UCLA Ronald Reagan Medical Center

THE MEDICAL STAFF OF THE
RONALD REAGAN UCLA MEDICAL CENTER

RULES AND REGULATIONS

Article 1. Admissions

1.1 All patients shall be admitted to the Medical Center without restriction based upon race, color, religion, ancestry, sexual orientation, or national origin.

1.2 The Medical Center may admit patients suffering from all types of diseases.

1.3 Except in an emergency, no patient shall be admitted to the Medical Center until a provisional diagnosis has been stated and Medical Center Admissions has been informed. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.

1.4 All patients shall be attended by a member of the Medical Staff and shall be assigned to the Clinical Service concerned in the treatment of disease that necessitated admission. A member of the Medical Staff with admitting privileges and who is responsible for the medical care of the patient while in the Medical Center shall be designated the Attending Physician.

1.5 Medical Staff members admitting patients shall be held responsible for giving information as may be necessary to protect other patients, visitors, and staff from any danger.

1.6 The procedure for admission to the Medical Center shall be formulated by the Director of the Medical Center after conference with the Medical Staff Executive Committee.

Article 2. Informed Consent

2.1 No elective surgery or invasive procedure shall be commenced without the ascertainment by the attending Medical Staff member (and an anesthesiologist, if appropriate) that a properly executed informed consent is a matter of record.

2.2 An informed consent, briefly, must furnish the patient with sufficient information that he or she can make an intelligent choice of whether or not to undergo the operation.

2.3 The patient shall not be asked to sign the consent form until the nature, purpose, and the major and usual risks, benefits and alternatives involved in the operation has been explained to the patient by the designated surgeon.

Article 3. Medical Treatment

3.1 In accordance with the Medical Center's Hospital Utilization Review Plan, the health care patients receive at the Medical Center shall be medically necessary, consistent with

professionally recognized standards for quality medical care and provided at the appropriate level of care.

3.2 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 practitioners associated with the patient's care.

3.3 Any qualified practitioner with clinical privileges at the Medical Center may be called for consultation within that practitioner's area of licensure and privileges. A Medical Staff member should seek consultation in doubtful or difficult cases or whenever it appears that the quality of medical service may be enhanced thereby. A consultation should be completed by a Medical Staff member as soon as possible after the request is received and no later than 24 hours.

3.4 Patients who are impaired due to the effects of alcoholism will be referred for psychiatric consultation, as appropriate.

3.5 For the protection of patients, the Medical Staff and nursing staff, and the Medical Center, certain principles are to be met in the care of the potentially suicidal patient:

a. Any patient known or suspected to be suicidal must have a consultation by a Medical Staff Member assigned to the Psychiatry Service.

b. A patient known to be suicidal upon admission shall receive psychiatric care and whatever other service the emergency situation requires. Appropriate physical provisions and nursing coverage must be made available for the patient's safety. If these cannot be ensured, the patient should be referred, if possible, to the Resnick UCLA Neuropsychiatric Hospital or other facility that has appropriate accommodations.

3.6 All patients in the Medical Center shall be available for undergraduate and graduate medical training.

3.7 No research shall be conducted on or involve any patient at the Medical Center until all requirements of the University of California, the Medical Center and the UCLA Human Subjects Protection Committee (Institutional Review Board) are met. All such research must be carried out in accordance with all applicable UCLA policies regarding Human Research.

3.8 It shall be the responsibility of the attending Medical Staff member (in addition to any other individual) to notify Risk Management immediately (and file an incident report) whenever an untoward development occurs in the course of patient care.

Article 4. Assessment of Patients

All patients admitted for inpatient care shall have a medical history taken and an appropriate physical examination, as described in Medical Staff Policy and Procedure: History and Physicals.

The Attending Physician is responsible for ensuring that the appropriate patient assessments are performed as further described in Medical Center Policy, Assessment of Patients.

Article 5. <u>Orders for Treatment</u>

5.1 All orders for treatment shall be in writing, shall be written clearly, legibly and completely, and shall be dated, timed 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.

5.2 Verbal orders shall be considered to be in writing if dictated by a Medical Staff member lawfully authorized to prescribe and given to appropriate licensed or registered personnel for services within their scopes of practice. They shall only be used in an emergency.

5.3 All telephone orders must be countersigned by the responsible practitioner as soon as possible and, in any case, within 48 hours. All telephone orders shall be read back to the person giving the order by the person taking the order.

5.4 All patients who have been transferred from one level of care to another (e.g., critical care, telemetry, medical/surgical, obstetrical, skilled nursing) and patients immediately post surgery shall have all orders rewritten.

5.5 Only drugs and medications listed on 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 and Therapeutics Committee. Other non-formulary drugs may be approved on an individual case basis by the Pharmacy and Therapeutics Committee or the Director of Pharmacy.

5.6 Narcotic orders will be valid only for 72 hours. Automatic stop orders will apply to other controlled substances as directed by the Pharmacy and Therapeutics Committee.

Article 6. <u>Surgical and Invasive Procedures, Records and Reports</u>

6.1 No elective (or urgent) surgical or invasive procedure may be started unless that medical staff member designated in the informed consent is present.

6.2 The Attending Physician will be present for all critical and key portions of the procedure and be immediately available in the Operating Suite to furnish services during the entire procedure.

6.3 In surgical cases, the provisional diagnosis shall be recorded in the pre-operative note by the surgeon before the operation.

6.4 All surgical patients shall have a medical history taken and an appropriate physical examination prior to surgery per Medical Staff Policy and Procedure: History and Physicals.

6.5 Except in emergencies, prior to surgery, the anesthesiologist (or surgeon if no anesthesiologist is involved) should ensure that the following items appear in the patient's medical record:

a. a history and physical examination was performed and recorded within the past 24 hours; and

b. a written informed consent for the surgical/interventional procedure.

6.6 If the history and physical and all of the above elements are not recorded in the patient's medical record prior to surgery, the operation shall be cancelled unless the Attending Physician states in writing that such delay would lead to an adverse event or irreversible damage to the patient. The above requirements shall not preclude the rendering of emergency medical or surgical care to a patient in dire circumstances.

6.7 The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post anesthetic follow-up of the patient's condition.

6.8 All operations performed shall be fully described by the operating surgeon. All tissue and foreign objects removed by operation, with the exception of placentas from normal/uncomplicated pregnancies and procedures in which there is no identifiable specimen, i.e., no distinct piece of tissue that is incidental to the procedure, shall be submitted to Pathology for analysis. The pathologist shall make such examinations as considered necessary to arrive at a pathological diagnosis and sign the report.

6.9 When the operative report is not placed in the medical record immediately after surgery, a progress note should be entered immediately into the record to provide pertinent information for anyone attending to the patient. All surgical operations shall be fully described and recorded immediately by the operating surgeon or designee. Operative reports shall be dictated or written immediately after surgery. If this is not possible, a note will be placed in the chart including the minimum elements, including the name of the primary surgeon and assistants, findings, technical procedures used, specimens (if any) removed, estimated blood loss and postoperative diagnosis.

a. Estimated blood loss should be documented in the operative note for minimally invasive procedures that occur in the operating room setting, inclusive of ambulatory surgical centers. Minimally invasive procedures performed in outpatient clinics are exempt from recording estimated blood loss.

6.10 A staff surgeon's name should not be listed on patients' operative records as surgeon or assistant, unless that surgeon was scrubbed and actively participated in an important portion of the operation. In such instances, the surgeon must sign the dictated Operative Report.

6.11 When a scrubbed Attending Surgeon and a surgical resident are both participating as co-surgeons, the names will be listed as "surgeon" and "assistant" on the Operation Record.

6.12 The senior surgeon or designate will inform the Operating Room circulating nurse of the

name or names of the responsible surgeons and the order in which they are to be entered in the Operation Records.

6.13 In operations requiring two surgeons or teams of surgeons (usually with different skills, e.g., a urologist and a general surgeon in the creation of an ileal conduit), the operative record will reflect which procedures are done by each surgeon.

6.14 Rules for the conduct of the Operating Rooms shall be formulated by the Hospital Operating Rooms Policy Committee and must be adhered to by all Medical Staff members.

Article 7. Medical Records

7.1 A Medical Staff member shall be responsible for the preparation of a complete and legible medical record for each patient. This record shall include identification data; chief complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory, x-ray, and others; provisional diagnosis; medical or surgical treatment; pathological findings; progress notes; final diagnosis; condition on discharge; and follow-up and autopsy report when available.

7.2 There will be a physician note on every patient every day reflecting the patient's condition and the treatment plan. This note may be written by the attending physician or their designee. A progress note will be entered in the medical record whenever there is a significant change in patient status or significant adverse event.

7.3 Every record shall contain written evidence of a critical review of the patient and the medical record by a member of the Attending Medical Staff. No medical record shall be filed until it is complete.

7.4 All entries in the medical record must be legible and complete and must be dated, timed and authenticated. The author of each entry must be identified and must authenticate his or her entry. Medical records may be authenticated by electronic signature, in lieu of a medical staff member's signature.

7.5 The medical record for each patient must be complete and filed within 14 days from the date of discharge.

7.6 The Attending Physician shall cooperate with Medical Center Administration in the timely preparation, completion, submission, and maintenance of all records and reports that the Medical Center Administration deems necessary. The Chief of Staff may determine, upon the recommendation of a Chief of Service, that an Attending Physician who fails or refuses to complete or maintain medical records as requested (or required) shall be subject to one or more of the following: formal reprimand, retention of notification of failure to complete medical records in the medical staff member's credentials files, denial of privileges until the records are complete, and/or suspension until the records are complete. Non-completion of medical records by an Attending Physician may result in termination of appointment pursuant to Article V, Section 4, and Article VII, Section 4 (5) of the Medical Staff Bylaws.

7.7 Patient care orders written by medical students and allied health professionals/ independent licensed practitioners not authorized to sign orders must be countersigned by a person that is lawfully authorized to prescribe.

7.8 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 or charts from the Medical Center is grounds for suspension of the practitioner for a period to be determined by the Medical Staff Executive Committee.

7.9 Access to records may be granted to a medical staff member who is not the patient's attending or consulting medical staff member in the context of quality peer review or research projects conducted under the auspices of a medical staff committee provided that patient confidentiality is at all times preserved.

Article 8. Standards Related to Pathology/Clinical Laboratory

8.1 All patient specimens for diagnostic testing must be submitted to the Department of Pathology/Clinical Laboratory for evaluation.

8.2 The Medical Center's Department of Pathology/Clinical Laboratory provides for prompt performance of adequate examination in anatomic pathology, hematology, chemistry, microbiology, clinical microscopy, parasitology, immunohematology, molecular pathology, serology, and virology, related to pathology and clinical laboratory services.

8.3 While the patient is under the Medical Center's care, all laboratory services shall be performed in the Medical Center's pathology/clinical laboratory or approved reference laboratories.

8.4 When a test report requires clinical interpretation, any relevant clinical information shall be provided with the request for interpretation.

8.5 When specific organized central pathology and clinical services are not offered, the Department of Pathology shall identify acceptable reference or contract laboratory services and make recommendations to the Medical Staff Executive Committee for approval.

Article 9. EMTALA Compliance

9.1 General. Under EMTALA (the Emergency Medical Treatment and Active Labor Act), the Medical Center (including its outpatient clinics) must provide a medical screening examination and stabilizing treatment within the capabilities of the staff and facilities available at the Medical Center, including ancillary services routinely available to the emergency department, to any person who requests it, regardless of such person's insurance coverage or ability to pay. If the Medical Center does not have the capabilities

to stabilize a person's emergency medical condition, such person shall be transferred to another health care facility only as set forth in Medical Center policies and procedures.

9.2 Medical Screening Examination and Stabilizing Treatment. All persons who present to the Medical Center and who request an examination and treatment for an emergency medical condition (which includes a pregnant woman in labor) shall be provided with a medical screening examination by a qualified medical person (as defined in Section 9.3 below) sufficient to determine whether an emergency medical condition exists. Upon the determination that the person has an emergency medical condition, such person shall be provided with stabilizing treatment within the capabilities of the staff and facilities at the Medical Center, including delivery of the child and placenta for women in labor.

9.3 Qualified Medical Persons. Only a qualified medical person may perform a medical screening examination to determine if a patient has an emergency medical condition. A "qualified medical person" means a physician, dentist, or other person qualified by experience and training to perform medical screenings such as a Registered Nurse, Advance Practice Nurse or Physician Assistant acting within the scope of their license pursuant to protocols and standardized procedures approved by the medical staff.

9.4 On-Call Medical staff members. As required by law, the Medical Center will use its available resources, including the services of its on-call medical staff members, to provide ongoing evaluation and stabilizing treatment of persons with an emergency medical condition.

a. Responsibilities of On-Call Medical staff members. The Emergency Department shall maintain a list of medical staff members who are on-call to come to the Medical Center to provide further examination or stabilizing treatment for a patient with an emergency medical condition. Medical Staff members who are on-call have the following responsibilities:

(i) They must respond to the emergency call within thirty (30) minutes and be at the Medical Center within a timely and appropriate time ***from*** the time the emergency call is made.

(ii) They must not refuse to come to the Medical Center to provide further examination or stabilizing treatment for a patient when requested to do so by an Emergency Department physician.

(iii) They must report to the Emergency Department for a consultation if requested by a member of the Medical Staff.

(iv) They must admit an emergency patient, obtain any needed consultations, and are responsible for the patient during hospitalization and responsible for appropriate follow-up arrangements at discharge or transfer. At the time of discharge the patient will be provided with discharge instructions and other appropriate follow-up arrangements.

(v) They must make notes in the medical record in accordance with Medical Center policies and procedures.

b. Report in Medical Record of On-Call Medical staff member who Fails to Come to the Medical Center. When a patient is transferred to another facility in a medically unstable condition due to the failure of an on-call medical staff member to come to the Medical Center to provide further examination or stabilizing treatment for the patient at the request of the Emergency Department physician, as required by law, the Medical Center must write the name and address of the on- call medical staff member in the patient's medical record that is sent to the receiving facility.

9.5 Transfers of Patients in Medically Unstable Condition. If the Medical Center does not have the capabilities to stabilize a person's emergency medical condition, such person shall be transferred to another health care facility only as set forth in the Medical Center's policies and procedures. Such policies and procedures shall reflect that a patient in a medically unstable condition shall be transferred only if:

a. the patient's medical staff member has signed a certification that, based upon the information available at the time of the transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the patient and the unborn child, from being transferred; or

b. the patient makes an informed request for the transfer; and

c. the transfer is effectuated in accordance with Medical Center policies and procedures.

Article 10. Discharge

Patients shall be discharged only on written order of a medical staff member or an allied health care professional who has the appropriate standardized procedure, delegated agreement, or scope of practice which is in accordance with licensure, law and regulation.

At the time of discharge, the record is to be complete, with a final diagnosis, discharge note, and medical staff member's signature. Should a patient leave the Medical Center against the advice of the Medical Staff member, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

Article 11. Patient Deaths and Autopsies

11.1 In the event of a patient death in the Medical Center, the deceased shall be pronounced dead by a Medical Staff member (who must be a licensed physician) within two hours of the time of discovery of death. If the member of the resident medical staff pronounces the patient, the resident staff member must immediately contact the Attending Physician to discuss the diagnosis and completion of the death certificate. The body shall not be released until an entry has been made and signed in the medical record of the deceased by

a Medical Staff member. Policies with respect to the release of bodies shall conform to state and local laws.

11.2 The law requires death to be reported to the coroner in the following circumstances:

a. Violent, sudden, or unusual deaths.
b. Unattended deaths.
c. Deaths related to or following known or suspected self-induced or criminal abortions.
d. Known or suspected homicide, suicide, or accidental poisoning.
e. Deaths known or suspected as resulting in part from or related to an accident or injury, either old or recent.
f. Deaths due to drowning, fire, handing, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, or aspiration.
g. Where the suspected cause of death is sudden infant death syndrome.
h. Death in whole or in part occasioned by criminal means or associated with a known or alleged sex crime.
i. Deaths suspected to be due to contagious disease that has not been reported to the Department of Health Services.
j. Deaths due to occupational diseases or hazards.

11.3 Medical Staff members are encouraged to request autopsies on all patient deaths. Autopsies shall be requested on all deaths except for terminal illnesses when death is expected, coroner's cases, and following intrauterine fetal demise when no evidence or suspicion of congenital anomalies is present or suspected.

11.4 Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without written consent or properly executed telegraphic or telephonic consent, obtained from the nearest relative or legally authorized agent.

Article 12. Medical Students

Medical Students from an accredited institution who have been enrolled in the David Geffen School of Medicine at UCLA may participate in the care of UCLA Medical Center patients. They may write notes in the medical record and may write orders; all notes and orders must be cosigned 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 OR case. MS3, MS4 or such identification must be noted beside their name when they write a note in the patient chart.

Article 13. Residents/Housestaff

(a) All medical care provided by Resident Medical Staff is under the supervision of members of the Attending and Teaching staff. Such care shall be in accordance with the provision of a program approved by and in conformity with the Accreditation Council on Graduate

Medical Education of the American Medical Association, the American Osteopathic Association, or the American Dental Association's Commission Dental Accreditation. Residents must be supervised by teaching staff in such a way that the trainee assumes progressively increasing responsibility for patient care according to their level of training, ability and experience.

(b) The responsibilities of the Attending and Teaching Medical Staff to the Resident Medical Staff include: conducting teaching rounds and constructively evaluating presentations made by the Resident Medical Staff, reviewing the progress of patients presented to them by the Resident Medical Staff, directly observing the Resident Medical Staff and evaluating their work, supervising, as necessary, procedures performed by the Resident Medical Staff as part of their training and patient care, and assuring proper utilization of Medical Center services by periodically reviewing with the Resident Medical Staff the needs for continuing hospitalization of patients presented.

(c) Patient care orders may be written by the Resident Medical Staff. Individual Clinical Services may establish guidelines consistent with their teaching functions and State and Federal Law. The Resident Medical Staff are authorized to interact with Nursing Service and all other Medical Center departments in the capacity of medical staff practitioners under supervision of the Attending and Teaching Medical Staff.

(d) A chief of Service may request attending privileges for fellows to perform clinical work in the medical discipline for which they have had previous training if the privilege requested is unrelated to the area of their current training. Such applicants must meet all the requirements, qualifications, and responsibilities of the Medical Staff, and are subject to such policies as may be established by the Chief of Staff.

Article 14. 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.

Approved by:

Medical Staff Executive Committee: July 27, 2023
Medical Staff: July 27, 2023
Governing Body: July 31, 2023