with the Ortho NPs and/or intern to set the plan of care for the Ortho-related problems for patients on the 3rd FIS team.

3. The FIS Hospitalist will be the primary caregiver with Ortho serving as a close consulting service for patients on the 3rd FIS team. Ortho NPs and intern will coordinate dispo plan and follow-up for any Ortho-related medical issues. Otherwise, the hospitalist will manage all other aspects of care and discharge.

4. For overnight and weekend issues, the overnight FIS Overnight Hospitalist can be the first "go-to" person for any acute medical issues that arise on the Ortho Service in-patients.
ATTACHMENT C -- CLINICAL SERVICE CHIEF OF ORTHOPEDIC SURGERY JOB Description

CLINICAL SERVICE CHIEF OF ORTHOPEDIC SURGERY SERVICE
JOB DESCRIPTION

Chief of Orthopedic Surgery Clinical Service

Position Summary:

The Chief of Orthopedic Surgery 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 Orthopedic Surgery 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 Orthopedic Surgery 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 Orthopedic Surgery 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.