

**LOS ANGELES COUNTY + UNIVERSITY OF SOUTHERN CALIFORNIA
MEDICAL CENTER**

RULES AND REGULATIONS

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1 GENERAL STATEMENT

The LAC+USC Medical Center Attending Staff Manual of Rules and Regulations covers the major responsibilities of the Attending Staff and has been developed to assist physicians, dentists, podiatrists and clinical psychologists providing care to the patients in the LAC+USC Medical Center. These Rules and Regulations are formulated to assure the professional standards of medical and surgical care in the Medical Center. They also serve to provide protection for the patient, the Medical Center, Medical Center personnel and the professional staff.

Attending Staff members are required to abide by the Bylaws, these Rules and Regulations, LAC+USC Medical Center policies and practices of the Medical Center and the Los Angeles Department of Health Services (DHS) approved by the Executive Committee, the standards of the Joint Commission and all applicable laws and regulations.

All members of the Attending Staff shall pledge that they will not (a) engage in the practice of rebating a portion of a fee or utilize other inducements in exchange for a referral, (b) deceive a patient as to the identity of the responsible physician and surgeon, or (c) cooperate in the performance of any surgical operation or procedure under circumstances in which the responsibility for diagnosis and care of a hospitalized patient is delegated to anyone who is not fully qualified to take this responsibility.

These rules and regulations shall be revised to reflect the Attending Staff's current practices with respect to medical staff organizations and functions and shall be adopted by the governing body before becoming effective, who's approval shall not be withheld unreasonably. Neither body may unilaterally amend these rules and regulations. Questions concerning this manual may be directed to the Attending Staff Office at (323) 226-6225.

2 ADMISSIONS AND DISCHARGES

2.1. *General Policy*

All patients shall be under the direct care of a member of the attending staff. A patient may be admitted to the Medical Center only by Attending Staff members who have admitting privileges or by physicians who have temporary Attending Staff appropriate privileges.

All practitioners shall be governed by the Medical Center's admitting policies. A general consent form signed by or on behalf of every patient admitted to the Medical Center must be obtained at the time of admission or in the case of an emergency, as soon as possible after admission.

All patients routinely shall be participants in the teaching programs of the Keck School of Medicine of the University of Southern California and will be cared for by a member of the Attending Staff. Special circumstances may dictate that a patient will not participate in the teaching program. A member of the housestaff may participate in their care and will be delegated such responsibilities as are appropriate to his or her level of training and experience. The Attending Staff shall document in the medical record his or her supervision of residents and medical students by countersigning appropriate orders, histories and physical examinations, reports, summaries, and any discharge summaries delegated to housestaff.

2.2 *Admissions*

A. **Admissions from the Department of Emergency Medicine**

The Department of Emergency (DEM) has authority to directly admit patients to services in the Medical Center in accordance with the general policies of the Medical Center. In areas where the DEM does not have the authority of direct admission they shall refer patients who are potential admissions to the admitting area of the proper service.

Any service receiving an admission may route the patient to another service only if it is in the best interests of the patient, does not result in the patient remaining in or returning to the DEM and with permission to transfer to the other service after consultation. This need not be a formal consultation, but may be simply an evaluation related to the decision concerning the interdepartmental transfer.

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The results of this consultation should be documented in the chart. Inquiries should be directed to the Director, Department of Emergency Medicine, Room 1011, General Hospital; phone 226-6667. The attending staff member in charge of the patient is responsible for the care of the patient until discharged from the Department of Emergency Medicine or transferred to another departments' care.

B. Admissions or Referrals from 24-Hour Clinics

No 24-hour clinic in the Medical Center has the authority to admit or refer its patients to any service other than its own without prior acceptance from the receiving service. The patient will remain the responsibility of the 24-hour clinic and its department until proper disposition has been made, even if this requires admission to their own service. The 24-hour clinics do not have the authority to return patients who require further care to the DEM or appropriate emergency area, without acceptance by the accepting physician of record. In the event of a disagreement between the 24-hour clinic physician and the physician of the service requested to accept the patient, the Chiefs of Services or their designated representatives should mediate the dispute, in accordance with Medical Center policy on the chain of command.

C. Admissions from Outpatient Clinics

Patients of the Outpatient Clinics who require direct admission should be admitted to an inpatient service and not to the DEM, unless the patient requires immediate stabilization. All calls requesting admission should be directed to the Admissions Office (409-2182) for evaluation and bed assignment. Whenever admissions are to an attending physician or resident's own specialty, he or she will be responsible for the admission referral, with concurrence of the clinic attending staff where appropriate. When an attending physician or a resident deems that an admission to another specialty is indicated, he or she should obtain concurrence from an attending physician in his or her clinic and should then discuss the case with the admitting service to which admission is desired. No patient should be referred or returned to the DEM from any clinic, ward or "walk-in" area, without acceptance by the accepting physician of record. Exceptions will be made for patients "in extremis" whose best interests are served by having them stabilized in the DEM or appropriate emergency area. The Patient Flow Manager and the Medical Alert Center should be utilized to coordinate the transportation of all patient transfers.

D. Scheduled Admissions

Physicians will follow the processes outlined in Medical Center policies on scheduled admissions.

E. Intensive Care Units (ICUs)

Direct admissions to ICUs will only be upon acceptance of the receiving ICU physician; patients declined for ICU admission may be admitted to the appropriate general inpatient service.

2.3 Admission Orders

The date and time of the admission is the date and time of the inpatient bed assignment. An admission to an inpatient bed occurs only upon the written order of a physician. The order becomes effective at the time and on the date indicated by the physician. The order shall be documented in the medical record.

The documentation shall include:

- Accepting attending physician
- Accepting Service
- Physician's signature and staff ID number
- Date
- Time
- Admitting or provisional diagnosis

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- Allergies

2.4 **Patient Passes**

Patient passes are not permitted without permission from the chief of service or designee.

2.5 **Transfers**

A. **Transfer of Patients Within the Medical Center**

When patients are transferred from one hospital service to another, orders in force at the time of transfer remain in force until the staff of the receiving service has had an opportunity to review and issue new orders. At that time all previous orders are automatically cancelled. Inpatients who require emergency treatment must be handled via the "consultation" process and should not be sent to the Department of Emergency Medicine. A transfer summary must be documented by the sending team. An accepting note must be documented by the accepting team. Acceptance orders must include the name of the accepting attending physician. Medication reconciliation will be completed as per Medical Center approved policy.

B. **Transfer of Patients Outside the Medical Center**

Transfers to another acute care hospital, intermediate care or skilled nursing facility must be in compliance with Federal and State legal requirements and current Medical Center policy regarding transfers. All transfers must have the approval of the attending physician.

If a patient to be transferred is an inpatient, the consent of the patient or the patient's parent or guardian should be obtained and documented before the transfer is made. The patient shall be discharged from the Medical Center at the time of the transfer. If the patient refuses to be transferred, the refusal shall be noted in the medical record and the patient shall not be transferred. The transfer of a patient to another hospital for care as an LAC+USC patient will require the authorization of the Chief Medical Officer or designee.

All adult and pediatric patient transfers must be coordinated by the Medical Alert Center. Neonatal transfers must be coordinated by the NICU 409-3322.

2.6 **Discharge of Patients**

A patient will be discharged only upon approval of the Attending and on a written order of a Resident and/or the Attending Physician or designee.

2.7 **Patients who leave Against Medical Advice (AMA)**

If a patient refuses to wait for a discharge order, the patient will be requested to sign a release before departure. A notation of the incident shall be made on the patient's medical record, as described in Medical Center policy. When discharging a patient who signs out against medical advice and for whom medications are prescribed, the patient should be directed to sign a statement that he or she has been instructed regarding the use of the medicine. The statement should include an acknowledgment that the patient has been advised to call or return or to seek alternative sources of care if, in his or her opinion, they have ongoing concern over their medical condition.

2.8 **Admitting Staff**

A. **Physician of Record**

For inpatients, the Physician of Record shall be the licensed attending physician with current attending staff privileges to diagnose and treat patients, who admitted the patient. Medical services may designate patient care teams that are composed of an attending physician and one or more post-graduate physicians. Patients who require hospitalization may be admitted either directly to an Attending Physician or to a Team. In those instances where the patient is admitted directly to an attending physician, the attending physician shall be the physician of record and shall be responsible for signing the admitting history and physical examination. In those instances when the patient is admitted to a Team, the physician of record for any day shall be the attending physician assigned to

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the Team on that day. The designated Team attending physician may be changed at any time by the action of the medical service with the approval (direct or delegated) of the department chair or designee. The name of the admitting physician must be documented in the admitting orders.

B. Responsibilities of Attending Staff

All employees, attending staff, house staff and volunteers shall at all times put the patients' health and well being first and shall provide considerate and respectful patient care. All administrative operations shall be conducted in an ethical manner consistent with the mission, vision, values, strategic plan, goals and Medical Center policies. All physicians are responsible for preparing complete documentation of their treatment of patients as set forth in this Attending Staff Rules and Regulations. All physicians and providers who write in the chart, dictate, order tests, prescribe medications or access the Institution's Information Systems are required to have a Staff ID (SID) number. A SID number will be issued by the Attending Staff Office or the Graduate Medical Education Office upon completion of a signature card in Data Administration that includes the physician's name, and sample signature.

Every entry in the chart must be properly authenticated which includes:

1. The date and time
2. The physician's signature
3. The physician's staff identification (ID) number

All prescription forms for inpatient or outpatient medications must include the signature and Staff Identification number of the prescriber. Prescriptions will not be considered valid unless there is a signature specimen on file against which it can be verified. The pharmacy cannot dispense medications without establishing the identity of the requesting physician.

The physician of record or designated member of the attending staff is responsible for the admission history and physical examination record and shall acknowledge this responsibility by authenticating it with signature, date, time and staff identification number in accordance with Attending Staff Rules and Regulations and Medical Center policies. An admitting history and physical examination shall be done within 24 hours of an admission for each patient by a doctor of medicine or osteopathy, or for patients admitted only for oromaxillofacial surgery, by an oromaxillofacial surgeon who has been granted such privileges, in accordance with LAC+USC Medical Center Bylaws. If the attending physician signing the admission history and physical is a designee, they shall include the name of the physician of record in their notation. For prolonged hospital stays, progress notes shall document the continuing involvement of the physician of record in the care of the patient. The physician of record is required to discharge the patient and prepare the discharge summary but may delegate that responsibility to another physician or mid-level provider.

C. Chain of Accountability

Only privileged members of the Attending Staff will be responsible for the medical care and treatment of each patient in the hospital, for the prompt completion and accuracy of the medical record, and for necessary special instructions. The attending staff member that admits a patient will fulfill these responsibilities until the patient is discharged or until such time as responsibility for the treatment of the patient is transferred to another attending staff physician on staff. The house staff and attending staff member is required to keep appropriate hospital personnel informed as to where he or she can be reached in case of emergency. In the event that the staff of Data Administration find it impossible to identify the author of an entry in the chart, the following sequence will be used to assign the responsibility for completing the entry to another physician:

1. Individual on record as the Senior Resident/Fellow of the team to which the patient was assigned
2. The Attending Physician of Record of the team to which the patient was assigned
3. The Chief of the Service

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4. The Department Chair

In the event that Administration is unable to determine who should complete or sign a required entry or if a dispute arises, the Chair of the Health Information Committee, who shall report to the Executive Committee will make the final determination and assignment of responsibility.

D. Disciplinary Action

Physicians who fail to complete their charts within the time limits indicated in this directive shall be notified in writing by the Health Information Management Office and will be given three (3) working days to complete deficient and delinquent charts charged to him or her.

Any physician that has a chart (or charts) that have been deficient for 14 days will be considered delinquent and the physician may be subject to the following action until all charts are completed:

1. Denial of requests for vacation and voluntary leave.
2. Denial of promotion within the training program and/or denial of completion certificate.
3. For those visiting from other programs, rejection of subsequent requests for rotations.
4. Suspension of any or all patient-care related privileges, including elective surgical privileges, etc.
5. Physicians with incomplete charts may be relieved of all ward activities and will be assigned to Health Information Management until all incomplete charts are completed.
6. Failure to comply with this reassignment may result in suspension and/or other disciplinary actions. It is the responsibility of the physician to see that he or she has no incomplete charts. These measures are detailed in LAC+USC Medical Center Policy.
7. It is imperative that all staff adhere to these regulations. Failure to follow these rules is considered a serious denial of responsibility and may result in disciplinary action. Every physician is expected to maintain complete records on the patients under their care. When medical records are delinquent, the physician supervisor or Department Chair will be notified. When deficiencies remain uncorrected, surgical privileges may be revoked and the delinquent individual may be suspended and/or dismissed. Notations may be placed in the physician's performance record documenting these actions. Furthermore, a physician's failure or refusal to comply with this policy, when requested to do so by the hospital, can subject the physician to a charge of unprofessional conduct under Business and Professions Code Section 2361 of the State Medical Practice Act (Business and Professions Code Section 2000, et seq.). Accordingly, a physician who engages in the described conduct place themselves at risk for disciplinary action by the Medical Board of California.

E. Responsibility of Service Chiefs or Designee

1. The Service Chiefs or Designee shall be responsible for monitoring the current list of delinquent physicians and informing the physician of the number of incomplete charts.
2. Insure that all physicians complete their charts in accordance with Medical Center policy.
3. Insure that suspended physicians' electives, Operating Room privileges, etc. are revoked pending completion of all delinquent charts.
4. Insure that physicians comply with reassignment to the Deficiency Monitoring Room to complete all incomplete charts.

F. Responsibility of the President of the Attending Staff Association

1. Directly notify physicians with charts that are delinquent for more than 14 days of the reassignment and possible disciplinary action that will be taken if all incomplete charts are not completed as specified in applicable LAC+USC Medical Center and Attending Staff Policies.

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2. Obtain verification from Health Information Management when the physician has completed all his or her charts.
3. Final decision for suspension or other disciplinary action shall be the function of the President of the Attending Staff Association.
4. Require that no physician will be permitted to sign out of this facility without completing all outstanding records.

G. Appeal Mechanism

Appeals regarding disciplinary action are delineated in the Attending Staff Association Bylaws and Medical Center policy. These guidelines are in accordance with: The California Attorney General's opinion of December 9, 1975, regarding physician's records and unprofessional conduct under the Medical Practices Act, Section 805, California Business and Professions Code, Title 22, California Administrative Code, Joint Commission Standards, the Memorandum Of Understanding with the Committee of Interns and Residents and applicable Civil Service Procedures and Regulations.

3 BLOOD TRANSFUSIONS

Whenever it seems likely that a patient will need a blood transfusion, the physician will discuss this matter with the patient beforehand and obtain the patient's consent. The discussion will include the risks and benefits of transfusion, the alternatives to transfusion, and the possibility of directed donations and of autologous transfusions, where this is feasible and available. The physician will document in the patient's medical record that the standardized written information summary was given to the patient, consistent with State regulations and Medical Center policy. Consent for blood transfusion shall be in effect as described in policy for an episode period of up to one year unless there is a measurable change in risk for transfusion, in such case, a new consent would be required.

4 CLINICAL PATHWAYS

The Attending Staff will develop, implement, maintain and encourage the use of all clinical pathways approved by clinical departments providing the involved patient care. The goal is to provide evidence-based care for each patient, optimize use of resources, and collect data to benchmark quality of care within the Medical Center to other healthcare organizations.

5 CONSENTS

5.1 Background

Informed Consent must be obtained from the adult with decision-making capacity or legal/surrogate representative (guardian) for recommended diagnostic and treatment plans. Informed consent is a process in which the attending physician or his or her designee speaks with the patient or the patient's legal representative and provides sufficient information regarding the recommended treatment or procedure enabling the patient or the patient's legal/surrogate representative to make an informed decision. Telephone consent may be obtained if delay would result in harm to the patient. Documentation must include a witness to the conversation, in person or by phone. The informed consent process requires that there be sufficient time for the patient to have his or her questions answered so that an informed consent decision can be made. The Informed Consent must consist of at least an explanation to the patient or the legally responsible person, the nature of the procedure and/or treatment, the risks and benefits, the alternatives, including no treatments with the risks and benefits, disclosure of the identity of the responsible surgeon, when he or she is other than the attending physician; any alternative treatment or procedures and their attendant benefits, risks and complications and risk and/or effect or consequences if the recommended treatment or procedure is refused. The treating physician or physician designee is responsible for obtaining the Informed Consent.

Specific, voluntary disclosures to patient about risks may not be necessary when:

- The risk(s) are commonly understood to be known by the patient; or
- Patient specifically requests not to be informed of risks.

Medical Center Policies and Procedures outline specific guidelines requiring informed consent to be obtained,

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including the use of iMed Consent.

5.2 Restraint and Seclusion

The medical staff policy / procedure for restraint and seclusion shall be as defined in the Hospital administrative policy.

5.3 Special Situations

Consent for hysterectomies, sterilizations, investigational drugs or devices, participation in human experimentation, reuse of hemodialysis filters, treatment for breast cancer, use of psychotropic medications, electroconvulsive psychotherapy, and involuntary commitment for psychiatric disorders must be secured in the manner specified in the laws applicable to these particular procedures. The laws are described in the current edition of the CAHHS Consent Manual and any questions regarding them should be referred to Risk Management.

6 CONSULTATIONS

6.1 Criteria

Medical practice includes the proper and timely use of consultation. Judgment as to the seriousness of the illness and resolution of any doubt regarding the diagnosis or treatment rests with the practitioner responsible for the care of the patient. Except in an emergency, consultation with another qualified practitioner is required in the following cases:

1. where the diagnosis and/or treatment plan is in doubt;
2. the patient has a significant clinical problem outside the scope of the practitioners expertise;
3. if a patient develops clinically significant signs or symptoms of a mental disorder, drug or alcohol abuse, dependence or addiction, a psychiatric consultation may be obtained; or
4. consultation as required by legislation or regulation.

The organized Attending Staff, through the President of the Association, Executive Committee and Department Leaders have oversight responsibility for assuring that consultants are called as needed.

6.2 Qualifications

A consultant must be well qualified to give an opinion in the field in which the opinion is sought. The status of the consultant is determined on the basis of an individual's training, experience and current clinical competence and privileges granted.

6.3 Requests

The patient's Physician of Record is responsible for requesting consultations. It is the duty of the Department leaders to make certain that members to the staff obtain consultations when indicated. The President of the Attending Staff and Department leaders may request consultations on a patient's behalf.

If a nurse or other direct care provider has any reason to question the appropriateness of the care provided to any patient, or believes that consultation is needed and has not been obtained, he or she may call this to the attention of the Physician of Record. If warranted, the supervisor of the nurse may be notified, who may in turn, refer the matter to the Department Leader, the President of the Attending Staff or the Chief Medical Officer. The Service Chief, Medical Director, and/or Chief of Staff may then request a consultation for the patient, or take other appropriate action. If the nurse or other direct care provider is not satisfied, the situation must be reported directly to the Chief of Staff or designee.

6.4 Categories

The minimum response times to the following categories should be adhered to:

Trauma STAT

5 minute response time

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Emergency	1 hour response time
Urgent	8 hour response time
Routine	24 hour or longer response time, as indicated by request

Department rules and regulations may further identify categories and response times in order to deliver optimal patient care.

6.5 Performance of Consultations

A satisfactory consultation includes examination of the patient, as necessary, and review of the medical record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, consultations performed prior to surgery shall be reported before the operation, except in emergency cases. Consultation shall be prepared in accordance with the standards set forth in the rules regarding medical records.

7 CREDENTIALS FILES

The credentials files, in either electronic or paper form, of Attending Staff applicants and members shall contain all relevant information regarding the practitioner that is needed to evaluate the professional competency and performance of Attending staff applicants and members. The electronic or paper credentials files shall be retained in strict confidence in the Attending Staff Office. An applicant or member shall be granted access to their own file after notice to the President or designee; may review, and receive a copy of only those documents provided by or addressed personally to the member. A summary of all other information shall be provided to the member, in writing, by the President of the Attending Staff Association or designee within a reasonable time. Such summary shall disclose the substance, but not the source, of information summarized. Disclosures shall be made in connection with any fair hearing or formal hearing, as provided in the Attending Staff Association Bylaws. Refer to ASA Policy on Credentials Files for details.

8 DEATHS

8.1 Forgoing Life-Sustaining Treatment

The Guidelines For Forgoing Life-Sustaining Treatments For Adult Patients in the LAC+USC Medical Center should be referred to and adhered to. For all patients, every medical action should include considerations regarding the relief of suffering and maintenance of patient comfort, hygiene and dignity. It is the right of an adult person capable of giving informed consent to make his or her own decision regarding medical care after having been fully informed about the benefits, risks, and consequences of treatment alternatives, even when such a decision might result in shortening the individual's life. This includes the right to refuse any treatment including forgoing any life-sustaining treatment. Refer to ASA Policy on Forgoing Life Sustaining Treatments for details.

8.2 Determination of Death

Pronouncement of death shall be made in accordance with the laws of the State of California as delineated in the ASA policy on Declaration of Death.

In cases of death in which the patient is a potential donor of organs and other body parts under the Uniform Anatomical Gift Act, in conformity with hospital protocols established pursuant to California Health and Safety Code Sec. 7184. Medical Center Policy on Organ and Tissue Donation, details the policy and procedures to be followed in all cases of death or imminent death.

8.3 Autopsy

A. Coroner's Autopsy

Relevant statutes and listing of conditions requiring referral to the Coroner for evaluation are printed on the reverse side of the form, "Hospital Report - Coroner's Case" (Form #18) and on the "Intern's Cause of Death" (Form #562). All physicians should be familiar with these criteria. In general, referral is required when death is attributed in part to an extrasomatic condition, event or substance,- including infections

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which are reportable, when death was not preceded by medical care; when the deceased was in prison or under sentence at the time of death; and when the cause of death is unknown. A decision regarding the need for a referral to the Coroner should be made immediately after the patient's death. Only after it has been determined that the patient's death does not come under the jurisdiction of the Coroner is it appropriate to seek consent for autopsy.

B. Non-Coroner's Autopsy

It is the policy and goal of the Medical Center to obtain postmortem examinations on all patients who die during the course of treatment at the Medical Center. Staff members shall attempt to secure consent for autopsies in all deaths except coroner's cases. No autopsy shall be performed without valid consent as provided in Medical Center policy. The physician in attendance best pursues this goal immediately after death by verifying that the death is not a Coroner's Case. If possible, contact should be made with the relatives who are present at the time of death. Any discussion with family members regarding the postmortem examination must be documented in the chart. If consent is not obtained for a postmortem examination, refusal shall be documented in the medical record.

All non-coroner autopsies shall be performed or supervised by a Medical Center pathologist. In compliance with state regulations, the patient's attending physician shall be advised by the pathologist or designee of the date, time and place of the autopsy. Provisional anatomic diagnoses shall be recorded upon completion of the autopsy and the completed protocol shall be made a part of the record within sixty days.

9 DISASTER PLAN

All members of the Attending Staff shall be familiar with the Medical Center's Disaster Plan. Normal hospital procedures shall be superseded upon the implementation of the Medical Center's Disaster Plan. Credentialing processes during a declared disaster are delineated in the bylaws and in policy on Disaster Privileges.

10 DRUGS

10.1 Drug Formulary

The LAC+USC Medical Center Pharmacy and Therapeutics (P&T) Committee is comprised of physicians, pharmacists, nurses, and administration representing the facilities and programs within the Medical Center.

The Pharmacy and Therapeutics Committee renders guidelines, restrictions, policies, and decisions pertaining to medications at all facilities, programs, and services in the LAC+USC Medical Center. As per the Bylaws, the P&T committee will forward all guidelines, restrictions, policies and decisions to the Executive Committee of the Attending Staff Association for review and action.

The LAC+USC P&T Committee will review requests to modify the formulary submitted by physicians and co-signed by the Medical Department's Clinical Chairperson. Medications are assessed based on need, efficacy, risk and cost. Decisions may be forwarded to the DHS P&T Committee for final review. Use of pre-printed orders and electronic medical record order sets may be developed for use in the inpatient and outpatient settings in accordance with accreditation standards. The orders must be reviewed and approved by the Pharmacy and Therapeutics and Medical Executive committees at least every 2 years.

Medications listed in the formulary are either:

- General formulary items available for routine use
- Restricted Drug – prescribing will be limited in scope to either a particular medical service or disease state.

Non-formulary medications may be prescribed to individual patients when pharmacologic and/or therapeutic considerations so dictate. Requests for non-formulary drugs require the approval of either the P&T Chairperson, the Medical Officer of the Day (MOD), or the Chief of Pharmacy Services.

All Investigational Drugs require the approval of the Investigation Research Board (IRB).

For policies regarding controlled substances, please refer to the Medical Center policies.

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For information on specific medication policies (ie. Automatic Stop Orders), please refer to the Pharmacy Policy and Procedure Manual, and the Nursing Generic Structures and Standards (ie. Medication Administration Times).

10.2 **Medication Safety**

All healthcare professionals are required to provide information to improve medication safety. Information can be provided on Adverse Drug Reaction Forms or Medication Error Tracking Forms. These forms are reviewed and reported to the Pharmacy and Therapeutics Committee. This information is used to evaluate medications that are available on the formulary.

The use of abbreviations is discouraged when writing prescriptions. Abbreviations are a well documented source of medication errors. All practitioners with privileges and housestaff must be compliant with policies on the proper use of abbreviations.

All drugs dispensed to both inpatients and outpatients must be dispensed by written order or written prescription to be filled by the Pharmacy Department

Inpatients: Drugs are ordered on the physician order form of the patient's chart by postgraduate and attending physicians and mid-level providers. Mid-level providers shall include the name of the supervising physician on inpatient orders and on prescriptions. In emergency situations, a verbal order may be accepted and recorded on the physician order form. Such orders must be signed by the physician as soon as possible, and in all cases, within 24 hours. Medication orders should include the generic name of the drug.

Outpatients: All prescriptions must include the following information:

- Patient's name and address
- Date of issue
- Drug name, strength, dosage form, quantity ordered, and directions for use
- Patient's diagnosis/problem/complaint
- Patient's allergies
- Prescriber's printed name, state license number, DEA number, if available, SID number, and contact telephone number
- Prescriber's signature

10.3 **Prescriptions and Laboratory Tests for Employees**

Medications and laboratory tests are not available for use by employees. Physicians may not issue prescriptions for employees unless the employee is registered as a clinic patient or is admitted as an inpatient. Having a hospital number does not constitute being a patient. Physicians are prohibited from writing prescriptions or ordering laboratory tests on all employees. (County, USC, contract) Los Angeles County prescription blanks may not be used for fellow physicians, nurses, or any other employee. A licensed physician may write a prescription on a personal (non-County) prescription form for any bona fide patient. Los Angeles County employees may fill prescriptions written for them by their private physicians at the LAC+USC Medical Center pharmacy at the cost of the medication for the pharmacy.

11 **MEDICAL RECORDS**

Additional policies pertaining to Medical Record Documentation appear in the Housestaff Manual. In the event of a conflict, the Rules and Regulations included here take precedence over policies, including those in the Housestaff Manual.

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11.1 Contents

A. History and Physical

1. **Indications:** A history and physical examination (H&P) is required for every patient who is admitted for inpatient care or who receives, for any purpose and by any route, general, spinal, or other major regional anesthesia or moderate or deep sedation (with or without analgesia) for which there is reasonable expectation that there may be loss in protective reflexes. The history and physical examination will be performed by a practitioner who has been granted specific privileges to do so through the Attending Staff credentialing process or by a non-staff physician delegated by an Attending physician. The Attending physician shall be accountable for the patient's medical history and physical examination by reviewing and co-signing it to assure it accurately reflects the patient's condition.
2. **Entry:** The history and physical examination (electronically created, legibly handwritten or dictated and transcribed) must be performed and recorded in the chart within twenty-four (24) hours after admission to the hospital, and before any procedure requiring anesthesia or moderate or deep sedation (as defined above) takes place.
3. **H&P Prior to Admission:** An appropriate history and physical that has been obtained within thirty (30) days prior to admission may be placed in the record in lieu of a new history and physical examination, provided that an update note indicating any changes in the patient's condition in the intervening period are noted in the chart. If there has been no change in the patient's condition the physician shall document that the H&P was reviewed, the patient was examined and no change has occurred since the H&P was completed.
4. **Readmission:** If a patient is readmitted to the hospital within 30 days for the same or a related problem, a legible copy of the previous history and physical examination may be placed in the medical record in lieu of a new complete history and physical examination. In that case an interval history and physical examination must be recorded in the chart indicating any changes in the patient's condition.
5. **Contents:** In all cases, the recorded history and physical examination must include sufficient detail to allow the formation of a reasonable picture of the patient's clinical status. The Chief of each Service will describe any special content that is required.
 - a. **INPATIENT:** A complete history and physical examination in the inpatient setting will include, at a minimum, the following elements:
 - (1). Chief complaint
 - (2). History of present illness
 - (3). Past medical and surgical history
 - (4). Medications and allergies
 - (5). Family and social history
 - (6). Relevant review of systems
 - (7). Vital signs, pain score and general condition
 - (8). Physical examination of heart, lungs, abdomen, and mental status
 - (9). Additional elements of the physical examination (including eyes, fundoscopic, ear nose throat, neck, breast, rectal, vaginal, genitourinary, musculoskeletal, lymphatic and neurologic, and psychiatric) may be included as clinically appropriate
 - (10). Assessment or Impression

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- (11). Treatment Plan
- b. OUTPATIENT:** Patients who have outpatient procedures (under general or regional anesthesia or moderate/deep sedation) may have an abbreviated history and physical examination recorded using the elements defined below. If the patient is subsequently admitted to the Inpatient service, a complete history and physical examination must be performed according to the requirements above.
- c. The Short History and Physical Examination or Moderate/Deep Sedation History and Physical Examination** should include the following elements:
- (1). Chief complaint
 - (2). History of present illness
 - (3). Relevant past medical and surgical history
 - (4). Current medications and allergies
 - (5). Family and social history, if clinically indicated
 - (6). Relevant review of systems, if clinically indicated
 - (7). Vital signs, pain score and general condition
 - (8). Physical examination of heart, lungs, abdomen, and mental status
 - (9). Additional elements of the physical examination relevant to the patient's condition or planned procedure, including eyes, fundoscopic, ear nose throat, neck, breast, rectal, vaginal, genitourinary, musculoskeletal, lymphatic and neurologic, and psychiatric exams) should be included when clinically applicable
 - (10). Impression
 - (11). Treatment plan

For patients undergoing procedures under moderate or deep sedation the history and physical examination should include a pre-sedation assessment including the following:

- (1). History of previous complications from anesthesia or sedation
 - (2). Confirmation of NPO status
 - (3). ASA classification
- d. Attending Documentation Requirements:** Every patient that is admitted must have a complete history and physical examination performed and documented in the chart within 24 hours of admission. An Attending Physician must review each admission within 24 hours of admission. This review must be performed but may be documented in several ways:
- (1). Countersign (authenticate) the Admitting History and Physical and make any additions or corrections needed.
 - (2). Write a separate, properly authenticated, progress note indicating that the patient and the Admitting History and Physical have been reviewed. Include any additional comments as indicated.
 - (3). If admissions are reviewed during rounds or an intake conference within 24 hours of admission, it is acceptable to indicate that:

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- i). The case and the proposed management has been reviewed, or
- ii). The Attending agrees with the proposed management as documented in the Admitting History and Physical, or
- iii). The Attending agrees with the management plan as modified by discussion during the conference (as documented in the chart), and
- iv). The Attending properly authenticates this entry.

Forms may be created, either for handwritten or electronic completion as approved by Medical Center Policy #414. Completion of sections shall be based on the level of care required ranging from focused to comprehensive. Sections may be left blank, if not appropriate to complete based on the presentation.

B. Progress Notes:

Pertinent progress notes shall be recorded soon after observations so as to provide appropriate patient care to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with the specific orders as well as the results of tests and treatment. Progress notes shall be written at least daily. They should give a pertinent, chronological report of the patient's course in the Hospital, including any changes in condition and the results of treatment. Progress notes should be headed by the name of Service and date.

C. Operation or Invasive Procedure Notes:

1. Chart Note:

Every time an invasive procedure or operation is performed, a note must be made in the patient's chart immediately and before the patient is transferred to another area that documents:

- a) The patient's pre-procedure and post-procedure diagnosis
- b) A description of the informed consent that was obtained
- c) The details of the procedure that was performed
- d) Findings, specimens, prosthetics / implants
- e) Any complications
- f) Fluids administered, blood lost
- g) Participants in the procedure
- h) The patient's condition at the conclusion of the procedure
- i) Type of Anesthesia

2. Dictated Procedure Notes:

The full details of the procedure may be electronically created or dictated for transcription in addition to the immediate post-procedure notation. The electronically created or dictated note is not a substitute for the immediate direct notation. Some services may require an electronically created or dictated procedure note. In those cases when the detailed procedure note will be electronically created or dictated the dictation must be completed immediately after the completion of the procedure and immediately after the preparation of the handwritten summary. Physicians who have not completed a complete procedure notation in the chart nor completed the dictation within 24 hours are delinquent. In addition, all transcribed notes must be signed within seven (7) working days after transcription is completed.

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D. Discharge Records

1. Discharge Summary:

Upon discharging a patient from the hospital, an electronic summary shall be prepared that reiterates the reasons for admission, the patient's course including significant surgical and non-surgical events, final diagnosis, condition on discharge, the instructions given to the patient and the follow-up care that is required. If applicable the discharge summary should note any autopsy reports that are available. The summary may be located in a single record or contained in two parts; Part 1, the Discharge Instruction Form and Part 2, the Discharge Summary Record.

Diagnoses must be written without abbreviations and in sufficient detail to allow diagnostic current ICD-CM Classification of Diseases) coding. The name of attending and documentation that the attending concurs or agrees with the discharge plan shall be included in the discharge summary.

Obstetric and newborn patients may use the POPRAS forms in lieu of Discharge Record indicating principal diagnoses and surgical procedures.

A discharge summary, it should be dictated or completed within three days of the patient's discharge for any patient who has remained hospitalized for more than twenty-four hours. Dictation will be delinquent after fourteen days. Either of the following formats for dictation is acceptable, Physicians are required to attest to, or confirm by their signature, that the discharge diagnoses and procedures noted on the medical record are acceptable and correct. The Data Administration Section of Information Management Services may ask physicians, to again attest to a diagnosis if information is obtained at a later date.

2. Patient Discharge Instructions:

The written Patient Discharge Instructions must be completed by a physician, dentist or podiatrist (intern or resident) at discharge. Patient Discharge Instruction forms must include discharge instructions, including instructions to the patient to present the Discharge Record to the primary care provider upon follow-up. Indication of patient's ability to work or disability duration and diet should be included. Every effort will be made to use the patients preferred language. If an intern completes the Patient Discharge Instruction Record a supervising physician must review and authenticate (Date, Time Signature and staff Identification number) it.

E. Psychiatric Records

1. Requirement for Evaluation:

A psychiatric evaluation of the patient should be recorded in the patient's chart when a physician first sees the patient after admission. This must occur within 24-hours after admission to the ward.

2. Format for Evaluations:

Psychiatric evaluations shall include elements as defined in the current version of Diagnostic and Statistical Manual of Mental Disorders (DSM).

3. Discharge from Inpatient Psychiatric Admission, i.e., Augustus Hawkins

- a. Initial Presentation and Reason for Hospitalization, including name, MRUN, date of admission and date of discharge.
- b. Findings of initial assessment and the provisional diagnosis
- c. The significant findings of the various examinations performed, including laboratory findings and consultations.
- d. Summary of the patient's clinical course, including treatment and outcome.

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- e. The final assessment of the patient's condition stated in terms that permit a specific measurable comparison with the conditions on admission avoiding vague relative terms such as "improved".
- f. Final Formulation and Diagnosis:
 - (1) Axis I - Major Psychiatric Diagnosis –
Condition at Discharge - Prognosis
 - (2). Axis II - Personality
Diagnosis - Condition at Discharge - Prognosis
 - (3). Axis III - Medical
Diagnosis - Condition at Discharge - Prognosis
 - (4). Axis IV - Psychosocial Stressors
Degree - Condition at Discharge - Further Needs
 - (5). Axis V - Level of Function Level –
Condition at Discharge -Educational, Occupational and Recreational Needs
 - (6). A Listing of All Complications
 - (7). Recommendations, Medications and Arrangements for Further Treatment and Continuing Care, Living Arrangement, and Follow-up

11.2 Completion of Chart Documentation

A. Inpatient:

All hospital and patient charts should be completed and signed by the time of discharge. They must be completed and signed within 14 days after discharge. In addition to the handwritten Patient Discharge Instruction Record, a dictated and electronically created Discharge Summary shall be required. Electronically created summaries must be created immediately upon discharge and no less than 72 hours after discharge. Electronically created documents should be signed by the original author within 7 days after discharge. If the author is not the responsible attending, the electronically signed discharge summary should be reviewed, edited, if necessary and signed by the responsible attending of record at the time of the discharge, no later than 14 days after discharge. .

B. Outpatient:

For outpatients, the record shall indicate the provider and the name of the Attending Physician who supervised the patient's care. A licensed physician must sign every outpatient chart entry. All outpatient medical charts must be completed at the time the patient is seen; i.e., physicians' notes, statement of cause and length of disability, if applicable, etc. Problem lists and medication reconciliation will be completed on each outpatient episode.

11.3 General Criteria For Recording In The Chart

A. Legibility

All entries in the chart must be easily legible.

B. Abbreviations

Abbreviations are acceptable if they are fully spelled out the first time that they are used in the documentation of an episode of care. This means once (or more) per admission and once (or more)

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per ambulatory visit record.

An abbreviation is acceptable if it is defined in either Dorland's Medical Dictionary or Stedman's Medical Dictionary or approved by clinical departments and is not on the prohibited abbreviation list. If Health Information Management staff identifies a prohibited abbreviation, it shall be recorded as a deficiency.

C. Completeness

Sufficiently detailed clinical information must be provided to enable another practitioner to assume responsibility for the treatment of the patient any time.

D. Timeliness

All required entries, whether handwritten, computer-generated or dictated as soon after a clinical event as is reasonably possible but in all cases must be completed within twenty-four (24) hours of the event. Discharge summaries of deaths may be delayed up to three days only if autopsy results are pending.

E. Accuracy

In order to correct an erroneous entry, line out with a single line in black ink and authenticate (Date, Time Signature and Staff Identification).

F. Relevancy

Notations made in the chart must be relevant to the patient's hospitalization and treatment. Relevancy is facilitated by problem oriented recording.

G. Continuity

Documentation of significant issues once introduced into the record, e.g., significant abnormal physical findings or lab reports, should continue until resolution. All physicians are required to update the Problem List form when indicated.

H. Reproducibility

All entries in the chart must be made in black ink.

I. Confidentiality

It is the policy of the Medical Center to maintain the confidentiality of information about patients and the Medical Center staff who care for them. Information will only be released with the patient's authorization or in compliance with court or other legal orders, as described in policies on privacy. The authorization must specify the intended recipient (individual or organization), the nature of the information to be released and the period of time covered.

For the written authorization to release information about a patient to be effective it must be signed by the patient, the parent or legal guardian of a minor patient or a legally appointed conservator. The Director of Health Information Management is responsible for the release of information. Inquiries should be directed to the Patient Information Office, Clinic Tower A2D (409-6850, weekends 226-6221).

When responding to a call about a patient in what is represented as an emergency, the recipient should, as a minimum effort, verify the authenticity of the caller, check the accuracy of the telephone number given and return the call before releasing the information. Verbal communication about a patient with anyone other than those individuals the patient or guardian is not allowed. Verbal or written communication about the patient's condition with third parties requires the patient's authorization.

J. Retrievability

Medical records must be returned to the files on the day of clinic visits and for discharged patients the

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chart must be sent to the Central Discharge Unit immediately on the day of discharge. Medical records may not be removed from the Medical Center except by subpoena or by a court order.

K. Retention

Inpatient: If a patient is admitted, the paper record, if requested (226-6221, is to go to the ward with the patient. If a patient is not admitted, the record should be returned to Health Information Management (HIM).

The previous paper Medical Record ("old chart") is to be kept at the ward station until 48 hours after admission at which time it will be retrieved by HIM staff and placed in the Central Discharge Unit (CDU). Old charts will be held in the CDU until discharge and will be made available to the ward staff, if needed, during the course of the admission until the patient is discharged. At that time, the Ward Clerk will return the current chart to Health Information Management by taking it to the CDU.

Outpatient Clinic: All paper records are to be returned to Health Information Management by the end of the day of the patient's clinic appointment. Users shall return the records at the end of the allowed time.

L. X-Rays and other Imaging Studies

X-Ray films and other Diagnostic Imaging Studies are a part of the health record. Films will be made available for patient care in accordance with the policies and procedures established by the Radiology Department. Films checked out to clinics or other patient care areas are not to be removed from those locations by physicians or other staff.

Only individuals with valid Staff Identification (SID) numbers will be allowed to check out films as individuals. Films will only be loaned for limited periods of time as specified in the policies of the Radiology Department. Failure to return loaned films will result in sanctions (including limitation of future access to films) and possible disciplinary action in accordance with the policies and procedures approved by the Radiology Department.

11.4 Orders

A. Types of orders

All Housestaff and Attending Staff, Physicians, Dentists and Podiatrists may write orders per granted privileges. Orders written by mid-level providers shall include the name of the supervising physician. Orders written by Medical Students must be countersigned and authenticated with signature, name, Staff ID number, dated and timed by a supervising medical staff member

1. Order Forms:

Orders must be written on designated "Physician's Orders" forms or entered into order management. Each order, or series of orders, must be authenticated (Date, Time, Signature and Staff ID number). Any amendments to orders must be authenticated (Date, Time, Signature and Staff ID number) by all authors or the order shall be deemed to be incomplete.

2. Medication Orders:

Each order for medication must include:

- Generic, preferred, name of drug
- Size of dose - in the metric system, preferred, of weights and measures
- Interval of administration
- Route of administration
- Duration of administration, to include start and stop dates (except for terminal patients, DEA Schedule II controlled substances orders can be written for no more

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than three days)

3. Parenteral Solutions Orders:

IV orders must be renewed every 24 hours except, "Keep Open" IVs without additives.

4. Oxygen Orders:

An order is required for oxygen therapy. No PRN orders for oxygen are allowable. Respiratory Therapy orders must include specific time duration for each treatment, medication, O₂ percent or compressed air and frequency. The physician must review all forms of respiratory therapy every 5 days or they will be automatically stopped.

5. Restraints Orders:

Patients can only be restrained or secluded on the order of a physician and in conformance with the LAC+USC Medical Center's Policy and Clinical Protocols regarding the use of restraints. Orders for restraint or seclusion must include the duration of the order and cannot exceed 24 hours. No PRN orders are allowed. If continuing restraint (more than 24 hours) is indicated the patient must be reassessed and new orders written.

6. Transfer Orders:

Orders in effect at the time of transfer from one ward or service to another remain effective until canceled or until they expire, with the exception of a "No Code" Order.

7. Verbal Orders:

A verbal order, including telephone orders, shall be given only to a registered nurse or physician's assistant with time order was given, and only in an emergency. The order shall be authenticated with date, time, signature and SID as soon as possible and no later than 24 hours.

8. Discharge Orders:

An order on the "Physician's Orders" form should not be used for discharge without completion of the Discharge Instruction Record. This form should not be signed until the patient is ready for discharge.

9. Test Request Orders:

The housestaff and responsible attending physician's name and ID number must appear on all test request forms. If the physician completes the order through order management, or signs the request form, an order on the Physician's Order is not necessary.

The laboratory will check SID numbers for validity and to insure that the names and numbers corresponds. If a mismatch occurs or the number is invalid/inactive, the specimen will be placed on hold. Results that are on hold will be released only upon calling the laboratory and providing valid physician identification. Please consult the "Laboratory User's Manual" for further policies and procedures related to laboratory test ordering.

The housestaff and responsible attending's name and staff ID number must appear on all test forms. All orders for radiological services (x-rays) will contain the reason(s) for the examination. The requesting staff or authorized practitioner is responsible for providing this information.

10. Medication Reconciliation

A reconciliation of all medications shall be completed when a patient is admitted, discharged from inpatient or outpatient episode or transferred to another service or level of care as per policy.

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11.5 *Death Records*

1. **Completion of Certificate of Death**

- a. The physician pronouncing the patient dead should immediately complete the "Duplicate of Official Death Certificate", Form 562.
- b. The licensed physician assigned to the cases will complete the Official Certificate of Death within fifteen hours after death in accordance with Section 10204 of the Health and Safety Code. Interns may not sign the certificate of death. Licensed California Residents may sign the certificate. (California Residents pending receipt of their medical licenses may not).
- c. The Service Chief is responsible for establishing a specific order of responsibility for signing death certificates on his service. If the licensed physician assigned to the case is not available to sign the certificate, the next most appropriate physician should sign it.
- d. To insure that families of patients who have died are treated with the utmost respect and dignity, it is imperative that any Resident Physician who has had a death on his/her service maintains contact with the facility until the Official Death Certificate is signed. The supervising resident and attending shall be notified of any delay in completion of the official death certificate.

11.6 *Completion of Birth Certificate*

The collection of the data necessary to complete a Birth Certificate is the responsibility of the Health Information Management and is to be completed within 24 hours of the delivery or at the time of discharge, whichever is sooner as per Medical Center policy. The signature of the parent or informant (usually the mother) is to be obtained before discharge of the baby. The signature of the delivering Attending or physician designee shall be obtained within 48 hours. The Birth Certificate is produced through the Automated Vital Statistics System. The signature of the parent/informant is obtained on the ward when possible or at the Central Discharge Unit on discharge. The delivering Attending or physician designee shall sign the certificate within 48 hours of the delivery.

11.7 *Confidential Morbidity Report (CMR Card)*

Any diagnosed or suspected case of a reportable disease/condition must be reported to the County Health Department. The treating physician at the time of diagnosis is responsible for the immediate reporting and the completion of the Confidentiality Morbidity Report (CMR Card).

CMRs not completed on inpatients will be completed by Data Administration after discharge.

Three types of CMRs are available:

- Confidential Morbidity Report Form H-794 - report all reportable diseases, including lapses of consciousness,
- Confidential Sexually Transmitted Disease Morbidity Report Form H-1911, and
- Confidential Morbidity Report Form - Tuberculosis Suspects and Cases.

The diseases/conditions indicated with an asterisk (*) on the list must be telephoned immediately to the Acute Communicable Disease Control Staff of the Los Angeles County Health Department. Immediate reporting is done through the Department of Epidemiology. After hours (1-213-974-1234, weekends and holidays), the On-Call physician for Epidemiology or the CD consultant On-Call is contacted through the hospital operator x4906.

11.8 *Use of Medical Record*

Provision for evaluation of the quality of care rendered to inpatients and ambulatory care patients as reflected in the medical record is the responsibility of the Attending Staff Association Executive

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Committee, Health Information Committee, Clinical Departments and other Attending Staff functions. All medical records maintained by the Medical Records Department will be subject to review by the Attending Staff to ensure their adequacy as a medico-legal document and their adequacy for use in quality assessment activities.

The following policies shall be observed: Paper records will only be sent to Patient Care areas (wards, clinics and emergency rooms) where patient is being treated. All other requests will be sent to the Record Review Rooms. Records may be kept for seven (7) days. Records are, however, subject to being removed when needed for patient care.

11.9 Use of Imaging

General Policies for viewing imaging including x-rays: Users shall view imaging, including x-rays in the established areas, approved conferences, intensive care, surgery and admitting room. Imaging, including X-rays removed from the viewing rooms shall be returned within 8 hours.

12 MEDICAL SCREENING EXAMINATIONS (MSE)

Emergency Department coverage will be provided by fully qualified physicians as defined in the LAC+USC Attending Staff Bylaws. A Medical Screening Examination (MSE) will be provided to any patient who presents to the Emergency Department seeking care to determine if an emergency medical condition exists.

The MSE shall be performed by either a physician or by a mid-level provider who has been granted privileges to conduct a MSE. Medical Center Policy 541 and the Interdisciplinary Practices Policy and Procedure Manual contain the qualifications, categories, competencies required to perform specified privileges.

The MSE may also be performed by nurses in accordance with approved nursing protocols, as found in Medical Center Nursing Policies and Interdisciplinary Practices Policy and Procedure Manual.

13 MEDICO-LEGAL RULES AND REGULATIONS

13.1 Reportable Conditions

Physicians are required to be compliant with Title 17 - California Code Of Regulations Sec. 2572. Disorders Characterized by Lapses of Consciousness, Alzheimer's Disease and Related Disorders.

***13.2 Risk Management**

A. Event Notification

In support of its commitment to continuously improve safety and quality of care, the LAC+USC Medical Center requires that any employee who becomes aware of an incident, event, or injury (referred to as an "event") involving a patient, visitor, or non-County employee immediately notify his or her direct supervisor as per the Medical Center policies on Event Notification.

B. Subpoenas for Witness Testimony

Health Information Management Subpoena Unit will routinely accept all subpoenas in order to facilitate the delivery of the subpoenas and also to avoid the interruption of the subpoenaed physician's duties. Most subpoenas for witness testimony require that the physician merely be "on call" for testimony on certain dates.

If the subpoenaed physician wishes to refresh his or her recollection of the case, it is recommended that he or she report with his or her subpoena to the Subpoena Unit to request the patient's chart. PPG-I's should know that, as unlicensed medical personnel, they are not entitled to give expert testimony in a court of law. Residents, as licensed personnel, may give medical testimony in court. Questions regarding any of the above, should be directed to the Subpoena Unit at 226-6601. The Risk Management office should be notified at x226-6657 of any notification of a malpractice action.

Should a provider receive a Summons, suits, subpoenas, notice of Depositions relating to incidents, and telephone calls or other contacts by outside investigators, attorneys, etc. immediately contact the Risk Management office. Participating in a formal deposition or

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discussion of incidents with any representative of a plaintiff (patient) should only occur with the advice and/or the presence of Risk Management staff. This advice does not apply to discussion with relatives, family and/or other attending professional staff within the context of the usual physician/patient relationship.

C. Soliciting Business for Attorneys (Capping)

It is illegal for any County employee to solicit business for attorneys both on or off County property. To solicit any business for an attorney (i.e., to act as a runner or capper) is illegal under Sections 6151, 6152, and 6153 of the Business and Professional Code of the State of California that provides:

Detecting Capping

All employees, particularly those working in areas such as emergency rooms and orthopedic wards, should be alert to the possibility of capping activities. In some instances, cappers have the following characteristics:

1. Hand out business cards to patients or their relatives.
2. Take an unusual interest in patients.
3. Talk to patients without having any reason to do so in connection with their duties.

Reporting Capping

You are instructed to report any capping activities that you observe to your supervisor. You are further instructed to report any soliciting of business for attorneys, or the appearance thereof, including but not limited to activities specified in the preceding paragraph. If you are unsure who you are to report capping activities to, call Risk Management x226-6657 or see your personnel officer. He or she is responsible for transmitting all information to top management.

14 OPERATING ROOM RULES

Operating Room Rules, Policies and Procedures are delineated in the Operating Room Manual and should be referred to and adhered to.

15 PATIENT'S RIGHTS

All attending staff and housestaff are required to uphold all Policies and Regulations pertaining to patient's rights.

16 PROFESSIONAL STAFF

16.1 *Housestaff*

Guidelines for Supervision of Residents

1. Principles

- 1.1 The supervision of resident physicians is established to promote patient safety, enhance quality of patient care, and ensure compliance with the Accreditation Council for Graduate Medical Education (ACGME) Institutional, Common Program, Specialty and Subspecialty Program Requirements currently in effect. "Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth." (ACGME Common Program Requirements, July 1, 2011)
- 1.2 Although a portion of patient care is provided by residents, the ultimate responsibility for patient care and supervision of residents rests with the attending.

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- 1.3 In the clinical learning environment, each patient must have an identifiable, appropriately credentialed and privileged attending who is ultimately responsible for that patient's care.
- 1.4 An attending can only supervise those procedures for which the attending has been granted current privileges.
- 1.5 Each residency program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.
- 1.6 The supervisory lines of responsibility and policies for each program for care of patients must be communicated to the program's attendings and residents and must, at a minimum, incorporate the defined levels of supervision.

2. Definitions

- 2.1 "Attending": a member of the organized medical staff with specific privileges to perform invasive or operative procedures, deliveries, or other specific activities over which they supervise.
- 2.2 "Resident": a physician, dentist or podiatrist enrolled in an accredited residency training program including interns, residents and fellows, enrolled in a residency training program.
- 2.3 "Supervisory resident": a resident designated and documented to perform specific functions in patient care (i.e. specific operative procedures, deliveries or defined patient care activities) without direct attending supervision and who may supervise a non-supervisory resident to perform the specifically designated procedures as determined by each program.
- 2.4 "Non-supervisory resident": a resident who may not perform, without appropriate supervision, invasive or operative procedures, deliveries, or other specific activities without appropriate supervision from an attending or supervisory resident.
- 2.5 "Specific privileges": the authorization to perform invasive or operative procedures, deliveries, or other specific activities which have been granted by the medical staff.
- 2.6 "Procedural Competency": The process for designating that a resident has gained sufficient competency to function as a supervisory resident which shall include performance of a specific minimum of operative procedures, deliveries and other patient care activities directly supervised by attending and approved by the facilities Graduate Medical Education Committee and the Department Chair.
- 2.7 Supervision/Supervise: the act of providing oversight by an attending or supervising resident of the quality and safety of patient care provided by a resident physician utilizing one of the following levels of supervision:
 - 2.7.1 "Direct Supervision": The attending or supervising resident is physically present with the non-supervisory resident and the patient.
 - 2.7.2 "Indirect Supervision with Direct Supervision Immediately Available": The attending or supervising resident is physically within the hospital or other site of patient care, and is immediately available to provide direct supervision.
 - 2.7.3 "Indirect Supervision with Direct Supervision Available": The attending or supervising resident is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision.
 - 2.7.4 "Oversight": The attending or supervising resident is available to review procedures and encounters and to offer feedback after care is delivered.

3. Process

- 3.1 Assignments:
 - 3.1.1 The supervising attending(s) for patient care within the hospital and other sites of patient

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care (ambulatory clinic, emergency room, outpatient surgery, etc.) must be designated and the on-call schedule must be available for review 24/7 through the Sponsoring Institution's electronic on-call information management system.

- 3.1.2 The on-call schedule for residents for each program must be designated and available for review 24/7 through the Sponsoring Institution's electronic on-call information management system.
- 3.1.3 All supervision assignment must take into account the safety and well-being of the patients and the patient's right to quality care.
- 3.1.4 For those ACGME resident training programs that require direct supervision or indirect supervision with immediate availability in the provision of all or part of patient care an attending must be physically present in the hospital or other sites of patient care (ambulatory clinic, emergency room, outpatient surgery) during the time such supervision is required. This may require 24/7 in hospital attending as per ACGME program requirements.
- 3.1.5 On-call responsibilities: For those residents in ACGME training programs that do not require direct supervision or indirect supervision with immediate availability during night call assignments and on weekends an attending must be assigned for indirect supervision with availability at all times when the resident is on-call.
- 3.1.6 When a supervisory resident is included in the supervisory lines of responsibility for care of patients, attendings remain fully accountable for supervision of all residents.

3.2. Specific Procedures, Consultations or Services

- 3.2.1 Each program's resident supervision policy should include:
 - 3.2.1.1 the specific procedures, consultations or services that require direct attending supervision, and
 - 3.2.1.2 the specific procedures, consultations or services for which supervision by supervisory residents is appropriate with direct supervision immediately available or with direct supervision available.
 - 3.2.1.3 the extent of attending or supervisory resident presence required to adequately supervise procedures, consultations or services.

3.3 Procedural Competency

In order for a resident to gain procedural competency for patient care services including invasive and non-invasive procedures or consultation the following conditions are met:

- 3.3.1 documentation that the resident has demonstrated satisfactory competency to be granted procedural competency in the application and performance of the procedure(s), consultation or service;
- 3.3.2 demonstration of satisfactory performance of a specific minimum number of operative procedures, deliveries, or other defined patient care activities under direct supervision, including a specific minimum number under the direct supervision of an attending;
- 3.3.3 recommendation by the program director to designate a resident as a supervisory resident for the specific operative procedure(s), deliveries or defined patient care activities;
- 3.3.4 review and approval by the department chairman or their designee.

4. Invasive and Operative Procedures and Deliveries

- 4.1 An attending or supervisory resident shall see and evaluate each patient prior to any operative procedure or delivery and shall document this evaluation in the medical record.

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- 4.2 An attending is responsible to ensure the execution of an appropriate informed consent for procedures and deliveries with consent form and progress note documenting the consent discussion in the medical record.
 - 4.3 An attending is responsible to ensure appropriate supervision of residents during all operative or invasive procedures.
 - 4.4 An attending or supervisory resident shall be present with the patient for all operative or invasive procedures.
 - 4.4.1 If the attending is present for the operative or invasive procedure or delivery, he or she must document in the medical record that he or she has evaluated the patient and authorizes the procedure.
 - 4.4.2 If the attending is not present (see section 3.2) for the operative or invasive procedure or delivery, the supervisory resident must document in the medical record that he or she has discussed the case with the attending and the attending authorizes the resident to proceed.
 - 4.5 An attending must ensure an operative or procedure note is written or dictated within 24 hours of the procedure and shall document in all situations for which direct attending supervision is required.
- 5. Emergency Department/Urgent Care**
- 5.1 An attending must supervise the appropriate evaluation by the resident for each patient requiring an emergency department/urgent care visit.
 - 5.2 An attending or supervisory resident physician shall review and sign the patient's record prior to disposition.
- 6. Ambulatory/non-urgent care**
- 6.1 For each new patient, an attending shall supervise the resident's evaluation of the patient prior to disposition, as required by policy established under section 3.2.
 - 6.2 For follow up visits, an attending or supervisory resident shall supervise the non-supervisory resident physician's evaluation prior to disposition, the non-supervisory resident physician shall document that the attending concurs with the assessment and management (see section 3.2).
- 7. Inpatient admissions**
- 7.1 An attending must supervise the appropriate evaluation by the resident for each patient admitted to the inpatient service and document direct supervision in the medical record within 24 hours of admission.
 - 7.2 An attending must supervise the appropriate evaluation by the resident of each patient who is hospitalized on the inpatient service each 24 hours after admission and ensure there is documentation of this supervision in the resident's daily progress note or the attending shall record his or her own note.
 - 7.3 An attending shall discuss and approve the discharge planning with the resident. The resident shall document this discussion in the medical record or the attending shall record his/her own note.
- 8. Intensive Care**
- 8.1 An attending or supervisory resident shall discuss every new patient with the non-supervisory resident physician within 4 hours of admission to the Intensive Care Unit. The non-supervisory resident shall document this discussion with the attending or supervisory resident in the medical record.
 - 8.2 An attending shall see and evaluate each patient admitted to the Intensive Care Unit and shall

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document direct supervision in the medical record within 24 hours of admission.

- 8.3 The attending shall see and evaluate the patient in the Intensive Care Unit at least daily thereafter and discuss this evaluation with the resident. The attending shall ensure that the resident includes in the progress note that he or she has discussed the case with the attending, or the attending shall record his or her own note.

9. Diagnostic/Therapeutic Studies and Procedures

- 9.1 An attending shall supervise and document the performance and interpretation of invasive diagnostic/therapeutic procedures in accordance with sections 3 and 4 above.
- 9.2 An attending shall review and sign or co-sign diagnostic studies prior to dissemination of final interpretive reports.
- 9.3 An attending or supervisory resident physician shall concurrently supervise a non-supervisory resident physician for an immediate interpretation prior to the written report of diagnostic studies:
- 9.3.1 whenever results are necessary for immediate patient care decisions, or
 - 9.3.2 whenever studies are performed on patients in locations such as the Emergency Room or Intensive Care Units, when the clinical service requests immediate interpretation.
 - 9.3.3 the immediate interpretation shall be documented in the medical record prior to the written report.
- 9.4 Where diagnostic instruments are used in the evaluation of patients (e.g. ultrasound, Doppler, EKG, among others), an attending or supervisory resident shall supervise the non-supervisory resident when such instruments are used to evaluate patients and when the output of such instruments is interpreted.

10. Consultations

- 10.1 The attending from the treating service shall assure that in all instances where consultations are requested, they are communicated to the consulting service.
- 10.2 The attending from the consulting service shall assure the responses to consultation requests are initiated in compliance with medical staff rules and regulations.
- 10.3 The attending from the consulting service shall supervise and document the performance of consultations, in accordance with sections 3 and 4 above.
- 10.4 An attending must supervise the appropriate evaluation by the resident of each consultation and ensure there is documentation of this supervision in the resident's consultation note or attending or supervisory resident from the consulting service shall document his/her evaluation of the patient in the medical record.

11. Measurement of performance of residents in patient care.

- 11.1 Each department shall develop a policy and procedure for measurement and documentation of resident performance in patient care sufficient to support a systematic review of the resident's competence to perform the operative procedures, deliveries or other defined patient care activities without direct supervision for which the resident has been designated as a supervisory resident.
- 11.2 Each department shall include a systematic review of the resident's activities in patient care as an integral part of the departmental quality assurance process and the information shall be considered in the decisions on reappointment and promotion of each resident.

12. Monitoring

- 12.1. Credentials Committee and Medical Executive Committee will monitor compliance with sections 3.1, 3.2, 3.3, 11.1, and 11.2.

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- 12.2. Health Information Committee will include the documentation guidelines set forth in sections 4.1, 4.2, 4.3, 4.4, 4.5, 5.1, 5.2, 5.3, 6.1, 6.2, 7.1, 7.2, 7.3, 8.1, 8.2, 8.3, 9.1, 9.2, 9.3, 9.4, 10.1, 10.2, 10.3, and 10.4 in its review of records.

16.2 Medical Students

Medical students are students enrolled in the Keck School of Medicine of the University of Southern California. The policy of Keck School of Medicine of USC will be observed with regard to visiting students from other schools. Attending Staff members have ultimate responsibility for patient care and supervision. Progress notes should indicate when attending staff rounds are made, with whom and the recommendations for patient care.

The content of progress notes written by medical students can meet these requirements, but only when such notes are countersigned by a resident or other licensed physician. Lack of this professional substantiation of the student's note may have the same consequences as if no note had been written at all.

16.3 Mid-Level Providers

The patient care delivered by Mid-Level Providers (Allied Health Professionals) are limited to those procedures and practices appropriate to their experience and training and to privileges granted. The patient care delivered by these practitioners shall be the responsibility of a member of the Attending Staff. Refer to Medical Center Policy 541 and attachments.

16 PROCTORING

In order to evaluate the qualifications of applicants with new privileges or new appointees to the Attending Staff and current members requesting additional privileges or current members defined by the department leaders as requiring proctoring, the Attending Staff Bylaws, Department Rules and Regulations and policy require proctoring to ensure the current competency of practitioners.

17 RADIOGRAPHY / FLUOROSCOPY CERTIFICATES

All practitioners actuating an X-ray generator, operating an image intensifier or influencing radiating dose to patients while participating in the use of fluoroscopy are required to become certified by the California Department of Health Services as an X-ray supervisor and operator. Practitioners wishing to utilize fluoroscopy or radiography equipment must comply with the State of California requirement that a current copy of the license be kept in the practitioner's credentials file. A radiology supervisor and operator certificate issued by the California Department of Public Health shall be required of any licentiate who practices as a radiologist or radiation oncologist in accordance with the California Code of Regulations, title 17, section 30466.

APPROVALS on file