

MEDICAL STAFF
RULES AND REGULATIONS
2024

TABLE OF CONTENTS

ITEM

ARTICLE I INTRODUCTION	4
ARTICLE II CONDUCT	4
ARTICLE III ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS	4
A. Conditions and Restrictions of Admission	4
B. Who May Admit	5
C. Care of Family Members.....	5
D. Medical Responsibility	5
E. Admission Information Required for Protection	6
F. Provisional Diagnosis	6
G. Permanent Transfer of Care Responsibility.....	7
H. Intrafacility Patient Transfer	7
I. Detention of Patients	7
J. Absence of Patients.....	7
K. Emergency Admissions	8
L. Critical Care Units.....	8
M. Ambulatory Care Unit	9
N. Interfacility Transfer of Patients	10
O. Hospital Discharge	11
P. Patient Death	11
ARTICLE IV INFORMED CONSENT	12
A. Definition	12
B. Necessary Information.....	12
C. Medical Staff Responsibilities	12
D. Who May Consent	13
E. Witnesses	14
F. Telephone Consent	14
G. Language Barrier	15
H. Special Consents	15
I. Duration of Consents	15
J. Emergency Situations	15
K. Documentation of Emergencies.....	15
ARTICLE V PATIENT CARE	16
A. Orders for Treatment	16
B. Cardio-Pulmonary Resuscitation (Code Blue)	19
C. Laboratory	19
D. Radiologic Agents & Fluoroscopy	20
E. Consultations	20
F. Treatment of Infectious Patients	21
G. Drug Use	21
H. Equipment	23

I. Surgical Procedures Performed Outside the Surgical Suite	23
J. Emergency Situations	23
ARTICLE VI EMERGENCY DEPARTMENT (ED)	23
A. Philosophy	23
B. Coverage	25
C. Physician/Patient Relations	25
D. Care of Assigned Patients	25
E. Care of Unassigned Patients	26
ARTICLE VII MEDICAL RECORDS	27
A. Complete Medical Record	27
B. Chart Entries.....	27
C. Authentication.....	27
D. Complete History and Physical (H&P)	28
E. Dictations	29
F. Progress Notes	29
G. Discharge Summary	29
H. Continuing Ambulatory Care Services.....	29
I. Medical Record Entries by Residents	29
J. Removal of Records	30
K. Timely Medical Record	30
L. Suspension	31
M. Implications of Suspension	32
N. Reinstatement of Privileges	32
ARTICLE VIII RESIDENTS IN TRAINING	32
ARTICLE IX MEDICAL STUDENTS	34
ARTICLE X SMOKING POLICY	34
ARTICLE XI FAIR HEARING PROCESS CONCLUSIONS	35

MEDICAL STAFF

RULES AND REGULATIONS 2023

I. INTRODUCTION

The following Medical Staff Rules and Regulations are adopted as an adjunct to the Bylaws of the Medical Staff of Santa Monica-UCLA Medical Center.

Medical Staff members are required to abide by the Medical Staff Bylaws as well as all Medical Staff Rules and Regulations and departmental rules, regulations, policies and procedures. Medical Staff members shall also comply with all applicable laws and regulations and accreditation requirements that may be imposed on the hospital and its medical staff.

II. CONDUCT

Medical Staff members are required to continually demonstrate appropriate conduct to maintain Medical Staff membership. Appropriate conduct is defined as personal behavior based upon moral principals. Disruptive conduct is that which adversely affects the operation of the hospital, affects the ability of others to get their job done, creates a hostile work environment for hospital employees or other Medical Staff physicians, or begins to interfere with the physician's own ability to practice competently. Disruptive conduct includes, but is not limited to, rude or abusive behavior toward nurses, hospital staff or patients, negative comments to patients about other physicians or nurses or their treatment in the hospital, threats or physical assaults, sexual harassment, disruption of committee or departmental affairs, inappropriate comments written in medical record or other official document, and refusal or failure to cooperate with colleagues or staff in the provision of patient care in a timely or appropriate manner.

III. ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS

A. *Conditions and Restrictions of Admission*

The hospital shall accept patients for care upon recommendation of an Medical Staff member. Any person, regardless of age, race, creed, color, national origin or physical or mental impairment may be admitted to the hospital except for those having certain diseases or diagnoses outlined below for which the hospital is not equipped or staffed to provide care:

1. Psychiatric cases:

Patients diagnosed as psychotic are to be transferred to a county or private institution licensed to provide psychiatric care as soon as medically stable and transferable.

2. Attempted Suicides

a. Emergency Treatment:

Patients with known suicidal intent may be admitted for emergency treatment and shall then be transferred as soon as medically stable

to an institution licensed to provide psychiatric care. The attending physician shall offer a psychiatric consultation to all patients who have attempted suicide or who have taken a chemical overdose.

b. Unconscious Patients:

Unconscious patients from suicide attempts shall be admitted to the hospital. When conscious and responsive, patients shall be provided with continuous sitters until stable for transfer.

3. Substance Abuse

Patients are not admitted to SM-UCLAMC for primary management of substance abuse. Emergency treatment of medical conditions secondary to substance abuse may be offered provided the patient is not self-destructive or disruptive to the care or safety of others. Such patients shall be medically stabilized and transferred to an institution licensed for such care.

4. Burn Patients

a. Emergency Treatment:

Patients with serious or critical burns shall receive emergency treatment and be stabilized, then transferred to a licensed burn center where specialized burn care is available.

b. Transfer:

In cases where the patient is too unstable to be moved, the patient will be admitted and receive treatment until such time as the patient can be safely transferred.

B. Who May Admit

Patients shall be admitted only by a member of the Medical Staff who has been granted admitting privileges. Podiatrists may admit patients provided that a physician member of the Medical Staff is responsible for the admitting history and physical examination and for the medical care and evaluation of the patient.

Oral surgeons on the Medical Staff may admit patients and perform the admitting history and physical examination. A physician member of the Medical Staff is responsible for the medical care and evaluation of the patient.

C. Care of Family Members

Medical Staff members may not admit or care for members of their immediate families, administer anesthesia or observe at surgery. Immediate families are defined to include: grandparents, parents, spouse, children and grandchildren.

D. Medical Responsibility

1. Designation:

The Attending physician plans and directs the entire medical care of the patient, and is responsible for assuring that the patient receives appropriate and optimal care, including calling in consultants.

The admitting physician shall be the Attending physician of record unless he or she transfers responsibility to an accepting physician with appropriate privileges following a communication of the patient's findings and current care. The transferring physician shall enter an order in the chart to document the transfer of Attending physician responsibility to the accepting physician.

The Attending physician or designee, who must also be a member of the Medical Staff with admitting privileges, shall visit the patient at least daily during the acute hospital stay, shall make daily progress notes reflecting the progress of the management of the patient's condition and shall be available within an appropriate time frame for routine telephone communications from hospital personnel and within 30 minutes for those communications identified as urgent or emergent, including those from the Emergency Department.

2. Medical necessity:

In accordance with the Utilization Review Plan of SM-UCLAMC, the health care rendered to the patient is medically necessary, consistent with professionally recognized standards for quality medical care and is provided at the appropriate level of care.

3. Communication with Patients, Family Members and Surrogates:

The attending physician or designee is responsible for the timely transmission of necessary and appropriate reports and special instructions on the condition of the patient to the patient, the patient's family or surrogates, and other physicians associated with the patient's care.

4. Call coverage:

When off call, the attending physician is required to have another physician with the same privileges and in the same specialty/sub-specialty, who is on the Medical Staff at Santa Monica, who is available for appropriate coverage.

5. Medical Record:

The attending physician is responsible for the prompt completion and accuracy of the medical record and for necessary special instructions.

E. Admission Information Required For Protection

To the fullest extent possible at the time of admission, the attending physician shall give information as may be necessary to assure the protection of the patient, health care workers and others. This is specifically indicated in infectious or potentially infectious patients.

F. Provisional Diagnosis

Except in emergency cases, the patient's condition and provisional diagnosis shall be established on admission by the patient's attending physician.

G. *Permanent Transfer of Care Responsibility*

If responsibility for the patient's care is permanently transferred to another staff member, that staff member's agreement to assume responsibility must be obtained and an order entered into the patient's chart by the transferring attending physician stating the date and time of transfer of responsibility. A note regarding the transfer of responsibility shall also be placed in the progress notes by the transferring physician. This transfer agreement does not affect routine coverage.

The Nursing Department shall be notified of the transfer of care in a timely manner. The Admitting Department shall be notified in order to effect appropriate record changes.

H. *Intrafacility Patient Transfer*

Transfer of patients within the Hospital may be indicated due to a change in the patient's clinical condition, because of staffing or other administrative reasons, or for patient preference depending upon room availability.

Only transfers between clinical levels of care (critical care, medical/surgical) require a physician's order and updated patient care orders.

I. *Detention of Patients*

No mentally competent adult or emancipated minor shall be detained in the hospital unwillingly.

J. *Absence of Patients*

1. Authorized Temporary Absence/Hospital

a. Temporary absence of a patient must be authorized and documented in the medical record by the patient's attending physician. No patient shall be authorized temporary absence for more than twelve (12) hours. Generally, a patient will not be permitted to remain away from the hospital without being discharged and the circumstances documented in the progress notes by the attending physician.

b. Patients failing to return on time shall be immediately discharged.

2. Authorized Temporary Absence/Nursing Unit

a. An ambulatory, independently functioning patient may leave the nursing unit upon a physician's order documented in the medical record. The patient must notify nursing upon leaving and returning to the unit.

- b. A non-ambulatory patient may leave the nursing unit upon a physician's order. The patient must be accompanied at all times by an independent person such as a hospital employee, hospital volunteer, family member or visitor.
- c. Absence from the nursing unit shall be permitted only between the hours of 0800 and 2000 unless an exception is made and documented by the attending physician.

K. *Emergency Admissions*

After initial evaluation and care by the emergency department physician and consultation with the attending physician, emergency patients admitted during the evenings shall be seen by the attending physician at least within 12 hours consistent with the patient's clinical status, and in all cases no later than the following morning. Emergency patients admitted during the day shall be seen no later than the same evening.

L. *Critical Care Units*

1. Admission Policy:

a. Patient Priority

The priority for bed availability will be decided by the charge nurse in consultation with the intensive care coordinator physician and primary physician, and in accordance with critical care guidelines for high census. Should a conflict occur, the medical director of the unit will be consulted. All patients must meet admission and discharge criteria that are listed in the policy and procedures of the units. All critically ill patients must be co-managed by an intensive care coordinator physician (intensivist)

b. Direct Admissions

Patients being admitted from the community may be directly admitted to the critical care units if seen immediately prior to transfer by the attending physician and deemed sufficiently stable for direct admission to the unit. Otherwise, patients shall first be evaluated and stabilized in the Emergency Department prior to transfer to the critical care units upon order of the attending physician.

2. Patient Management:

Patients admitted to the adult ICU for critical care management, and/or requiring monitoring in the ICU for greater than 24 hours will be co-managed by an intensive care coordinator physician (intensivist). This intensivist will be on site to provide coordination of care and critical care exclusively in the adult ICU during all daytime hours on all days of the week (i.e. no other patient care responsibilities). This would typically be done by a group of on site intensivists physicians who work in shifts. Critical care management will include, but not be limited to, invasive and non-invasive

ventilation, use of intravenous vasoactive medications, and invasive hemodynamic monitoring. Consulting "on-site" intensivists will provide the critical care needs for the patient, and serves as the on-site coordinator of care while the patient is in the ICU. Primary and consulting physicians (including pulmonary consultants) will continue to provide medical care in the ICU along with the intensivist.

3. **Call Back Time:**
Urgent calls for a patient must be returned by the primary physician within 30 minutes. Calls to consulting physicians must be returned by the physician within an appropriate time frame; however urgent and emergency calls to the intensive care coordinator physician must be returned within 5 minutes, 95% of the time.
4. **Inter-facility Critical Care Unit Transfers:**
Transfers of patients from the critical care units of other hospitals to critical care units at SM-UCLAMC shall be permitted only upon the authorized approval of the receiving hospital and the attending physician, who shall first have spoken with a physician with close clinical knowledge of the patient's condition at the transferring hospital. In no event shall the restrictions imposed by the federal "anti-dumping" law (COBRA, 1989) or the state of California's "anti-dumping" law (SB-12) be abrogated.

M. *Ambulatory Care Unit (ACU)*

1. **Purpose:**
The ACU and the Woman's Place are designed to provide patient care services to those patients scheduled for surgery or medical treatments on an outpatient basis, and to serve as a pre-operative holding area for AM Admit patients.
2. **Physician Responsibility:**
The attending physician plans and directs the medical care of the patient. The attending physician is responsible for informing the patient that admission to the hospital may be necessary in the event it is medically indicated. If the patient does require admission to the hospital, it will be the responsibility of the physician to provide a written order for admission and orders for the patient in the appropriate hospital unit.
3. **Medical Record Requirements:**
A written or dictated history and physical shall have been performed according the Medical Staff Rules and Regulations. The hospital shall assure that this document is on the chart prior to the procedure. If the patient is admitted, the medical record must be in compliance with hospital policy as it relates to inpatients.
4. **Surgical Criteria:**

Candidates for the ACU must be patients who require surgical procedures that do not require anticipated overnight hospitalization except for AM surgery admissions. Woman's Place patients may be either outpatient, AM admit or require overnight stay. Isolation patients may be accepted in the ACU.

5. Medical Criteria:
Candidates for the ACU are patients who need medical procedures that require acute nursing care and hospital facilities for a limited time, typically less than 24 hours.

All patients having special radiological or other procedures requiring general or local standby anesthesia must be scheduled and admitted to the ACU or the Woman's Place. After the procedure, the patient may be discharged by either the radiologist or attending physician.

Patients scheduled for procedures without anesthesia may be admitted to the ACU at the discretion of the attending physician.

6. Discharge
The Medical Staff shall develop protocols for the discharge of patients from the ACU and the Woman's Place. Patients whose conditions do not meet the requirements of the protocols shall be seen by a physician prior to discharge.

The attending physician is responsible for writing the discharge order for patients undergoing local anesthesia.

Established criteria will be followed when discharging a patient undergoing regional, local-standby, conscious sedation or general anesthesia.

N. *Interfacility Transfer of Patients*

1. Stability Factor:
No patient shall be transferred from the Hospital or Emergency Department to another facility unless the condition is stable and the transfer would not be expected to jeopardize recovery. An attending or emergency physician is responsible for deciding whether the patient should be transferred. No patient will be transferred to another facility arbitrarily.
2. Transfer Order:
A physician must give the transfer order and determine the mode of acceptable transportation.
3. Receiving Facility:
No patient will be transferred unless arrangements have been made with the receiving facility, that there is assurance of a receiving physician and these arrangements are confirmed in advance. Arrangements for transfer

may be made by the Emergency or Nursing Department in conjunction with the Department of Social Services.

O. *Hospital Discharge*

1. Time of Discharge:
In general, the attending physician should write the discharge order for the patient before 1000.
2. Discharge Diagnosis:
The patient's discharge diagnosis must be written in the progress notes.

P. *Patient Death*

1. Pronouncement:
The deceased shall be pronounced dead by a physician immediately upon expiration. If the attending physician is not immediately available to pronounce expiration, a physician member of the Code Blue team shall be called to pronounce the patient dead.
2. Documentation:
The physician shall make an entry in the progress notes noting the time of death and shall document the factual basis for the determination of death.
3. Notification:
It is the responsibility of nursing personnel to notify the attending physician unaware of the patient's demise. It is also the responsibility of nursing personnel to notify primary consultants caring for the patient at the time of expiration. The attending physician is responsible for notifying the patient's family.
4. Autopsies:
 - a. Responsibility
It is the attending physician's responsibility to determine whether an autopsy is indicated and if so, to request it of the family.
 - b. Consent
A written consent signed in accordance with state law is mandatory before an autopsy can be performed. Other acceptable forms of consent include signed facsimiles from family members and monitored telephone calls. A pathologist has the prerogative to accept or reject these alternative forms of consent.
 - c. Notification & Education
Physicians will be notified when an autopsy on their patient is being performed, and findings will be used for educational purposes.
5. Certification of Death:

- a. **Attestation**
The certificate of death shall be completed and signed by the attending physician except in coroner's cases.
 - b. **Coroner's Case**
In a coroner's case, the attending physician or designee shall not complete or sign the certificate, and shall not solicit an autopsy, without authority of the coroner.
6. **Certificate of Fetal Death:**
The physician responsible for the delivery of the fetus shall complete and sign the Certificate of Fetal Death.

IV. INFORMED CONSENT

A. Definition

Informed consent is the process whereby the patient or the legal representative of an incompetent patient is given information regarding a recommended treatment or procedure which will enable the patient to arrive at a reasonable informed decision whether to give consent for performance of the treatment or procedure. All reasonable risks, benefits and alternatives shall be discussed with the patient or the patient's representative. Except in emergencies, neither surgical, special diagnostic nor therapeutic procedures may be performed unless informed consent is obtained from the competent patient, or if incompetent, a legal representative. Although documentation of informed consent from a physician's office may be placed in the patient's medical record, an additional consent for to receive care in the hospital is required and will be obtained by hospital personnel. The chart must contain written documentation that informed consent was obtained by the physician, and must reflect briefly the risks, benefits and alternatives discussed by the physician.

B. Necessary Information

The following information must be provided to the patient or legal representative in order to obtain an informed consent:

1. The indications or reasons for recommending the treatment or procedure;
2. The nature of the recommended treatment;
3. The risks, complications and expected benefits of the recommended treatment;
4. Any alternatives to the recommended treatment and their risks and benefits;
5. The expected natural course without the recommended treatment.

C. Medical Staff Responsibilities

1. The attending physician must provide patients or their legal representatives with the necessary information to make an informed consent about the need for specialized diagnostic or therapeutic procedures.

2. Physicians other than the attending physician have a duty to give patients or their legal representatives the necessary information to make an informed consent about specialized diagnostic or therapeutic procedures they will perform individually or with the attending physician.
3. The physician seeking an informed consent shall document in the patient's chart the discussions regarding the proposed procedure and that an informed consent was obtained or refused.

Such documentation shall describe any special or unique concerns of or related to the patient, including, when applicable, the circumstances of selecting a legal representative or surrogate decision-maker for an incompetent patient.

D. *Who May Consent*

1. Patient Competency:

For the purposes of consent, competency is defined as the ability to understand the nature and consequences of the proposed treatment, and communicate a decision. The determination of who has the legal capacity to consent to a procedure is based upon an evaluation of the competency of the patient by the attending physician, unless a court has assumed jurisdiction.

If the patient is an adult and competent, the patient is designated as the individual to consent.

If the patient is incompetent, the determination of who may give consent depends upon whether a third party has the legal capacity to consent to treatment and procedures on behalf of the patient. Incompetent patients include patients who have been declared incompetent to give consent by a court and those patients, who, in the opinion of their attending physician, are mentally retarded, senile, temporarily unconscious, under the influence of alcohol or drugs, or otherwise incapable of giving consent.

For an incompetent adult patient, consent can be obtained in the following order of priority:

- a. an attorney-in-fact, if the patient has executed a Durable Power of Attorney for Health Care, which remains valid;
- b. a conservator if the patient has been adjudicated incompetent to give consent for medical care and a conservator has been appointed;
- c. the patient's closest available relative if the patient does not have an attorney-in-fact or a conservator. This person shall be one related to the patient by blood, marriage or adoption and who appears to be close to the patient;

- d. significant others, such as people who have special relationships with the patient;
- e. a court if there is a dispute among persons as to who may be authorized to give consent or if close relatives disagree to the proposed treatment;
- f. In the absence of the parties identified above, and if competent consent cannot be obtained, documentation of the emergency situation must be provided in writing by the attending surgeon.

2. Minor Patients:

A minor is a patient who is under 18 years of age. Consents must generally be obtained from the minor's parent or guardian. Special considerations are when the parents are divorced, when a child is being placed for adoption or has been declared a ward of the court, or if the parents or guardians are unavailable.

- a. A minor may give consent when the minor:
 - i. Is or has ever been married;
 - ii. Is on active duty with the armed forces;
 - iii. Is over the age of 14 and has been declared to be emancipated by a court. The emancipation identification card should be copied for the record;
 - iv. Is over the age of 15 and is "self-sufficient", meaning that the minor is living away from home and is financially independent.
- b. A minor may give consent for treatment of the following conditions:
 - i. Pregnancy or the prevention of pregnancy, including abortion, provided the minor is sufficiently mature to understand the implications of the decision and that this action is not in conflict with current state or federal law;
 - ii. Reportable, communicable, sexually transmitted diseases provided the minor is age 12 or older;
 - iii. Rape, provided the minor is age 12 or older;
 - iv. Sexual assault;
 - v. Outpatient mental health, provided the minor is age 12 or older;
 - vi. Donation of blood, provided the minor is age 17 years of age or older.

E. Witnesses

When hospital personnel witness the signing of a consent form, they are only witnessing the signature of the patient or legal representative. By witnessing the signing of the consent, hospital personnel are not certifying that an informed consent for medical treatment or procedures has been given.

F. Telephone Consent

Telephonic informed consent from the patient's legal representative is acceptable if witnessed by two hospital employees who then document the conversation in the chart. To protect the legal rights of the patient, attending physician and hospital, the patient's legal representative must be informed that two hospital employees will be listening to the discussion as witnesses.

G. *Language Barrier*

Arrangements for an interpreter must be made for the patient if the patient or legal representative cannot communicate with the physician because of a language barrier. Documentation in the chart shall include the name of the interpreter and the interpreter's position at the hospital or relationship to the patient.

H. *Special Consents*

The following procedures require special consents:

1. Elective sterilization;
2. Hysterectomy;
3. Treatment for breast cancer;
4. Treatment for prostate cancer;
5. Silicone implants;
6. Reuse of hemodialysis filters;
7. Administration of investigational drugs or use of investigational devices;
8. Performance of experimental procedures.

The attending physician is responsible for ensuring that consent for the special procedure is obtained in the manner required by law, and that required forms, waiting periods and certifications have been completed.

I. *Duration of Consents*

A signed informed consent will be in effect until the patient or legal representative has revoked it, or there are changed circumstances which would materially affect the nature of the risks of the procedure or the alternatives to the procedure for which the patient consented.

J. *Emergency Situations*

An emergency situation is defined as one where, in the opinion of the attending physician, diagnosis and treatment appear to be immediately required and necessary to prevent death, deterioration or aggravation of a patient's condition that poses a threat to the patient's life or health status, or to alleviate severe pain. Diagnostic procedures and treatment may proceed under these circumstances without the patient's consent if the patient or legal representative is unable to give immediate consent.

K. *Documentation of Emergencies*

In emergency situations, the documentation shall consist of a progress note and shall describe:

1. the nature of the emergency;
2. the reasons consent could not be secured from the patient or legal representative;

3. the recommended treatment;
4. the probable results if treatment would have been delayed or not provided.

V. PATIENT CARE

A. *Orders for Treatment*

1. Requirements:

All orders for treatment shall be in writing, shall be written clearly, legibly and completely, and shall be dated and signed by the prescriber. Medication and intravenous solution orders shall be dated, timed, and signed by the prescriber and include the name of the drug, the dosage, the frequency of administration and the route of administration.

2. Verbal/Telephone Orders:

- a. Verbal orders shall be considered to be in writing if dictated by a person lawfully authorized to prescribe and given directly to a person lawfully able to accept a verbal order. They shall only be used in an emergency. All verbal or telephone orders shall be recorded in the patient's record, noting the date, time and name of the person giving the order and the signature and title of the person receiving the order. The order shall be "read back" to the person giving the order by the person taking the order.

Verbal/Telephone orders are orders for medications, treatments, interventions or other patient care that are communicated as oral, spoken communications between senders and receivers face to face or by telephone

All diagnostic and therapeutic verbal and telephone orders must be countersigned as soon as possible but no later than within 48 hours of the verbal or telephone order.

- b. Limited telephone orders to address a specific urgent issue may be accepted when the provider is:
 - Not present in the hospital or physically caring for a patient in the Emergency Department
 - Directly responding to a telephone request from a staff member authorized to accept telephone orders
- c. Verbal or telephone orders cannot be given:
 - For cytotoxic agents investigational drugs or blood transfusions except in an emergency.
 - Routinely, in place of daily written orders.

Verbal and telephones orders shall be accepted by designated staff members within their scope of practice:

Registered Nurses

Licensed Vocational Nurses
Pharmacists
Respiratory Therapists
Staff Registered Dietitians
Physical Therapists
Occupational Therapists
Speech Therapists

Transfusion Service staff may receive and record verbal and telephone orders related to blood products during emergency situations including Massive Transfusion Protocols/Tiers, and uncross-matched blood requests.

3. Re-Written Orders - When Required:
All patients who have been transferred from one level of care to another and patients immediately post surgery shall have all orders rewritten.

4. Formulary:
Only drugs and medications listed in the hospital formulary shall be administered to patients. Exceptions to this regulation are drugs under clinical investigation or for compassionate use as authorized by the Pharmacy, Therapeutics & Clinical Nutrition Committee (PT&CN). Other non-formulary drugs may be approved on an individual case basis by the PT&CN Committee or the pharmacist.

5. Automatic Stop Orders:
An automatic stop order will be imposed:
 - a. for all medications for patients undergoing surgery using any anesthesia except local;
 - b. for all restraint orders after 24 hours;
 - c. on all No Code (DNR) orders after 72 hours unless written "for the duration of the hospital stay;"
 - d. after 72 hours for all lab work ordered on a daily basis;
 - e. for all narcotics after seven (7) days;
 - f. for all transfusion orders after 24 hours;
 - g. for all antibiotics after seven (7) days unless duration specific is documented in the physician's orders;
 - h. for all drugs after 30 days;
 - i. for all pulse oximetry orders if not rewritten after 72 hours.

6. No Code (Do Not Resuscitate/ DNR) Orders:
 - a. If the patient has a no code designation based upon an advanced directive, or if it has been pre-determined that CPR is not to be instituted, an order to that effect must be written "for the duration of the hospital stay." In the absence of that specific order, the DNR order must be renewed every 72 hours.

- b. A verbal no-code order may be accepted from the attending physician if heard by two licensed nurses and if each separately notes the order on the chart. Nursing may call the physician back to ensure the accuracy of a verbal no code order prior to considering it valid. The verbal order must be countersigned by the attending physician within 24 hours.

- c. In all cases of patients with DNR orders, including patients with Durable Power of Attorney for Health Care or living wills, the attending physician must document in the medical record the following:
 - i. the patient's medical diagnosis and prognosis, including evidence forming the basis for the conclusion of the attending physician;

 - ii. a statement that the patient or surrogate has been fully informed of the medical facts described above and of the consequences of withholding or withdrawing life-sustaining procedures and that the patient or surrogate decision-maker has consented to the withholding or withdrawing of such procedures;

 - iii. any desires orally expressed by the patient;

 - iv. if the patient is mentally incapacitated, the factors upon which the determination of the patient's mental incapacity was based, a description of any discussions with family members or other surrogate decision-maker(s) concerning the patient's wishes;

 - v. a statement that the attending physician believes that the surrogate decision-maker is acting in accordance with the patient's known desires or best interests.

7. Restraint Orders:

Restraints will only be used when it has been deemed clinically necessary after an assessment of the patient's needs or when alternative or lesser restrictions are insufficient to protect the patient or others from injury or risk of intervention of necessary treatment. Restraints will only be applied upon written or verbal order of the attending physician. The order must include the reason for restraint, type of restraint and length of time the restraint may be applied. Patients in behavioral restraints must be observed by the nursing staff every 15 minutes. Restraint orders will be effective for 24 hours only; after 24 hours, restraint orders must be re-evaluated and if necessary, reordered. The types of restraints may include belts, cuffs,

muslin over the body, Posey belts, mittens, soft ties, folded sheets or leather restraints.

8. Discharge Orders:
Discharge orders must be in writing and dated. Discharges are recommended prior to 1000.

B. *Cardio-Pulmonary Resuscitation (Code Blue)*

1. Initiation:
Nursing personnel will initiate a Code Blue (CPR) on all patients who are found to be in acute cardiac or respiratory arrest or who are found non-responsive unless the attending physician has previously written a No Code (Do Not Resuscitate) order.
2. Responsibility:
The resuscitation effort shall be headed by a physician member of the Code Blue team, unless relieved by the patient's attending physician or consultant on the case. Assistance may be rendered by other house staff residents or members of the Medical Staff.
3. Duration of CPR:
Once CPR has been initiated, it must continue until effective spontaneous circulation has been restored, or the responsible physician directs that the resuscitation efforts be stopped.

C. *Laboratory*

1. The laboratory provides 24-hour coverage daily. It is open for full service from 0600 to 1700. After 1700, service will be limited to emergency procedures and presurgical orders for the following day.

The laboratory is open for outpatient service between the hours of 0800 and 1630 Monday through Friday, 0800 and 1200 on Saturday, and closed on Sunday.
2. In the operating room and other areas where a physician draws blood, proper patient identification is the responsibility of the physician and the nursing staff.
3. Clinical data shall accompany requests for tissue studies to aid the pathologist in rendering more informative interpretations of the results obtained, i.e., the tentative diagnosis, previous abnormal studies and, when indicated, the appropriate clinical history.
4. In an emergency involving massive acute blood loss, it is preferable to transfuse a patient with type-specific blood. If time is of the essence and

an antibody screen cannot be performed, the attending physician must be responsible for the requesting of unmatched blood and sign for same.

5. All blood used for transfusion shall be from volunteer donors.
6. The Paul Gann Act requires patients to be informed by their physicians about the options of using directed donor or autologous blood prior to an elective procedure.

D. *Radiologic Agents and Fluoroscopy*

1. The therapeutic use of radium or sealed radioactive sources shall be limited to physicians who have been granted this privilege and whose names appear on the hospital's Radioactive Material license. Only persons who have had suitable training and experience shall be permitted to handle radioactive materials.
2. An Medical Staff member must be certified by the State of California to supervise the use of or operate fluoroscopic equipment.

E. *Consultations*

1. **Who May Consult:**
Any qualified practitioner with clinical privileges in the hospital, or a physician who has been granted temporary privileges, can be called for consultation within that practitioner's area of licensure and documented expertise in accordance with Medical Staff Bylaws that refer to specialty designation.
2. **When To Obtain Consultation:**
It is considered sound medical practice to seek consultation when doubt persists as to the diagnosis or the preferred diagnostic or therapeutic measures to be pursued, within 24 hours unless otherwise specified. Consultation may be required if the chair of the appropriate department, or the Chief of Staff, determines the patient will benefit from such consultation.
3. **Contacting the Consultant:**
The attending physician is personally responsible for contacting the consultant and may not delegate that responsibility to hospital personnel. A consultant may not call another practitioner to see the patient without the approval of the attending physician.
4. **Documentation:**
The consultant must write or dictate a consultation report in addition to writing a brief note in the progress notes to summarize the findings. The report shall include the following elements: date and time, patient's name, medical record number, physician requesting consultation, reason for

consultation, history of present illness, a relevant physical exam, findings, impressions and recommendations.

5. Pediatric Consultation for Patients <18 Years of Age Admitted to Non-Pediatric Services.
 - a. Mandatory pediatric consultations are defined in the Pediatrics Rules and Regulations.
 - b. Consultation by Pediatric Hospitalists is available for all SM-UCLA inpatients <18 years of age.

Children under two (2) years of age who are undergoing surgery shall have a documented complete History & Physical examination performed by a pediatrician, family physician who has pediatric privileges, surgeon with pediatric training or emergency physician who has been in consultation with one of the above-referenced physicians. For children under two years of age, preoperative History and Physical performed by residents must be co-signed by the Attending physician with this privilege.

F. *Treatment of Infectious Patients*

1. All patients admitted to the hospital with an infection, and known or suspected to be contagious are required to be isolated from other patients. The same is true for all patients subsequently developing a contagious disease while in the hospital.
 - a. The Infection Prevention Committee is responsible for establishing isolation policies and procedures and for monitoring adherence to them by hospital personnel and by the members of the Medical Staff.
 - b. The Infection Prevention Committee chair has the authority to isolate patients suspected of having a communicable disease if the physician is unavailable and isolation of the patient is needed immediately. The attending physician must be notified as soon as possible. Infected patients may be removed from isolation when they are no longer considered contagious.
 - c. Situations in which the need for isolation may be in doubt may be resolved by consultation with the Infection Control Committee chair.

G. *Drug Use*

1. Standards:

All drugs shall meet the standards of the US Pharmacopoeia, National Formulary and the American Hospital Formulary Service, and be on the approved hospital formulary list, with the exception of drugs approved by the Research Committee for clinical investigation.

2. Narcotics:
All orders for narcotics shall be automatically discontinued after seven (7) days unless the order indicates the exact number of doses to be administered, the exact period of time for the medication is specified, or the attending physician reorders the medication.

3. Antibiotics:
Antibiotics shall be discontinued after seven (7) days unless the order indicates the exact number of doses to be administered, the exact period of time for the medication is specified, or the attending physician reorders the medication.

4. All drugs:
All drugs shall be discontinued after 30 days and must be reordered if still indicated.

5. Notification:
When a drug is due to be discontinued because of items 2, 3 or 4 above, the attending physician shall be notified prior to cancellation.

6. Canceled orders:
All drug orders shall be canceled when a patient undergoes surgery, and must be rewritten as part of the post-operative orders.

7. Expired Orders:
If a drug order expires during the night, it shall be called to the attention of the physician the following morning.

8. Adverse drug reaction:
When an adverse drug reaction occurs, the appropriate hospital staff shall notify the physician immediately to facilitate any remedial action necessary. Adverse drug reactions shall be documented in the patient's medical record by the nursing staff. The nursing staff shall also notify the clinical pharmacist.

9. DEA:
Any physician who administers or prescribes narcotics must be registered with the Drug Enforcement Administration and a copy of the current certificate must be on file in the Medical Staff Office.

10. Supplementation of Blood Products:
No supplemental medications or other IV solutions shall be given simultaneously in the same access line with blood or blood products except during operative procedures.

11. Experimental drugs:
Experimental drugs will be handled in the manner provided for in the policies and procedures established by the Pharmacy, Therapeutics & Clinical Nutrition Committee.

H. *Equipment*

Physicians may bring equipment into the hospital if it conforms to the electrical safety standards established by the Engineering Department. All such equipment must be inspected and approved by the Engineering Department prior to use.

I. *Surgical Procedures Performed Outside the Surgical Suite*

Surgical procedures are routinely performed in the surgical suite; surgery delivery rooms and ambulatory care unit operating rooms. Minor operative procedures, such as cardioversion, transvenous pacemakers, tracheostomy, tube thoracostomy, thoracentesis, paracentesis, suturing of small lacerations, incision and drainage of furuncles and placement of cardiac assist devices may be performed in the patient's room, in the Emergency Department, special care units or the Post-Anesthesia Care Unit.

J. *Emergency Situations*

1. Hospital Coverage:

Patient care at Santa Monica – UCLA Medical Center is covered 24 hours a day, every day of the year by physicians trained in advanced cardiac life support who are in-house at all times. They are responsible for responding to all hospital emergencies. In addition to this coverage, the attending physician will be notified of an emergency in a timely manner.

2. Emergency Privileges During Disasters:

The Executive Medical Board shall authorize the credentialing of non-Medical Staff physicians in the event of a disaster of sufficient proportion. A disaster of sufficient proportion will be defined by the declaration of a state of emergency, whether local, state or national; or by such a declaration by any officer of the Executive Medical Board, by the Medical Director, or by the President of the United States or the President's designee, in the absence of a timely declaration of a state of emergency.

VI. **EMERGENCY DEPARTMENT (ED)**

A. *Philosophy*

The Emergency Department of Santa Monica-UCLA Medical Center is staffed by physicians 24 hours a day, every day of the year. The Emergency Department strives to provide high quality and prompt emergency care to the community.

Under EMTALA, Santa Monica-UCLA Medical Center, which is a Medicare-participating hospital, will provide an appropriate screening medical examination to each patient presenting for emergency services, and any necessary stabilizing treatment. "Medical screening" is defined as the process required to reach, within

reasonable clinical confidence, the point at which it can be determined whether an emergency medical condition does or does not exist. The scope of the medical examination depends on the patient's presenting symptoms. The hospital will not request prior authorization or financial information before a patient has received a medical screening examination or until an emergency medical condition has been stabilized. If there is a disagreement between the treating physician and an off-site physician as to whether a patient is stabilized, the judgment of the treating physician takes precedence over that of an off-site physician. The emergency medical condition does not have to be resolved before an emergency patient may be transferred or discharged.

B. Coverage

1. ED Responsibilities

- a. Primary medical services in the ED are provided by physicians who have satisfactorily completed a recognized residency program in Emergency Medicine. These physicians shall be members of the Medical Staff and organized as a section of the Family Medicine Department.
- b. Members of the SM-UCLA Family Medicine residency program may also provide primary medical services in the ED under the direct supervision of an emergency medicine specialist staff member or the patient's attending physician.

2. Medical Staff responsibilities

- a. It is the responsibility of the Medical Staff to provide coverage for those patients in the ED who require hospitalization, or who require consultation in the opinion of the ED physician.
- b. Medical Staff departments and sections are responsible for establishing their own protocols for creating on-call panels to provide appropriate coverage for unassigned patients.
- c. It is the responsibility of the on-call physician to either honor the assigned call or arrange for a substitute to take call. Under no circumstances will hospital personnel be responsible for finding alternative call coverage.
- d. If the usual primary-to-specialty referral patterns are not successful in obtaining specialty assistance, the Chief of Staff or department chair will facilitate the on-call panel specialty physician providing the needed service.
- e. Medical Staff members may not sign out to the ED for their own personal coverage.

- f. Medical Staff members who are on-call for the ED have the following responsibilities:
 - i. They must be able to respond to emergency call within 30 minutes;
 - ii. They may not refuse to see any patient deemed unstable for transfer according to the emergency physician, regardless of the patient's financial status or other characteristics;
 - iii. They are obliged to report to the Emergency Department for a consultation if requested, despite the ability to consult on the telephone;
 - iv. The on call physician is responsible for the admission of the patient and for obtaining any needed consultation;
 - v. The on-call physician admits an emergency patient, that on-call physician is responsible for that patient during hospitalization and responsible for appropriate follow-up at discharge. There is no further responsibility after appropriate arrangements and documentation for follow-up at the time of discharge;
 - vi. The on-call physician and any consultant seeing a patient in the Emergency Department must make a note in the medical records.
- g. Call coverage for personal patients, as well as ED call, must be provided by physicians with Medical Staff privileges.

C. *Physician/Patient Relations*

Every effort is made to preserve and protect existing relationships between physicians and their personal patients. All patients presenting to the Emergency Department will be asked whether they have a personal physician. The patient who has a personal physician on the Santa Monica-UCLA Medical Center Medical Staff is an assigned patient. A patient without a personal physician on the Medical Staff is an unassigned patient.

D. *Care of Assigned Patients*

- 1. The following alternatives may be selected in the treatment of assigned patients at the advance option of the personal physician:
 - a. The ED will evaluate and treat the patient. A call will be placed to the personal physician only for consultation, admission or at the patient's request.
 - b. The ED physician will evaluate the patient and call the physician prior to instituting treatment. In the event the personal physician cannot be contacted or is not expected to appear within a time

period consistent with the clinical circumstances, the ED physician may, with the patient's consent, undertake appropriate treatment and disposition. A period of 30 minutes is considered adequate time for response from the personal physician.

c. The physician will be called immediately upon the patient's arrival and the patient will not be evaluated or treated unless the patient's life or health is in imminent danger, or the patient is in severe pain. It will be made clear to the patient that the ED physician is available; however, the choice of whether to wait for the private physician is the patient's except in life threatening circumstances.

2. A Medical Staff member may send a patient to the ED and ask the ED physician to see the patient, but must first call the ED to inform the staff of the patient's impending arrival.

3. If the disposition of the patient is to be discharged from the ED without having been seen by the personal physician, the patient will be instructed to return to the personal physician for follow-up care. A copy of the ED treatment sheet will be sent to the patient's physician regardless of whether that physician is a Medical Staff member.

4. Residents may see private patients in the ED under the supervision of the ED physician.

5. If an assigned patient requires consultation, it is the responsibility of the personal or covering physicians to recommend the specialists(s) of their usual referral patterns.

E. *Care of Unassigned Patients*

1. Patients without personal physicians will be immediately evaluated and treated by the ED physician.

2. Referral to an On-Call Physician

a. On-Call Referral:

If, after the evaluation by the ED physician, a consultation or admission is required, the ED physician will select a physician from the appropriate on-call panel. The on-call physician may call other consultants as necessary; calling other consultants is the responsibility of the on-call physician and may not be delegated to the ED physician.

b. Office Referral:

Patients not requiring admission will be referred to an appropriate physician list. The patient will be provided with the names,

addresses and telephone numbers of the doctors referred for continuing care.

- c. Fees:
On-call physicians and their consultants will see unassigned patients in the ED on a private patient basis. Services will be paid for by the patient on a fee-for-service basis agreed upon between the physician and the patient. The responsibility for billing and collecting these fees rests with the physician. Santa Monica-UCLA Medical Center is not responsible for this physician/patient relationship or for collecting fees. Each Medical Staff member agrees to release Santa Monica- UCLA Medical Center from any obligation in this regard.

VII. MEDICAL RECORDS

A. *Complete Medical Record*

The attending physician shall assist in the preparation of a complete medical record for each patient. This record shall include patient identification data; chief complaints; a complete history and physical examination; provisional diagnosis; consultations; laboratory, radiology, EKG, and other special diagnostic studies; operative reports; anatomic and clinical pathology reports; daily progress notes; a discharge summary; transfer summary; and an autopsy report, when performed.

B. *Chart Entries*

All entries in the medical record must be legible and complete and must be dated and authenticated. In the case of persistent illegibility, the Executive Medical Board may require an Medical Staff member to dictate all progress notes and block print all orders, in addition to the usual dictations. A brief note must also be written in the progress note at the time of dictation.

C. *Authentication*

Prior to the authentication of the electronic medical record, the Medical Staff member should review the medical record on-line for completeness and accuracy.

Medical records may be authenticated by a computer "signature" (or sequence of keys), in lieu of a physician's signature, only when that physician has placed a signed statement in the Hospital's administrative offices to the effect that he or she is the only person who:

1. Has possession of the computer "signature" (or sequence of keys).
2. Will use the computer "signature" (or sequence of keys).
The Hospital's goal is to convert its medical records system to an all electronic medical records system. As a result of that computer conversion certain medical records, as set forth in these rules and regulations, may only be authenticated by computer "signature" (or sequence of keys). As a

general rule, all medical records that have been generated through the Hospital's dictation system and all documents that are entered directly on-line will be electronically transcribed and forwarded to the physician's electronic signature queue and must be authenticated by computer "signature" (or sequence of keys). Accordingly, all Medical Staff members are required to submit to the UCLA Medical Center Computing Services a completed "Application for User ID".

D. Complete History and Physical Examination (Evaluation)

1. Time Requirements:

A complete evaluation signed or co-signed (history & physical) by a physician member of the Medical Staff with admitting privileges must be available on the medical record within 24 hours of admission for all patients.

2. Required Elements:

The evaluation (H&P, consultation, etc.) shall consist of: date of admission, performing physician's name, medical record number, chief complaint, history of present illness, past medical history, relevant social and family history, allergies, present medications, review of systems, physical examination, and assessment and plan appropriate to the patient's age..

The physical examination shall consist of vital signs, lungs, heart, and any other elements pertinent to illness, operation or procedure.

Pre-anesthesia physical will include at a minimum, airway, lung and cardiac exam.

Providing an H&P for patients undergoing minor surgery requiring no more than local anesthesia, is at the discretion of the Attending physician with consideration of the acuity of the patient and the risk of the procedure.

3. Podiatric H&P

In podiatric cases, the medical history and physical examination must be completed by a physician member of the Medical Staff. Podiatrists shall complete a history and examination pertinent to their care.

4. Dental H&P

In dental cases, the medical history and physical examination may be completed by the patient's oral surgeon who is a member of the Medical Staff only if qualified and credentialed to do so.

5. Interval History & Physical Examination:

Readmissions within 30 days for the same or related problem require an interval H&P that reflects significant changes in the H&P exam since the previous admission. The interval H&P may be separately dictated or written in the progress notes.

6. H&Ps By Non-Staff Members:

Physicians, who are not Medical Staff members, may perform an admission history and physical examination. The Attending physician assumes the responsibility of the clinical accuracy of the H&P performed by the non-staff member.

E. *Dictations:*

1. Surgery

Surgeons shall dictate or write a pre-operative note to document indications for surgery, and an operative report. In addition, a brief operative or procedure note must be written in the progress notes immediately after surgery or the procedure. The operative report shall be signed or co-signed by the surgeon of record within 24 hours post-procedure and shall contain the following elements: physicians' name; patient name; medical record number; date of procedure; pre-operative diagnosis; post-operative diagnosis; technical procedures used; specimens removed; the names of the surgeon, assistant surgeon(s) and anesthesiologist; and a description of the findings; and estimated blood loss for all procedures including minimally invasive procedures, inclusive of ambulatory surgical centers. Minimally invasive procedures performed in outpatient clinics are exempt from recording estimated blood loss.

2. From Outside

Physicians who respond to committee requests for information may not use the hospital dictation system for this purpose. Letters in response to committee requests for information shall be on the individual physician's letterhead in any legible format.

F. *Progress Notes*

Daily progress notes, dated and signed by the attending physician or their designee, and consultants actively engaged in the management of the patient are required on each patient. Residents are required to write, date and sign progress notes daily on the teaching patients assigned to their care.

G. *Discharge Summary*

The discharge summary shall be completed as soon as possible after discharge or signed/co-signed by a member of a the medical staff with admitting privileges within 14 days and shall contain the following elements: patient's name; attending physician; medical record number; admission date; discharge date; a clinical summary of the patient's hospital course, including relevant diagnostic studies, interventional procedures, transfusions and complications; condition on discharge; discharge diagnosis; follow up plan; diet; activity level; discharge medications; laboratory studies; and physician follow up.

H. *Continuing Ambulatory Care Service*

The attending physician must complete the ACU Admission and Discharge Record for patients receiving continuing outpatient ambulatory care service, such as repeated chemotherapy or transfusions.

- I. *Medical Record Entries by Residents*
All dictated admitting history and physical examinations, operative and procedure reports, and any other report dictated by residents must be electronically signed by the resident.
- J. *Removal of Records*
Records may be removed from the Medical Center campus and safekeeping only in accordance with a court order, subpoena, or other legal process. All original records are the property of the Medical Center, which is owned and operated by The Regents of the University of California. In case of readmission of a patient, all previous records shall be available for use by the Medical Staff member. Unauthorized removal of charts from the Medical Center is grounds for suspension of the practitioner for a period to be determined by the Executive Medical Board.
- K. *Timely Medical Record*
The accurate and timely completion of medical records is necessary to achieve proper documentation and continuity of quality care, generation of documentation for physician and hospital billing, accurate and relevant continuous quality improvement studies, completion of authorized medical research, reporting requirements of external authorities, compliance with legal requirements and to ensure timely physician attestation of discharge diagnosis for Medicare billing.
1. The pre-operative evaluation (H&P, consultation, etc. containing all required elements):
 - a. if done within 30 days prior to the procedure, shall be updated with an interval evaluation, signed and dated with reference to pertinent changes and within 24 hours of the procedure;
 - b. if done 30 or more days prior to the procedure, must be performed again within the time limits referenced above.
 - c. the use of a progress or consult note as an H&P for inpatients where LOS is greater the 30 days is acceptable as long as all the elements required for an H&P are noted therein.
 2. Admitting History and Physical:
 - a. Within 24 hours after admission or immediately before, an H&P examination shall be performed providing the patient condition permits;

If the dictated H&P is not available in the chart at the time of the Attending physician's first hospital visit, he or she shall document the essential elements of the patient's H&P in the progress notes. This note shall contain a summary of the present illness, allergies,

medications, any pertinent findings from the past, social, and family histories and review of systems, any pertinent findings on physical examination, and the physician's assessment and plans.

- b. When an H&P has been performed less than 30 days prior to admission, a new H&P must be performed. A copy of the prior H&P may be used as documentation. The examiner must document that he or she has reviewed the prior H&P, and must record any interval changes on the patient record;
3. A brief operative must be written post-surgery in the progress notes immediately after surgery or the procedure.
4. A dictated or written operative or procedure summary shall be signed or co-signed by the surgeon or proceduralist of record within 24 hours post-procedure and must contain all the required elements.
5. ED notes should be signed or co-signed within 72 hours
6. Verbal medication order(s) must be signed by the prescribing physician within 48 hours of giving the order(s), with the exception of restraint orders, which must be signed within 24 hours of giving the order(s).
7. The medical record for each patient must be complete and filed within 14 days from the date of discharge (Reference: California Code of Regulations Title 22, Section 70751. (See Medical Staff Medical Records Suspension Policy #3308)

L. *Suspension*

1. The Medical Staff Executive Committee (MSEC) will levy a five hundred dollar (\$500) fine on members who accumulate twenty-one (21) consecutive and/or forty-five (45) cumulative days of Medical Record suspension in one calendar year (January-December). After the initial fine is levied, if the member still remains on medical record suspension for thirty-one (31) consecutive and/or fifty-five (55) cumulative days in one calendar year (January-December), the member will be subject to a fifty dollar (\$50) daily fine until resolved.
2. The Medical Record Department will contact the staff member's office by telephone, email or pager, the day prior to being placed on suspension. A message will be left if the physician does not come to the telephone and the recipient of the message will be identified.
3. Surgeons who are on medical record suspension and who have cases already booked will not be permitted to perform surgery until all delinquent medical records are completed.

4. Once physicians are placed on suspension they will not be removed until all delinquent charts have been completed.

M. *Implications of Suspension*

1. Except as listed below, a staff member placed on suspension may continue to care only for patients who are already in the hospital on the day of suspension until their discharge.
2. If a staff member is on suspension, the practitioner shall not
 - a. admit a patient;
 - b. schedule surgical procedures;
 - c. perform surgery or assist on any surgical procedure;
 - d. administer any anesthetic agent;
 - e. perform any consultation in the hospital; or
 - f. give orders or otherwise care for patients admitted under another staff member's name for the purpose of avoiding these suspension rules.

N. *Reinstatement of Privileges*

All privileges previously held by the suspended staff member are automatically reinstated when all delinquent charts have been completed and during a general disaster.

VIII. RESIDENTS IN TRAINING

All medical care provided by Residents, ("Residents"), shall be provided under the supervision of qualified medical staff attending physicians as part of a GMEC-approved training program. Additional rules and regulations regarding Residents are set forth in the Policy on Medical Staff Policy Supervision of Residents.

- A. All patients in the hospital are the direct responsibility of an attending member of the medical staff.
- B. All Residency faculty are responsible for establishing proctoring criteria and mechanisms for procedures performed by Residents.
- C. Patients shall be managed by Residents under the supervision of the residency faculty. It is the responsibility of the supervising physician to inform the Medical Staff Office of the Resident's intended scope of practice during the rotation and how it will be supervised.
- D. Documentation: The following documentation rules shall apply only to approved supervising faculty physicians and Residents while providing clinical care through GMEC-approved training programs. All other medical staff (including faculty

physicians while not supervising Residents), shall follow the documentation rules set forth elsewhere in these Rules and Regulations.

1. The documentation requirements for care provided to patients who have been admitted to a teaching service and who are seen by Residents under the supervision of a faculty member through a formal GMEC-approved training program will be by progress notes entered into the record by the attending physician at a frequency appropriate to the patient's condition or change in condition¹, or reflected within the Resident's daily progress note. Residents must also make notes in the chart reflecting their ongoing consultation with the attending physician regarding each patient. Such progress note shall include the attending physician's name and shall also reflect the attending physician's approval of the treatment plan discussed with the Resident.
2. For patients admitted to an inpatient facility, an attending physician must interview and examine the patient early in the course of care (within 24 hours of admission including weekends and holidays). This supervision must be personally documented in a progress note no later than the day after admission.
3. For patients who have undergone a surgical procedure, an Attending surgeon must document his or her involvement in the post-operative care of the patient by at least one personally documented note. The immediate post-operative note will not suffice for this purpose.

For patients undergoing specific bedside procedures, the attending physician will be responsible for authorizing the performance of such procedure by the Resident and the Resident will document the attending physician's approval in the patient's chart. Such procedures should only be performed with the explicit approval of the attending physician to ensure that the Resident has the requisite training, education and experience to perform the procedure.
4. For patients needing consultations (including emergency consultations), an attending physician must interview and examine the patient within 24 hours of request.
5. An attending physician's personal approval of the patient's discharge plan must be documented.

¹ Changes in a patient's condition or a change to a higher level of care will require the attending physician to personally re- evaluate the patient in a timely manner proportionate to the situation, but not more than 24 hours after the request.

- E. Residents assigned to patients in critical care units will function under the general supervision of the medical director of the unit and the specific direction of the attending physician.
- F. The following rules shall apply to Family Medicine Residents only:
 - 1. Family Medicine Residents may be invited by any Medical Staff member in good standing to participate in the care of patients, at the discretion of the Family Medicine Senior Resident in consultation with the Residency Program Director.
 - 2. Family Medicine Residents will respond to requests to evaluate patients with acute changes in status.
 - 3. Code Blue Team physicians will respond to all Code Blue cases and assume charge until relieved or communication is received from the Attending physician.

IX. MEDICAL STUDENTS

Medical students who have been enrolled in the David Geffen School of Medicine at UCLA may participate in the care of Santa Monica – UCLA Medical Center & Orthopaedic Hospital patients. They may write notes in the medical record and may write orders; all notes and orders must be co-signed by a member of the Housestaff or Medical Staff by whom they are directly being supervised. No order may be taken off by nursing or note entered into the medical record until appropriately co-signed. Enrolled medical students may also participate in the Operating Room when they are with a member of the Housestaff or Medical Staff who is directly supervising them and who has appropriate privileges for the O.R. case. MS3 or MS4 or such identification must be noted beside their name when they write a note in the patient chart.

X. SMOKING POLICY

Santa Monica – UCLA Medical Center recognizes its responsibility to foster and promote a healthy society and workforce, and recognizes the health benefits that smoke-free air provides. This policy is intended to promote the health, safety and comfort of our patients, employees, visitors and Medical Staff members by establishing a smoke free environment. Enforcement of this policy is by the Executive Medical Board and it takes precedence over any inconvenience those patients or others might experience.

- A. Smoking is prohibited in all areas of the hospital, including all associated buildings, stairwells, loading dock, near air intake areas, construction sites, within 20 feet of any building entrance, patient rooms, meeting rooms and lounges.
- B. Only the following patient populations are eligible to receive a physician's order to smoke and are [permitted to do so in the designated out-of-doors smoking area

- under the supervision of health care personnel; long term or intermediate care and skilled nursing patients.
- C. When abrupt withdrawal of smoking would adversely affect the patient's outcome, the attending physician may authorize permission for the patient to smoke in the designated out-of-doors smoking area under the supervision of health care personnel.
 - D. There will be no medical exceptions allowed for hospital-based ambulatory care patients or for child or adolescent patients.
 - E. The only locale that is authorized for patient smoking is the Merle Norman Pavilion, first floor, south patio, behind Security desk.

XI. FAIR HEARING PROCESS CONCLUSIONS

- A. If a member of the Medical Staff initiates a fair hearing process related to any adverse action stemming from allegations related to Prohibited Conduct as defined in the University's Sexual Violence and Sexual Harassment Policy, it will communicate in writing this step to the Chair of the Academic Senate P&T Committee, as well as the DGSOM Vice Dean for Faculty, Academic Personnel Office, the Vice Chancellor for Academic Personnel, and the Vice Chancellor of Health Sciences.
- B. Once the fair hearing process is completed, the Chair of the Fair Hearing Committee will communicate their final determination to the to the Chair of the Academic Senate P&T Committee, as well as the DGSOM Vice Dean for Faculty, Academic Personnel Office, the Vice Chancellor for Academic Personnel, and the Vice Chancellor of Health Sciences.
- C. The Vice Chancellor for Academic Personnel will be asked to consider the Fair Hearing conclusions from the Medical Staff when assessing any P&T recommendations.

APPROVALS:

Medical Staff Executive Committee : 10/22/2024

Medical Staff : 10/31/2024

Governing Body: 10/31/2024