

**ZSFG EMERGENCY DEPARTMENT
RULES AND REGULATIONS
2017**

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I. EMERGENCY DEPARTMENT ORGANIZATION

A. SCOPE OF SERVICE

Emergency Department at Zuckerberg San Francisco General Hospital encompasses the evaluation, resuscitation, stabilization and other treatment of all patients who present to the Emergency Department. The Emergency Department also provides medical direction of out-of-hospital care when requested by paramedics in the City and County of San Francisco or San Mateo County. Emergency Department also provides training and conducts research that will enhance the treatment of patients requiring Emergency Department.

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 ZSFG Medical Staff Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

C. ORGANIZATION OF EMERGENCY DEPARTMENT

The Emergency Department Clinical Service (hereafter referred to as Emergency Department or E.D.) is governed by the Zuckerberg San Francisco General Hospital (ZSFG) Medical Staff and policies and procedures of the University of California San Francisco (UCSF).

1. Chief, Emergency Department

Position Summary:

The Chief of Emergency Department directs and coordinates the Department's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (ZSFG) 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 Emergency Department reports directly to the Associate Dean and the University of California, San Francisco (UCSF) Department of Emergency Medicine (DEM) 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 ZSFG 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 Qualification:

The Chief of Emergency Department is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

The major responsibilities of the Chief of Emergency Department 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 ZSFG and DPH;
- In collaboration with the Executive Administrator and other ZSFG 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 service providers by the Department.
- In collaboration with the Executive Administrator and other ZSFG 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 ZSFG Medical Staff Bylaws and the Rules and Regulations.

2. The following positions are appointed by and report to the Chief, Emergency Department.

a. Medical Director of Emergency Department

The Medical Director of Emergency Department provides the necessary vision and leadership to effectively motivate and direct Emergency Department in developing and achieving goals and objectives that are congruous with the values, mission and strategic plan of Zuckerberg San Francisco General Hospital and the Department of Public Health.

In collaboration with the Administrative Director and other Hospital Leaders, develops and implements policies and procedures that guide and support the provisions of services:

- Identify models of service (staffing/levels of service) to be implemented
- Participates in defining staffing needs and ratios of staffing for clinical operation
- Schedules Faculty for Clinical staffing in the Emergency Department
- Reviews and re-designs physical layout of the Department for optimal delivery of care
- Reviews and evaluates new products for delivery of clinical care
- Participates in interviewing and selecting new faculty for Emergency Department
- Participates in Annual performance review of faculty
- Acts as central liaison between Emergency Department and Clinical Services throughout the hospital
- Participates in performance improvement projects at monthly ED Executive Committee meetings
- Participates in the design and implementation of Annual Faculty Retreat to review and design new Clinical Service Models and Administrative Systems.
- Meets bi-weekly with Service Chief to review existing Clinical Operations and design new service models
- Generates minutes of the monthly ED Medical Staff meetings
- Co-Chairs the ED Clinical Operations Committee.
- Provides ongoing clinical oversight of the mid-level providers in the ED (nurse practitioners and physician assistants)
- Prepares an annual report of activities to the Chief

b. Medical Director of Performance Improvement and Patient Safety (PIPS)

The Medical Director of Performance Improvement and Patient Safety (PIPS) is responsible for organizing and implementing the Emergency Department Performance Improvement and Patient Safety Plan by collaborating with other members of Emergency Department and nursing staff. This position reports to the monthly Emergency Department meeting to keep the medical staff informed of PIPS issues. The PIPS director is the representative of Emergency Department to the Hospital Risk Management committee.

The Director of PI is expected to:

- Represent the ED at the monthly risk management committee
- Develop new measures of Quality Improvement for Emergency Care and measure them.
- Develop new processes to improve Quality of Care in the ED
- Collaborate with ED-Nursing Director of PIPS to improve quality of care.
- Monitor and report on performance and quality of care for the following processes
 - Conscious sedation (these cases are to be entered into the ED QA Database.
 - Complications
 - Intubations
 - Central venous access
- Monitor and report on
 - Number of Preventable and Non-preventable deaths in the ED
 - The total number of deaths in the ED
 - These cases are to be entered into the ED QA Database, categorized by the physician involved.
- Hold a quarterly PI meeting in collaboration with ED Nursing and Hospital PI.
- Monitor and develop reports on the National Patient Safety Goals (NPSG) as they apply to the ED
 - Develop and implement methods of improving compliance with the NPSG's
- Review episodic cases (U.O.'s or other cases reported to the Chief or Medical Director – for investigation) in collaboration with the Medical Director in which quality of care may be an issue. These reviews are to be entered into the departments QA case database in a timely fashion.

- Attend the weekly ED Executive Committee meeting
- Prepare an annual report to the Chief of Service describing the activities of the PIPS for the prior year (due June 30 of each year).
- Attend the ED physician leadership meeting (weekly).

c. Associate Residency Program Director

The Associate Residency Program Director is responsible for the scheduling, orientation, formal teaching, evaluation and coordination of house staff and medical students in the Emergency Department. This position reports monthly to the Emergency Department medical staff meetings and reports directly to the Residency Program Director as well as the Chief, Emergency Department.

d. Director of Pediatric Emergency Medicine.

The Director of Pediatric Emergency Medicine serves as a liaison to Pediatric Services. This position plans and implements protocols and recommends equipment needed for the care of children. This position reports to the Emergency Department medical staff meetings as needed. The director of Pediatric Emergency Medicine prepares an annual report of activities related to Pediatric Emergency Medicine.

e. Base Hospital Medical Director

The Base Hospital Medical Director ensures appropriate training, supervision and credentialing of Base Hospital physicians. This position is jointly responsible with the Nursing Base Coordinator for ensuring compliance with the Base Hospital Quality Assurance Plan and acting as liaison to the Emergency Medical Services Agency. This position reports to the ES medical staff meetings as needed.

e. Disaster Coordinator

The Disaster Coordinator is responsible for coordinating the Emergency Department Disaster Plan with the Hospital Disaster Committee and Emergency Department nursing. The position reports to the Emergency Department medical staff meetings as needed.

f. Management Services Officer (MSO)

The Management Services Officer (MSO) is responsible for the supervision of the medical office staff in the Emergency Department. Office staff responsible for payroll, credentialing, purchasing, budget development, professional fee billing and secretarial staff are supervised by this position. This position works with the other clinical

service MSOs, hospital administration, nursing, and the Dean's Office on departmental and interdepartmental issues.

g. Medical Student Education Director

The Medical Student Education is responsible for the scheduling, orientation, formal teaching, evaluation and coordination of medical student electives, activities and evaluations in the Emergency Department. This position reports monthly to the Emergency Department medical staff meetings.

D. ROLES AND RESPONSIBILITIES

1. Attending Physicians

a. Attending-In-Charge (AIC)

- Responsible for coordinating all transfers into the E.D.
- Completes yellow transfer cards and notifies triage and other attendings as necessary for all transfers into the E.D.
- Provides medical consultation to the base hospital telemetry station.
- Responsible for redistributing available medical staff to ensure optimal patient flow.
- Responsible for coordinating E.D. medical staff to respond to disasters and multi casualty incidents (see E.D. Policy, "Disaster Plan".)
- Responsible for notifying patients who have left the E.D. of clinically significant abnormalities of EKG or x-rays (see E.D. Policy, "Call Back Program".)

b. All Attendings

- Responsible for supervision of medical care delivered in the E.D. by house staff and medical students.
- Ensures adequate documentation on E.D. medical records (see XI.B. below)
- Responsible for transfer of patients out of the E.D. (Refer to XI.F. below and ED Policy, "Transfer of Patients from ED").
- Evaluates and writes notes on all patients seen in the E.D. prior to admission or discharge.
- Supervises sign-out rounds.
- Supervises procedures (see E.D. Policy, "Procedures: Table of Staff Approved to Perform").
- Writes all "do not resuscitate" orders.

- Ensures compliance with universal precautions.
- Sees all patients before patients are allowed to leave against medical advice (see XI.B. below).
- At discharge, ensures that patients have appropriate follow-up and discharge instructions (see XI.B. below).
- Notifies the Medical Examiner of all deaths in the E.D. and ensures that the death registry form is completed.
- Responsible for ensuring appropriate patients receive consultation.
- Communicates with attendings from consultation services where consultants are not available in a timely manner or when disagreements over management arise
- Works in a collaborative fashion with nursing:
 - Responds to nursing concerns by either carrying out requests of nursing staff or communicating reasons for not doing so.
 - Notifies charge nurse of problems with nursing care within the E.D.
 - Notifies the charge nurse of problems with equipment or lack of supplies.
 - Ensures compliance with dress code by house staff and students.
- Enforces the policy of medical staff, house staff and students not eating in the clinical areas.
- Serves as a role model to house staff and students.
- Teaches house staff and students whenever possible.
- Communicates directly with attendings, house staff and students who call in sick and notifies Chief of attending sick calls; documents house staff and student calls for the Director of Medical Education.
- Completes Unusual Occurrence reports in appropriate situations.
- Pages the Chief of Emergency Department for situations that have potential risk management implications.
- Notifies the main desk clerk when leaving the ED for any reason (meal break, back office, Radiology, etc.).
- Identifies appropriate patients for research studies and notifies appropriate research coordinators.

2. All Residents, Interns and Students

- Will attend an orientation session prior to their first shift.
- Will discuss with the ED House staff Coordinator any requested changes in their scheduled shifts.
- Will comply with necessary Emergency Department administrative requirements including:

- Having their picture taken
- Providing address and home telephone information
- Signing their Training Materials Receipt Form
- Returning the rotation evaluation form at the end of their rotation
- Will call and speak to the attending in charge when for any reason they cannot be present and on time for a scheduled shift (206-8111).
- Will not eat in the patient care areas.
- Will wear appropriate attire while in the patient care areas (see VIII.G. Appropriate Dress, below).
- Will inform the attending when they leave the clinical area for a meal break, or for any extended period of time.
- Will perform the medical functions of a resident, intern, or student, under the guidance and supervision of an attending. These include primary patient care and:
 - An appropriate history and physician examination
 - Determining the patient's primary care provider
 - An appropriate treatment plan
 - Appropriate use of their identification number when ordering laboratory, x-ray, EKG studies, or when ordering or prescribing medications
 - Follow-up of all diagnostic and therapeutic interventions
- Will document on the medical record all pertinent history, physical findings orders, procedures, reassessments and discharge instructions.
- Will follow appropriate body substance precautions.
- Will call consults as dictated by usual medical practice.
- Will immediately consult with the attending physician on patients who:
 - Are requesting to leave against medical advice
 - Are violent
 - Are unstable
 - Threaten lawsuits, grievance, etc.
 - Require admission
- Will ensure the attending writes a note and co-signs the medical record before patients are discharged or admitted.
- Will assist in identifying patients appropriate for enrollment in ED research projects.
- Will treat patients and hospital staff in a professional, courteous manner; at all times showing patients and co-workers respect.
- Will make an effort to learn by participating in, as allowed, ED Conferences and being receptive to teaching at the bedside.

3. Residents (Refer to CHN Website, House Staff Competencies link)

- Will help manage patient flow in their area.
- Will teach medical students and interns as time allows.
- Will evaluate and manage patients in the resuscitation rooms.
- Will comply with ED policy on holding over patients.

4. Interns and 4th Year Medical Students (“Acting Interns”)

- Will have all orders countersigned by a resident or attending before implementation.
- Will only evaluate and treat patients in resuscitation rooms as directed by a resident or attending.

5. Nurse Practitioner

- Provides care to patients in the Emergency Department Zones in accordance with policies approved by the Committee on Interdisciplinary Practice.
- Provides appropriate documentation for patients seen.
- Discusses appropriate cases, including, but not limited to all patients admitted, receiving consults or having CT scans, with the Zone 4 attending when necessary and obtains an attending note and signature for these patients.
- Contacts the Charge Nurse for absences due to illness.

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the Emergency Department is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations as well as with policies established by UCSF.

1. Full-time medical staff are hired after a national search and salary is based on academic, rank and step using the AAMC salary survey as a guideline.
2. Part-time (less than 50%) medical staff may be hired without a national search. Hourly compensation is based on time of day and day of week worked.
3. The applicant must receive a letter of recommendation from the Chief, Emergency Department, ZSFG.
4. The applicant must be eligible for the privileges requested in accordance with the privilege criteria requirements of the Emergency Department, ZSFG.
5. All Emergency Department medical staff applicants must apply for and receive a UCSF faculty appointment within six months of hiring.

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Emergency Department is in accordance with ZSFG Medical Staff Bylaws, and the Rules and Regulations.

1. Practitioners Performance Profiles

The Practitioner Performance Profiles will include an evaluation of clinical competence based on Performance Improvement and Patient Safety, and Utilization indicators and evaluation by the Chief of the Emergency Department. In the case of the Chief of Service, the Medical Director will perform the evaluation.

Direct observation is not required but may be performed if necessary as part of the peer review process.

2. Staff Status Change

The process for Staff Status Change for members of the Emergency Department is in accordance with ZSFG Medical Staff Bylaws, and Rules and Regulations.

3. Modification/Changes to Privileges

The process for Modification/Change to Privileges for members of the Emergency Department is in accordance with ZSFG Medical Staff Bylaws, and the Rules and Regulations.

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of Affiliated Professionals through Emergency Department is in accordance with ZSFG Medical Staff Bylaws, and the Rules and Regulations.

D. STAFF CATEGORIES

The Emergency Department staff fall into the same staff categories, which are described in the ZSFG Staff Bylaws, and the Rules and Regulations.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Emergency Department privileges are developed in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST

The Emergency Department Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES

Emergency Department privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, and the Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Emergency Department.

D. TEMPORARY PRIVILEGES

Temporary privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws.

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

Monitoring (proctoring) requirements for Emergency Department shall be the responsibility of the Chief of the Service and may be delegated to the Medical Director of the Emergency Department.

1. All new Emergency Department medical staff must be proctored within the first *6 months*. The applicant is proctored by the Chief, or a designee of the Chief, by direct observation in the clinical area.
2. Proctoring includes a review of evaluations of the applicant by other clinical service medical staff, house staff, nurses and patients.
3. Proctoring includes a review of clinical indicators such as 7-day revisit admissions through the Performance Improvement and Patient Safety process.

B. ADDITIONAL PRIVILEGES

Request for additional privileges for the Emergency Department shall be in accordance with ZSFG Medical Staff Bylaws, and the Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Emergency Department shall be in accordance with ZSFG Medical Staff Bylaws, and the Rules and Regulations.

V. EDUCATION

Ongoing attending physician education is provided by Case Conferences, Trauma Video Recording Reviews, ED Meetings and PIPS activities. The ED encourages and supports

faculty to attend the Annual Society of Academic Emergency Medicine meeting as well as the Scientific Assembly of the American College of Emergency Physicians.

VI. EMERGENCY DEPARTMENT HOUSESTAFF TRAINING PROGRAM

(Refer to CHN Website for House staff Competencies link.)

- A. All new house staff and students undergo orientation as outlined in Section VIII.A. Orientation.
- B. House staff and students receive training in the following:
 - 1. Case conferences held at least once per month
 - 2. Residency didactic lectures held every Thursday.
 - 3. Trauma video recording reviews held monthly
 - 4. Bedside supervision/teaching of all patients seen by housestaff and students.

VII. EMERGENCY DEPARTMENT CONSULTATION CRITERIA

- A. Consultation requested of Neurosurgery, Trauma, and Psychiatric Emergency Department (PES) should be requested by residents and attendings. In general, students and interns should not be communicating requests for other consults unless a resident or attending is not available to speak to the consultant.
- B. Requests for consultation should be documented clearly on the medical record. This should include the time the consult is requested, the service and the name of the consultant.
- C. If unable to contact a consultant, the Emergency Department attending should be notified. The attending will then call the attending of the consultation service.
- D. Consultations requested of social services should be documented in the same way the consultations are noted for the various medical services.
- E. Consultants make recommendations to the Emergency Department Attendings. If there are disagreements about carrying out a recommendation of a consult, this should be discussed. Disagreements regarding admission and discharge which cannot be resolved should be referred to both the attending physician on the consulting service and the Medical Director or Chief of Emergency Department at the time the disagreement cannot be resolved. The final decision to implement the recommendation of a consult rests with the Emergency Department Attending physician for patients discharged from the emergency department.
- F. The following general guidelines apply for the type of patients in whom consultations should be requested:
 - 1. Trauma/Surgery**
 - All patients meeting Trauma 900/911/912 criteria
 - All patients with spinal or pelvic fractures

- All patients being admitted to ZSFG for traumatic injuries requiring ICU or pediatric admission
- Patients with cellulitis, lymphangitis or other cutaneous infection (not on the head or face) requiring possible admission
- Possible surgical abdomens (i.e., appendicitis, acute cholecystitis, perforated viscus, etc.)
- Possible compartment syndromes
- Burns which may require admission
- Any possible aortic aneurysm, either dissecting or rupturing
- Caustic ingestions
- First time pancreatitis
- Possible ischemic bowel
- Painful or not easily reducible hernias

2. Obstetrics/Gynecology

- Any possible ectopic pregnancy
- Possible pelvic inflammatory disease
- Pregnant narcotic addicts
- Endometritis
- Precipitous deliveries in the ED
- All seriously or critically ill pregnant patients
- Severe vaginal bleeding

3. Pediatrics

- Pediatric consultants should see any patient (under the age of 18) in the ED if requested to do so by the ED attending physician.
- All patients under the age of 5 should be seen in the ED by the pediatric consult.
- Telephone contact may suffice for children between the age of 5-12.
- The decision to consult pediatrics is at the discretion of the Emergency Department Attending Physician for patients between the age of 12 and 17. (Notification of the Pediatric consult resident for any patient under the age of 18 is recommended.)
- Pediatrics is acting as a consultant on such patients and is not the primary provider and is not responsible for procedures performed on these patients in the ED nor responsible for ED charting.
- After Pediatric UCC closes, pediatric residents are available in the ED to see patients under age 18 as the primary provider with supervision by the ED attending. A senior resident, chief resident, and pediatric attending is available by phone for consultation if needed.

4. Orthopedic

- All significant fractures requiring follow up other than ribs, skull and facial bones
- All dislocations not easily reduced
- All axial spine fractures
- Osteomyelitis
- Septic arthritis
- Septic bursitis
- All patients unable to ambulate because of acute orthopedic problems

5. Neurosurgery

- Any patient with neurologic deterioration for whom head CT is being ordered to evaluate intracranial bleeding or hydrocephalous
- All fractures of the axial spine (orthopedics should also be called to consult)
- Possible acute spinal cord compression (neurology should also be called)

6. Neurology

- Diagnosed or possible strokes and TIA's
- New onset seizures and Status epilepticus
- Dementia without previous evaluation
- Movement disorders of undetermined etiology
- Possible spinal cord compression
-

7. Anesthesiology

- Trauma patients requiring intubation according to the agreed upon schedule of airway responsibility.
- Medical patients with failed airways

8. Maxillofacial Service

- All facial fractures
- Significant facial lacerations not to be repaired by interns and medical students such as lacerations involving cartilage, lip lacerations involving vermilion border, large facial lacerations, complex facial lacerations
- Infections involving the face or scalp possibly requiring admission

9. Plastic Surgery

- Burns to the face, hands and perineum

10. ENT (Otolaryngology)

- Intractable epistaxis
- Upper airway obstruction
- Laryngeal or esophageal foreign bodies

- Possible epiglottitis

11. Oral surgery

- Significant dental trauma

12. Ophthalmology

- Any patient in whom an adequate eye exam cannot be performed where the patient complains of decreased vision or pain, or has altered mental status
- Patients with blowout fractures and entrapment
- Patients with possible rupture or penetration of the globe.
- Significant eye injuries including patients with hyphema, lacerations of the eyelids including the margin or the tarsal plate, or the lacrimal drainage system.

13. Urology

- Patients with possible urethral obstruction and infection
- Kidney stones with intractable pain
- Patients with trauma and gross hematuria, blood at the meatus, scrotal hematoma or high riding prostate
- Severe epididymitis or orchitis
- Cellulitis of the scrotum or the perineum

14. Psychiatry

- Any patient with suicidal ideation or attempt
- Patients with new onset psychosis
- Psychotic patients exhibiting severe behavioral problems
- Any patient thought to be gravely disabled because of psychiatric reasons.

15. Hand Service

- Patients with trauma or infection distal to the elbow requiring consultation as above for Trauma or Orthopedic services

VIII. OPERATIONAL ISSUES

A. ORIENTATION

1. All medical students will attend a one-hour orientation, which will include a tour of the E.D.
2. Interns and Residents will view an on-line orientation website prior to their first shift.

3. Attending staff will receive the Emergency Department Rules and Regulations, view the housestaff on-line website and attend a one-hour meeting with the Chief of Emergency Department or the Medical Director as an orientation. Additionally, new attending staff will spend their first shift with a current E.D. attending.
4. Attendings-In-Charge will receive a special orientation to the Base Hospital given by the Medical Director of the Base Hospital. They will be required to pass a written test covering the policies and procedures of the Base Hospital.

B. SCHEDULING

1. Medical students' schedules are made by the medical education coordinator.
 - Medical students will not average more than 48 hours clinical time per week
 - Medical students will have at least one 24-hour period off per week.
 - Medical students shifts will be no longer than eight hours.
 - Medical students will not be required for clinical duty when student lectures are scheduled.
2. Interns schedules are made by the medical education coordinator.
 - Interns will not average more than 60 hours clinical time per week.
 - Interns will have at least one 24-hour break from clinical time each week.
 - Intern shifts will not be longer than twelve (12) hours. Every attempt will be made to equally distribute night shifts.
3. Resident schedules will be made by the medical education coordinator.
 - These residents will not work more than 60 hour per week.
 - There will be at least one 24-hour time period without clinical work per week.
 - Shifts will not be longer than twelve (12) hours.
5. Attending schedules
 - Schedule requests from part-time faculty must be submitted at two months ahead of time.
 - Part-time faculty must work a minimum of three shifts per month unless prior arrangements are made with the Chief, Emergency Department.
 - Part-time faculty must work at least one night per month.
 - Part-time faculty must average two out of every seven

shifts on weekends unless special arrangements are made with the Chief.

- Faculty may not work more than 12 consecutive hours.

5. Full-time faculty must submit their schedule request at least two months ahead of time. Full-time faculty must note on their schedule request reasons for days off (i.e., personal, reason for work related business).

- Full-time faculty must request vacation or non-work-related time off (more than 3 consecutive days off in a row) before schedule requests are submitted.

6. Request for changes and schedules are made in the following ways

- Medical students, interns and residents must notify the medical education coordinator at least 24 hours prior to any scheduled trade.
- Attendings must notify the Assistant to the Chief prior to a traded shift.

C. SICK CALLS AND MISSED SHIFTS

1. Medical students and house staff must call the attending physician in the clinical area to which they are assigned when unable to work a scheduled shift.
 - The attending in charge will redistribute personnel as necessary.
 - Students and house staff may be required to make up missed shifts as determined necessary by the Director of Medical Education.
2. Attendings unable to attend a shift should notify the Chief or Medical Director.
 - An On-Call system exists to provide coverage in the event that an attending physician is unable to attend a shift. The on-call physician may attempt to find a replacement for the originally scheduled attending physician.
 - If unable, the on-call physician provides a replacement for the vacancy.
 - The Chief or Medical Director of Emergency Department should be paged if the on-call physician cannot be reached.
3. A missed shift without a notification will result in a formal warning. A second missed shift without notification within a year may result in disciplinary action.

D. SIGN-OUT ROUNDS

Sign-out rounds are held several times each day. At all sign-out rounds, patients should be presented completely and the individual who will assume responsibility for the patient must be assigned at that time. Patients who require admission should be admitted prior to sign-out rounds and patients able to be discharged should be discharged prior to sign-out rounds.

1. Confidentiality must be maintained at all times.
 - The discussion of patients should be quiet and held several feet away from the patients so that confidentiality is maintained.
 - The use of derogatory terms is unprofessional and will not be tolerated.
2. At the change of resident or attending shifts both residents and attendings should round on all patients in their respective areas.
3. At 6:00 AM all medical staff in the E.D. will round on all patients.
4. Attendings should sign-out any pending transfers and current diversion status.
5. All patients must be examined by the oncoming physician even if the patient has already been evaluated.
6. At the conclusion of each case discussion, a plan for further therapy and diagnostic evaluation must be outlined. The end points for admission or discharge must also be discussed.

C. DIVERSION

1. E.D. total diversion is carried out as outlined, and in the E.D Policy “Diversion: Total in the Emergency Department.”
 - Patients, nursing staff and medical staff should be redistributed as the need arises to attempt to avoid total E.D. diversion.
 - If it becomes apparent that the E.D. is unable to provide the standard of care for incoming patients, the charge nurse and attending in charge should confer regarding the need for total E.D. diversion.
 - If it is felt necessary to declare total E.D. diversion, the AIC and Charge Nurse may initiate total E.D. diversion.
 - It should be recognized that total E.D. diversion does not divert ambulances with patients for whom the E.D. is a special receiving facility (i.e. trauma, burns, prisoners, critical obstetrics, etc.).
 - Coming off of total E.D. diversion does not require the approval of the Chief, Emergency Department and should be done as quickly as possible, but not sooner than 2 hours after initiation of total E.D. diversion.
 - When under total E.D. diversion, the E.D. should not accept any transfers other than trauma patients, prisoners, *critical pediatrics, critical obstetrics, burns, and patients from clinics at ZSFG.*

D. AVAILABILITY

The Chief, Emergency Department or his designee, is available 24 hours per day, every day for questions, consultation and back up.

- 1.. The Chief or Medical Director should be called for any significant risk management issues (see below).
2. The Chief or Medical Director should be called when there are disputes between the E.D. and a potential admitting services or between admitting services regarding the need for admitting a particular patient.
3. The Chief or Medical Director should be called when an attending is unable to work a shift in the acute area of the E.D.
4. The Chief or Medical Director should be called when there are significant conflicts between medical and nursing staff in the E.D.
5. The Chief or Medical Director should be called whenever there is an activation of the hospital's disaster plan.

E. APPROPRIATE DRESS

Emergency Department medical staff and members will dress appropriately at all times.

1. The dress of medical staff should evoke a sense of confidence and respect from the patients.
2. Men or women may wear matching top and bottom ZSFG scrub suits.
3. Men may also wear slacks with a tie and white coat.
4. Women may wear a dress, skirt and blouse, or slacks and white coat.
5. The following dress is not acceptable:
 - wearing only the top or bottom of the scrub suit;
 - wearing scrubs from other institutions;
 - blue denim (jeans);
 - tee shirts and sweat shirts
6. Medical staff must wear a name tag that includes the full name and level of training (i.e. medical student, intern, resident, etc.)

IX. DISCIPLINARY ACTION

The San Francisco General Hospital Medical Staff Bylaws, Rules and regulations will govern all disciplinary action involving members of the ZSFG Services.

X. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

A. CLINICAL INDICATORS

Clinical indicators include but are not limited to deaths in the E.D., 7 days revisit

admissions, deaths, procedural sedation, patients leaving AWOL or AMA, and airway intubation.

B. CLINICAL SERVICE PRATITIONERS PERFORMANCE PROFILES

The Medical Director, PIPS, prepares an annual report summarizing the performance of individual practitioners based on their clinical indicators.

C. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

The Emergency Department PIPS Committee consisting of physicians, nurses, and Emergency Department staff is responsible for gathering information, identifying problems, developing and assessing the results if solutions are proposed to solve problems. These reports are made available to the Chief of Emergency Department and the Nursing Director of Emergency Department.

D. MONITORING & EVALUATION OF APPROPRIATENESS OF PROFESSIONAL PERFORMANCE

1. Physicians – Refer to Section IV. - Proctoring and monitoring.
2. House staff are monitored by their supervising attending physicians on each shift. Evaluations are performed at the faculty meeting each month and reported back to individual house staff service.
3. Affiliated Professionals (nurse Practitioners) are evaluated by the attending physicians. Attending physicians provide feedback to the Medical Director, Ambulatory Care, Emergency Department Departments. When applicable, clinical indicators used for attending physicians are used for nurse practitioners.
4. ZSFG Employees other than Affiliated Professionals are monitored and evaluated by their immediate supervisors. Attending physicians provide feedback to appropriate supervisors directly and through the Chief, Emergency Department.

XI. CLINICAL ISSUES

A. EVALUATION OF PATIENTS

1. Patients initially seen in the resuscitation rooms are seen initially by residents or attendings. After initial evaluation an intern or student may be assigned the care of the patient with a plan provided by the attending or resident.
2. Patients seen in other areas of the E.D. may be seen initially by students, interns, residents, nurse practitioners or attending. Generally, the attending should remain available to hear presentations of new cases and be available to consult on potential admissions or discharge. However,

- when patients are waiting to be seen and attendings are not involved in other clinical matters, patients should be seen primarily by attendings.
3. All cases seen by students and interns must be presented to residents or attendings prior to sending patients to x-ray or administering medications. All patients seen by interns and students must be presented to a resident or an attending as soon as the initial evaluation has been completed to develop a plan for necessary therapy and diagnostic studies. This discussion should always include the criteria, which will determine whether the patient is admitted or discharged from the E.D.
 4. At the time of discharge or admission, the student, intern or resident should discuss the case with the attending who will then approve the discharge or admission and write the Attending Note (see XI.B.1O below.)

B. DOCUMENTATION

1. Before seeing the patient, the physician or medical student places their initials on the locator board in the appropriate space, sign the medical record and note the time that the evaluation of the patient is initiated.
2. Attending physicians, at the time of admission or discharge, are responsible for ensuring that all appropriate documentation is present on the medical record.
3. The pertinent history is documented. This includes but is not limited to all pertinent positive and negative history:
 - Appropriate timing of the onset of illness or injury.
 - Pertinent past medical history and review of symptoms.
 - Identification of the patient's Primary Care provider (PCP) and or usual source of care.
 - Results of attempt to contact PCP must be documented.
4. Appropriate Physical Exam is documented:
 - The patient's general appearance is noted.
 - Wounds are described in terms of size and location.
 - When appropriate, detailed Neurologic exams are documented including gait (this may require serial examinations as patient's mental status improves).
5. Procedures:
 - All procedures are carefully documented, including prep, anesthetic and extent of procedure
 - The results of procedure, including complications, are documented.
 - When attendings perform airway intubation, the "Intubation Form" must be filled out and a copy left in the bin mailbox of the Medical

Director or Chief of Emergency Department

6. Orders will be documented and signed:
 - This includes all orders for IV, medications, restraints, oxygen, laboratory test, EKG's, cardiac monitoring x-rays, diet, neurological checks and vital signs.
 - All orders must be timed and signed at the time they are written.
 - Before discharge, any verbal orders documented by the nursing staff must be signed by physicians.
7. Patients whose clinical condition changes should have their reassessments documented in the appropriate section on the chart. Examples include:
 - Any discussion with friends or family should be documented here
 - Attendings leaving at the end of a shift should write a note in this section for complicated patients whose disposition has not been decided upon.
 - Patients with shortness of breath
 - Patients with altered mental status
 - Patients in distress
 - Patients with abdominal pain
8. Request for consultation must be documented:
 - Time consultation is called, services and name of consultant must be documented in the appropriate section of the chart.
 - Consultants may make their note in the chart or on a separate consult sheet if copy is left with the E.D. medical record.
 - Telephone consults must be documented specifically.
9. At the time of discharge the following must be completed:
 - Discharge diagnosis, must be specific and should include all pertinent diagnosis present in the E.D. (i.e. "multiple contusion", "alcoholism", "alcohol withdrawal", etc.)
 - Mechanism of injury may be a diagnosis but should never be the only diagnosis
 - Instructions to patients, especially those symptoms necessitating immediate return to the E.D. must be carefully documented.
 - The clinics to which the patient is being referred and the time frame requested for follow-up must be documented.
10. Attending signature with date and time must be written prior to admission or discharge.
11. An attending note should be completed for all admitted and discharged patients. This must include:

- A brief description of exceptions from and/or additions to the intern/resident note and the most pertinent findings
- A review of pertinent lab and diagnostic data
- The attending’s presence for all procedures performed in the E.D.
- The diagnosis(es)
- The plan for the patient’s follow-up or admission.
- The condition on discharge should be either “good” or “fair”, only patients with chronic problems and appropriate follow-up may be discharged in “poor” condition, never use the word “stable” to describe the condition in discharge
- The time and date of discharge must be documented
- The attending must sign the chart prior to patient’s leaving.

The following situations require special documentation and are discussed below:

- Patients leaving against medical advice
- Patients requiring restraints
- Threatening or violent behavior on the part of patients.

C. ADMISSIONS

It is the policy of the Emergency Department to admit those patients to the hospital who are likely to benefit from hospitalization or who are likely to deteriorate if discharged from Emergency Department. Patients are also admitted for pain control if deemed necessary.

1. When it is recognized that a patient required admission to the hospital, the admitting papers should be submitted as quickly as possible. The admitting diagnosis, service, admitting resident, admitting attending and need for isolation should be noted on the registration papers which are turned in to the main desk.
2. The admitting service should be notified when a patient requires admission to their service. A patient cannot be sent upstairs without approval of the admitting service. Disagreements should be immediately discussed by the attending physician on the admitting service and the emergency department attending physician. Continued disagreements should be referred to the Medical Director or Chief of Emergency Department.
3. Patients requiring admissions who have insurance requiring transfer if deemed stable should be discussed with the admitting service. Those patients who are deemed stable and require a transfer should be transferred. (See. XI.F.below)
4. All ICU admissions require calling the ICU resident for clearance of a

bed. This is the rate limited step in order to obtain a bed for an ICU patient and should be done as soon as the need for an ICU bed becomes apparent.

5. The following rules also apply to admissions:
 - Prisoners with chest X-ray consistent with tuberculosis must be admitted unless active tuberculosis can be ruled out
 - Children with significant trauma should be admitted to the trauma service with pediatrics consulting
 - An admitting team may only discharge an admitted patient from the E.D. after discussion with the attending physician on the admitting service and requires a note from the inpatient attending physician of record.

D. TRANSFER INTO EMERGENCY DEPARTMENT

Transfer into and out of the Emergency Department is only approved and arranged by attending physician (See ZSFG Administrative Policy 20.7)

1. All requests for transfer to the Emergency Department should be documented by the Attending in Charge (AIC) on the yellow cards. Referring physicians and nurses should be called at the time of disposition unless requested not to do so. The completed yellow transfer card should be left at the triage desk and the pink copy should go to the charge nurse.
2. All non-trauma transfers from other hospitals into Emergency Department are first screened by the transfer coordinator for eligibility and availability of beds. If patients are deemed eligible and ZSFG beds are available, the transfer coordinator notifies the Attending in Charge who will then contact the referring physician. Patients are only accepted if they are then deemed stable for transfer.
 - Patients who are obviously a direct admission should not be accepted to Emergency Department. The referring physician should be referred to the Chief Resident on the appropriate service.
 - Patients from Laguna Honda Hospital and City Clinics should always be accepted unless there is no bed available for potential admission, the patient is in critical condition (in which case the patient will be transported by paramedics to the nearest appropriate receiving facility), or, ZSFG is on diversion.
3. Patients who meet trauma center criteria from San Francisco hospitals should always be accepted for transfer. These calls need not go through the coordinator.

4. Patients who meet trauma criteria from hospitals outside of San Francisco should be referred to the attending physician on the trauma service for acceptance of transfer.
5. Whenever a transfer is accepted, the triage nurse should be notified of the incoming transfer as well as the residents and attending in the area to which the patient will be triaged.

E. TRANSFER OUT OF EMERGENCY DEPARTMENT

Transfer out of the Emergency Department may only be *completed* by attending physician in the ED (See ZSFG Administration Policy 16.5)

1. Stable patients who either require a transfer or in whom a transfer is required because of insurance purposes may be transferred with their consent.
2. Unstable patients in whose transfers are required in order to provide appropriate care may be transferred with patient's consent. If the patient is unable to consent these patients may also be transferred.
3. The process for arranging a transfer is as follows:
 - The attending physician asks the charge nurse to have the transfer coordinator verify the patient's eligibility.
 - Upon verification of the patient's eligibility the transfer coordinator notifies the attending physician of the patient's insurance coverage.
 - The attending physician speaks to the appropriate physician to accept transfer.
 - If the patient has a PCP to accept the transfer, the PCP should be notified. If the PCP accepts direct admission, the Emergency physician at the receiving institution need not be notified, however, if the attending physician requests that the patient be transferred through the receiving hospital's Emergency Department, then the Emergency physician at the receiving institution should be notified.
 - If the patient has no PCP, the Emergency physician at the receiving institution should be called to accept the transfer.
 - Once an accepting physician has been identified the ZSFG E.D. attending physician should notify the charge nurse that the transfer has been accepted and document the acceptance on the E.D. medical record
 - The charge nurse should then request the transfer coordinator to prepare necessary transfer documents, copy x-rays and provide transportation (as requested by the attending physician) for transfer.
 - The transfer coordinator shall ensure that the appropriate transfer

forms are filled out and provides copies of the medical records, x-rays and EKG's.

4. If the patient has been seen by a consultant in the ZSFG Emergency Department, then specialist communication may be necessary. The ZSFG ED attending should inform the ZSFG consulting physician that a receiving consultant needs to be notified.

F. DISCHARGE AND FOLLOW-UP

1. Patients with Primary Care Providers (PCP's) who can provide necessary follow-up should be referred to these physicians.
2. Out of county patients should be referred to their PCP or the County hospital in which they reside.
3. Every effort should be made to refer San Francisco patients without PCP to primary care clinics in the Department of Public Health. Only those patients requiring specialty care should be referred to specialty clinics.
4. Discharge plans should be discussed with relatives or friends accompanying the patient whenever possible and appropriate.
5. All patients should be instructed in the signs and symptoms which may require their immediate return to the E.D. and these instructions must be documented.
6. Upon discharge, patients are provided with *a copy* of their E.D., prescriptions, instruction sheets, and if necessary, bus tokens or taxi vouchers to ensure their safe transport home.
7. Homeless patients and those patients requiring the services of a social worker should receive a consultation from the social worker prior to discharge.
8. All patients being discharged from the Emergency Department meet with an eligibility worker at the Discharge Desk to ensure complete registration has been obtained.

XII. RISK MANAGEMENT

A. AVAILABILITY

The Risk Manager for the University of California is available 24 hours per day on pager (719-9078). The Chief of Emergency Department, or designee, is also available 24 hours per day by pager

1. For any questions that may have medical legal implications (see below) the UC Risk Management and Chief, Emergency Department, should be paged.
2. The Unusual Occurrence reporting system does not negate the need to

page the UC Risk Manager and Chief, Emergency Department.

3. Medical records may only be copied for risk management purposes in the Emergency Department and must be kept in a secure location. They may not be removed from the hospital premises. Any copies of medical records must be discarded in a manner that will not breach patient confidentiality.
4. Requests for information from attorneys or investigators must go through the UC Risk Management.

B. LEAVING AGAINST MEDICAL ADVICE (AMA)

(Refer to ZSFG Administrative Policy 1.10)

1. Patients must be able to understand the consequences of leaving against medical advice before leaving AMA.
2. Patients leaving against medical advice must be interviewed by the attending physician prior to leaving.
3. If a patient attempts to elope from the E.D. prior to being interviewed by the attending physician, the institutional police should be called to restrain the patient until interviewed by the attending physician.
4. Patients leaving against medical advice must be informed of the risks of leaving.
5. Patients leaving against medical advice should be given discharge instructions, medications and follow-up as any other patient would receive.
6. Patients leaving against medical advice should be informed as to the conditions which would require immediate return to the E.D.
7. Patients leaving against medical advice should have the above-mentioned discussions documented in their chart.
8. Patients leaving against medical advice should be asked to sign the AMA form. If they refuse *this should be noted and it should be made a part of the permanent medical record.*

C. RESTRAINTS

(Refer to E.D. Policy, “Use of Restraints in ED” and ZSFG Administrative Policy 18.9).

1. Patients may be restrained for either safety or behavioral reasons.
 - Patients on 5150’s may be placed in restraints if necessary to avoid elopement.
 - Patients at risk for falling or otherwise hurting themselves may be placed in restraints.
 - Patients may be placed in restraints if deemed necessary by the attending physician (see below).

2. Physicians and nurses should review each patient's status before removing restraints.
3. Whenever restraints are used an order form should be filled out and dated and signed by the ordering physician. The order should specify the use of restraints for not more than four (4) hours.
4. If a patient is taken out of restraints prior to the time ordered for restraints to be discontinued; an order to discontinue restraints should be written, timed and signed.

D. CONSENT

(See ZSFG Administrative Policy 3.9)

1. Patients registered into the E.D., if able, sign a consent which permits evaluation and emergency treatment in the E.D.
2. If procedures need to be performed which are not emergent in nature and the patient is unable to consent, then consent should be obtained from a family member or durable power of attorney.
3. Patients unable to consent at registration may have an emergency procedure performed if, "implied consent" applies. The concept of "implied consent" means that a patient with severely impaired ability to understand the consequences of refusing care would, if able to understand the situation, consent to necessary evaluation and treatment.
 - These patients should not only be held but may also be treated.
 - Any necessary treatment should be performed in these cases.
 - The reason for invoking "implied consent" must be carefully documented.

Examples:

- a. A patient with a gun shot wound to the abdomen may not be able to understand the consequence of leaving because of severe anger or fear and may be held because of the high likelihood of death or permanent disability.
- b. A patient with a scalp laceration due to a fall who is mildly intoxicated and has been observed for several hours may not be permitted to leave, based on the severity of head injury and degree of intoxication.
- c. A severely demented patient with a paronychia who is somewhat combative may be held until evaluation of the infection has been

completed because of severe impairment in ability to understand the consequence of leaving.

4. Blood transfusions in the E.D. always require completion of the Blood Transfusion Consent form.
5. Consent for surgery or other procedures to be performed outside of the E.D. should be obtained by the admitting service.

E. DO NOT RESUSCITATE ORDERS AND DEATH IN EMERGENCY DEPARTMENT

1. Only attending physicians may write do not resuscitate orders in the chart.
 - The order should state reason for the order.
 - Any contact with the family should be noted.
 - The order should specify what procedures may or may not be performed (intubation, defibrillation and use of medications).
 - These orders do not apply to admitted patients outside the E.D.
2. All deaths in the E.D. must be reported to the Medical Examiner's office (see E.D. Policy, "Death in the ED")
 - Attending physicians should not agree to sign the death certificate when requested by the Medical Examiner's office.
 - The Medical Examiner may choose to take the patient or sign the patient out to a private physician who will then sign the death certificate.
 - The death registry form should be completed by the E.D. attending physician.
 - No devices (tubes, catheters etc.) are to be removed from a deceased patient in the ED.

F. UNIVERSAL PRECAUTIONS

(Refer to E.D. "Exposures to Blood and Body Fluids by Staff")

1. Part of all orientations will include discussion of the use of universal precautions
2. Any exposure to blood or body fluid by medical staff should be reported to the attending physician who will provide the person exposed with information regarding the needlestick hotline.
3. Medical staff exposed to blood or body fluids will be given the option of leaving the E.D. for the remainder of their shift.
4. Strict confidentiality will be maintained regarding this exposure. Unusual Occurrence forms will not include the name of the person exposed.

G. USE OF INTERPRETERS

1. Medical staff should not rely on anything less than fluency in patient's language to interpret for their patients.
2. The use of hospital interpreters and the AT&T interpreter line should be used whenever possible.
3. Family members should not be used to interpret for patients with problems related to drug abuse, alcohol abuse, cancer, pregnancy, HIV or sexually transmitted diseases.
4. The use of an interpreter, AT&T line, family or friend as an interpreter should be noted in the chart.

XIII. MEETING REQUIREMENTS

In accordance with ZSFG 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.

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

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

A. EMERGENCY DEPARTMENT STAFF MEETINGS

1. Emergency Department staff meetings are held on the 2nd Tuesday of each month at 3:00 pm

The Emergency Department staff meeting will consist of:

- *Evaluation of housestaff and students*
- *Clinical issues*
- *Educational Programs*
- *Medical Research*
- *Administrative topics*
- *Performance Improvement and Patient Safety*
- *Billing and Documentation issues*
- *The Medical Directors report*
- *The PIPS Director report*
- *The Ultrasound Director report*
- *Any ad hoc committee reports*

2. Full-time faculty are required to attend 67% of medical staff meetings.
3. Part-time medical staff are required to read the minutes of the medical staff meetings and are held accountable for all information contained in these minutes.
4. Attendance and participation in the Departments weekly Residency Teaching conferences is determined by the Residency Program Director in consultation with the Department of Emergency Medicine Steering committee.

XIV. ADOPTION AND AMENDMENT

The Emergency Department Rules and Regulations will be adopted and revised by a majority of all Active members of the Emergency Department annually at a quarterly held Emergency Department meeting.

ATTACHMENT A - EMERGENCY DEPARTMENT PRIVILEGE FORM

Privileges for San Francisco General Hospital

Requested

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.

EDEMERGENCY MEDICINE 2010

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

12.10 Core Privileges

Responsible for all transfers into and out of the Emergency Department as well as supervision of all biotelemetry operations. Renders care to adults and children in all areas of Emergency Department. Provides patient management, including diagnostic and therapeutic treatments, as well as procedures and interventions. Supervises house staff and students.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or a member of the Clinical Service prior to 10/17/00.

PROCTORING: 5 observed cases

12.20 Procedural Sedation

Provides procedural sedation of all forms for patients undergoing procedures in Emergency Department

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or a member of the Clinical Service prior to 10/17/00. Physician has: completed appropriate residency or clinical experience; read Hospital Policy 19.8 SEDATION; completed the educational module and post test as evidenced by a satisfactory score on the examination; signed the Physician Attestation Form and submitted it to the Medical Staff Services Department

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 5 cases or completion of the educational module and post test as evidenced by a satisfactory score on the examination, and a signed the Physician Attestation Form submitted it to the Medical Staff Services Department

12.30 Acute Trauma Care

Comprehensive emergency management of the acutely injured trauma patient, providing initial resuscitation and management of acutely injured trauma patients

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-

Certified by the American Board of Emergency Medicine or a member of the Clinical Service prior to 10/17/00.

1. Completion of ACGME-approved residency with Board certification/eligibility in Emergency Medicine, Internal Medicine, or Family Practice
2. Availability, clinical performance and continuing medical education consistent with current standards for Emergency Medicine physicians at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgery

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 5 cases

12.40 Airway Management

Comprehensive management to control, protect and intubate the airway including medications, adjuncts and cricothyroidotomy.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or a member of the Clinical Service prior to 10/17/00

PROCTORING: Review of 6 intubation cases and demonstration of proficiency in the Seldinger technique emergency cricothyroidotomy on a standardized model.

REAPPOINTMENT: Review of 3 intubations cases. Either review of one cricothyroidotomy or demonstration of proficiency in the Seldinger technique emergency.

12.50 Thoracotomy

Perform emergency thoracotomy in the absence of a Surgery Attending or Surgery Senior Resident when the conditions outlined in the Emergency Department policy--Thoracotomy -Emergency Care of the Patient Requiring Thoracotomy are met

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or a member of the Clinical Service prior to 10/17/00

PROCTORING: One peer-reviewed procedure performed or first-assisted or, participation in a thoracotomy cadaver training session in the previous 5 years

REAPPOINTMENT: One peer-reviewed procedure performed or first-assisted on or,

12.60 Ultrasound

12.61 FAST (Focused Abdominal Sonography in Trauma)

Detection of pericardial or peritoneal fluid

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine, or a member of the Clinical Service prior to 10/17/00 and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation of 25 studies or membership of the Clinical Service prior to 7/1/08 is required. If evidence of 25 documented and reviewed studies from residency or another institution with completion of proctoring is provided, then the requirement is documentation and review of 3 studies at ZSFG

PEER REVIEW: Documentation and review of 3 studies

- _____ _____
- 12.62 Pregnancy
Detection of intrauterine pregnancy or peritoneal fluid
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine, or a member of the Clinical Service prior to 10/17/00 and didactic instruction in ultrasound technology and imaging 16 hours
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at ZSFG
- _____ _____
- 12.63 Focused Echocardiography
Detection of pericardial effusion, detection of any cardiac activity, and evaluation of global left ventricular systolic function.
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine, or a member of the Clinical Service prior to 10/17/00 and didactic instruction in ultrasound technology and imaging 16 hours
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at ZSFG
- _____ _____
- 12.64 Aorta
Detection of abdominal aortic aneurysm
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine, or a member of the Clinical Service prior to 10/17/00 and didactic instruction in ultrasound technology and imaging 16 hours
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at ZSFG
- _____ _____
- 12.65 Abdomen Right Upper Quadrant
Detection of gallstones, sonographic Murphy's Sign, pericholecystic fluid and gallbladder wall thickening
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine, or a member of the Clinical Service prior to 10/17/00 and didactic instruction in ultrasound technology and imaging 16 hours
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at ZSFG
- _____ _____
- 12.66 Renal
Detection of hydronephrosis and intrarenal calculi
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine, or a member of the Clinical Service prior to 10/17/00 and didactic instruction in ultrasound technology and imaging 16 hours
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at

another institution with completion of proctoring, then requirement is documentation and review of 3 studies at ZSFG

12.67 Deep Venous Thrombosis

Detection of compressibility in the common femoral and popliteal veins

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine, or a member of the Clinical Service prior to 10/17/00 and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at ZSFG

12.68 Pneumothorax

Detection of pneumothorax

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine, or a member of the Clinical Service prior to 10/17/00 and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution, then requirement is documentation and review of 3 studies at ZSFG

PEER REVIEW: Documentation and review of 3 studies

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:

Division Chief

date

Service Chief

date

ATTACHMENT B - EMERGENCY DEPARTMENT POLICIES

Please refer to policies maintained in Clinical Service Office

**ATTACHMENT C - EMERGENCY DEPARTMENT STUDENT/INTERN
ORIENTATION MANUAL**

Please refer to policies maintained in Clinical Service Office

ATTACHMENT D - EMERGENCY DEPARTMENT HOUSE STAFF MANUAL

Please refer to policies maintained in Clinical Service Office