

**~~ZSFG~~HZSFG EMERGENCY DEPARTMENT  
RULES AND REGULATIONS  
2021**

**EMERGENCY DEPARTMENT  
RULES AND REGULATIONS  
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## **I. EMERGENCY DEPARTMENT ORGANIZATION**

### **A. SCOPE OF SERVICE**

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

### **B. MEMBERSHIP REQUIREMENTS**

Membership on the Medical Staff of San Francisco General Hospital is a privilege which shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards and requirements set forth in ZSFG Medical Staff Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

### **C. ORGANIZATION OF EMERGENCY DEPARTMENT**

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

#### **1. Chief, Emergency Department**

##### *Position Summary:*

The Chief of Emergency Department directs and coordinates the Department's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (ZSFG) and the Department of Public Health (DPH). The Chief also insures that the Service's functions are integrated with those of other clinical departments and with the Hospital as a whole.

##### *Reporting Relationships:*

The Chief of Emergency Department reports directly to the Associate Dean and the University of California, San Francisco (UCSF) Department of Emergency Medicine (DEM) Chair. The Chief is reviewed not less than every four years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the

Associate Dean, the UCSF Department Chair, and the ZSFG Executive Administrator, upon approval of the Medical Executive Committee, and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.

*Position Qualification:*

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

*Major Responsibilities:*

The major responsibilities of the Chief of Emergency Department include the following:

- Providing the necessary vision and leadership to effectively motivate and direct the Service in developing and achieving goals and objectives that are congruous with the values, mission, and strategic plan of ZSFG and DPH;
- In collaboration with the CEO and other ZSFG leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement, reviewing and approving Service policies and procedures, identifying new clinical services that need to be implemented, and supporting clinical service providers by the Department.
- In collaboration with the CEO and other ZSFG leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;
- Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of Service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and
- Performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws and the Rules and Regulations.

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

**a. Medical Director (Vice-Chief) of Emergency Department**

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

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

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

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**b. Director of Performance Improvement, Quality Improvement and Patient Safety (PIPS)**

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

The Director(s) of PI\QI are expected to:

- Represent the ED at the monthly risk management committee
- Develop new measures of Quality Improvement for Emergency Care and measure them.
- Develop new processes to improve Quality of Care in the ED
- Collaborate with ED-Nursing Director of PIPS to improve quality of care.
- Monitor and report on performance and quality of care for the following processes
  - Complications
  - Intubations
  - Central venous access
- Monitor and report on
  - Number of Preventable and Non-preventable deaths in the ED
  - The total number of deaths in the ED
- Hold a quarterly PI meeting in collaboration with ED Nursing and Hospital PI.
- Monitor and develop reports on the National Patient Safety Goals (NPSG) as they apply to the ED
  - Develop and implement methods of improving compliance with the NPSG's
- Review episodic cases (U.O.'s or other cases reported to the Chief or Medical Director – for investigation) in collaboration with the Medical Director in which quality of care may be an issue.
- Attend the weekly ED Executive Committee meeting
- Prepare an annual report to the Chief of Service describing the activities of the PIPS for the prior year (due June 30 of each year).
- Attend the ED physician leadership meeting (weekly).

**c. Associate Residency Program Director**

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

**d. Director of Pediatric Emergency Medicine.**

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

**e. Base Hospital Medical Director**

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

**e. Disaster Coordinator**

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

**f. Medical Student Education Director**

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



## **D. ROLES AND RESPONSIBILITIES**

### **1. Attending Physicians**

#### **a. Attending-In-Charge (AIC)**

- Provides medical consultation to the base hospital telemetry station.
- Responsible for redistributing available medical staff to ensure optimal patient flow.
- Responsible for discussing diversion countermeasures with the CN and AOD
- Responsible for coordinating E.D. medical staff to respond to disasters and multi casualty incidents (see E.D. Policy, "Disaster Plan".)

#### **b. All Attendings**

- Responsible for supervision of medical care delivered in the E.D. by house staff and medical students.
- Ensures adequate documentation on E.D. medical records (see XI.B. below)
- Responsible for transfer of patients out of the E.D. (Refer to XI.F. below and ED Policy, "Transfer of Patients from ED").
- Evaluates and writes notes on all patients seen in the E.D. prior to admission or discharge.
- Supervises sign-out rounds.
- Supervises procedures (see E.D. Policy, "Procedures: Table of Staff Approved to Perform").
- Writes all "do not resuscitate" orders.
- Ensures compliance with universal precautions.
- Sees all patients before patients are allowed to leave against medical advice (see XI.B. below).
- At discharge, ensures that patients have appropriate follow-up and discharge instructions (see XI.B. below).
- Ensures notification of the Medical Examiner of all deaths in the E.D. and ensures that the death registry form is completed.
- Responsible for ensuring appropriate patients receive consultation.
- Communicates with attendings from consultation services where consultants are not available in a timely manner or when

- disagreements over management arise
- Works in a collaborative fashion with nursing:
    - Responds to nursing concerns by either carrying out requests of nursing staff or communicating reasons for not doing so.
    - Notifies charge nurse of problems with nursing care within the E.D.
    - Notifies the charge nurse of problems with equipment or lack of supplies.
    - Ensures compliance with dress code by house staff and students.
  - Enforces the policy of medical staff, house staff and students not eating in the clinical areas.
  - Serves as a role model to house staff and students.
  - Completes Unusual Occurrence reports in appropriate situations.
  - Pages the Chief or Medical Director of the Emergency Department for situations that have potential risk management implications.
  - Identifies appropriate patients for research studies and notifies appropriate research coordinators.

## **2. All Residents, Interns and Students**

- Will review orientation materials prior to their first shift.
- Will discuss with the ED Housestaff Coordinator any requested changes in their scheduled shifts.
- Will comply with necessary Emergency Department administrative requirements including:
  - o Having their picture taken
  - o Providing address and home telephone information
  - o Signing their Training Materials Receipt Form
  - o Returning the rotation evaluation form at the end of their rotation
  - o Returning any meal cards and parking cards at the end of their rotation
- Will call and speak to the attending in charge (AIC) when for any reason they cannot be present and on time for a scheduled shift (628-206-8111) and contact the EM Chief Resident on call (Jeopardy Chief) and Housestaff Coordinator for possible coverage.
- Will not eat in the patient care areas, only in the provider room or ED lounge.
- Will wear appropriate attire while in the patient care areas (see VIII.G. Appropriate Dress, below).
- Will inform the attending when they leave the clinical area for a meal break, or for any extended period of time.

- Will perform the medical functions of a resident or student, under the guidance and supervision of an attending. These include primary patient care and:
  - o An appropriate history and physician examination
  - o Determining the patient's primary care provider
  - o An appropriate treatment plan
  - o Appropriate use of their identification number when ordering laboratory, x-ray, EKG studies, or when ordering or prescribing medications
  - o Follow-up of all diagnostic and therapeutic interventions
- Will document on the medical record all pertinent history, physical findings orders, procedures, reassessments and discharge instructions.
- Will follow appropriate body substance precautions.
- Will call consults as dictated by usual medical practice.
- Will immediately consult with the attending physician on patients who:
  - o Are requesting to leave against medical advice
  - o Are violent
  - o Are unstable
  - o Threaten lawsuits, grievance, etc.
  - o Require admission
- Will treat patients and hospital staff in a professional, courteous manner; at all times showing patients and co-workers respect.
- Will make an effort to learn by participating in, as allowed, ED Conferences and being receptive to teaching at the bedside.

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

- Will evaluate and manage patients in their assigned clinical areas.
- Senior residents will help manage patient flow and teach medical students and interns as time allows.
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**4. 4<sup>th</sup> Year Medical Students ("Acting Interns")**

- Will only evaluate and treat patients in resuscitation rooms as directed by a resident or attending.

**4. Nurse Practitioner**

- Provides care to patients in the Emergency Department in accordance with policies approved by the Committee on Interdisciplinary Practice.
- Provides appropriate documentation for patients seen.
- Discusses all patients who will be admitted with an attending.

- Contacts the Charge Nurse for absences due to illness.

## **II. CREDENTIALING**

### **A. NEW APPOINTMENTS**

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

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

### **B. REAPPOINTMENTS**

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

#### **1. Practitioners Performance Profiles**

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

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

#### **2. Staff Status Change**

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

**3. Modification/Changes to Privileges**

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

**C. AFFILIATED PROFESSIONALS**

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

**D. STAFF CATEGORIES**

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

**III. DELINEATION OF PRIVILEGES**

**A. DEVELOPMENT OF PRIVILEGE CRITERIA**

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

**B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST**

The Emergency Department Privilege Request Form shall be reviewed annually.

**C. CLINICAL PRIVILEGES**

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

**D. TEMPORARY PRIVILEGES**

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

**IV. PROCTORING AND MONITORING**

**A. MONITORING (PROCTORING) REQUIREMENTS**

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

1. All new Emergency Department medical staff must be proctored within the first *6 months*.
2. Proctoring includes a review of evaluations of the applicant by other clinical service medical staff, house staff, nurses and patients.
3. Proctoring includes a review of clinical indicators such as 72-hour revisit admissions through the Performance Improvement and Patient Safety process.

**B. ADDITIONAL PRIVILEGES**

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

**C. REMOVAL OF PRIVILEGES**

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

**V. EDUCATION**

Ongoing attending physician education is provided by Case Conferences, Trauma Video Conference, ED Meetings and PIPS activities. The ED encourages and supports faculty to attend the Annual Society of Academic Emergency Medicine meeting as well as the Scientific Assembly of the American College of Emergency Physicians.

**VI. EMERGENCY DEPARTMENT HOUSESTAFF TRAINING PROGRAM**

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

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

**VII. EMERGENCY DEPARTMENT CONSULTATION CRITERIA**

- A. Consultation requested of all services should be requested by residents and attendings. Students and interns should request consults under the supervision and guidance of a resident or attending.

- B. Requests for consultation should be documented clearly on the medical record. This should include the time the consult is requested, the service and the name of the consultant.
- C. If unable to contact a consultant, the Emergency Department attending should be notified. The attending will then attempt to contact the~~call the~~ attending of the consultation service.
- D. Consultations requested of social services should be documented in the same way the consultations are noted for the various medical services.

#### 1. Trauma/Surgery

- All patients meeting Trauma 900/911 criteria
- Trauma patients with spinal or significant pelvic fractures
- All patients being admitted to ZSFG for traumatic injuries requiring ICU or pediatric admission
  - Patients with cellulitis, lymphangitis or other cutaneous infection that may require surgical debridement.
  - ~~Suspected~~Possible surgical abdomens (i.e., appendicitis, acute cholecystitis, perforated viscus, etc.)
  - ~~Suspected~~Possible compartment syndromes
  - Burns which may require admission
  - Any ~~suspected~~possible aortic aneurysm, either dissecting or rupturing, that is not being transferred
  - Caustic ingestions
  - ~~Suspected~~Possible ischemic bowel
  - Painful or not easily reducible hernias

#### 2. Obstetrics/Gynecology

- Any ~~significant~~significant concern for ectopic pregnancy
- ~~Significant~~nificant concern for pelvic inflammatory disease
- Pregnant patients addicted to narcotics
- Endometritis
- Precipitous deliveries in the ED
- All seriously or critically ill pregnant patients
- Severe vaginal bleeding

#### 3. Pediatrics

- Pediatric consultants should see any patient (up to age of 21) in the ED if requested to do so by the ED attending physician.

#### 4. Orthopedic

- Fractures requiring follow up
- Dislocations not reduced by ED providers
- Axial spine fractures

- Septic arthritis

**5. Neurosurgery**

- Any patient with neurologic deterioration for whom head CT is being ordered to evaluate intracranial bleeding or hydrocephalous
- Fractures of the axial spine
- Suspected acute spinal cord syndrome

**6. Neurology**

- Diagnosed or suspected strokes and TIA's
- New onset seizures and status epilepticus
- Dementia without previous evaluation
- Movement disorders of undetermined etiology

**7. Anesthesiology**

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

**8. Oral Maxillofacial Service**

- Facial fractures not covered by the ENT or plastic services
- Facial lacerations involving cartilage, lip lacerations involving vermilion border, large facial lacerations, complex facial lacerations

**9. Plastic Surgery**

- ~~Significant b~~Burns to the face, hands and perineum
- Hand consults when not covered by Orthopedics

**10. ENT (Otolaryngology)**

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

**11. Ophthalmology**

- Patients with blowout fractures and entrapment
- Patients with ~~suspected~~possible rupture or penetration of the globe.
- Significant eye injuries including patients with hyphema, lacerations of the eyelids ~~that include~~including the margin or the tarsal plate, or the lacrimal drainage system.

**13. Urology**

- Patients with urethral obstruction and infection
- Kidney stones with intractable pain



- Patients with trauma along the urogenital tract
- Severe epididymitis\orchitis
- Testicular torsion
- Cellulitis of the scrotum or the perineum

**14. Psychiatry**

- Patients with suicidal or homicidal ideation
- Patients with new onset psychosis
- Any patient thought to be gravely disabled because of psychiatric reasons.

**15. Hand Service**

- Patients with significant trauma or infection distal to the elbow covered by either the Orthopedics or Plastic surgery services

**VIII. OPERATIONAL ISSUES**

**D. ORIENTATION**

1. All medical students will attend a one-hour orientation, which will include a tour of the ED.
2. Interns and Residents will view an on-line orientation material prior to their first shift.
3. Attending staff will receive the Emergency Department Rules and Regulations, view the housestaff on-line website and attend a one-hour meeting with the Chief of Emergency Department or the Medical Director (Vice Chief) as an orientation. Additionally, new attending staff will spend their first shift with a current E.D. attending.
4. Attendings-In-Charge (AIC) will receive a special orientation to the Base Hospital given by the Medical Director of the Base Hospital. They will be required to pass a written test covering the policies and procedures of the Base Hospital.

**E. SCHEDULING**

1. Medical students' schedules are made by the medical education coordinator.
  - Medical students will not average more than 48 hours clinical time per week
  - Medical students will have at least one 24-hour period off per week.
  - Medical students shifts will be no longer than eight hours.
  - Medical students will not be required for clinical duty when

student lectures are scheduled.

2. Interns schedules are made by the medical education coordinator.
  - Interns will not average more than 60 hours clinical time per week.
  - Interns will have at least one 24-hour break from clinical time each week.
  - Intern shifts will not be longer than twelve (12) hours. Every attempt will be made to equally distribute night shifts.
  
3. Resident schedules will be made by the medical education coordinator.
  - These residents will not work more than 60 hour per week.
  - There will be at least one 24-hour time period without clinical work per week.
  - Shifts will not be longer than twelve (12) hours.
  
5. Attending schedules
  - Schedule requests from part-time faculty must be submitted at two months ahead of time.
  - Part-time faculty must work a minimum of three shifts per month unless prior arrangements are made with the Chief, Emergency Department.
  - Part-time faculty must work at least one night per month.
  - Part-time faculty must average two out of every seven shifts on weekends unless special arrangements are made with the Chief.
  - Faculty may not work more than 12 consecutive hours.
  
5. Full-time faculty must submit their schedule request at least two months ahead of time. Full-time faculty must note on their schedule request reasons for days off (i.e., personal, reason for work related business).
  - Full-time faculty must request vacation or non-work-related time off (more than 3 consecutive days off in a row) before schedule requests are submitted.
  
6. Request for changes and schedules are made in the following ways
  - Medical students, interns and residents must notify the medical education coordinator at least 24 hours prior to any scheduled trade.
  - Attendings must notify the Assistant to the Chief prior to a traded shift.

### **C. SICK CALLS AND MISSED SHIFTS**

1. Medical students and house staff must call the attending physician in the clinical area to which they are assigned when unable to work a scheduled shift.
  - The attending in charge will redistribute personnel as necessary.
  - Students and house staff may be required to make up missed shifts as determined necessary by the Director of Medical Education.
  
2. Attending schedules
  - Schedule requests must be submitted by the due date or requests may not honored.
  - Faculty must request off any days they do not wish to work, including unassigned holidays.
  - Part-time (per diem) faculty must work a minimum of four shifts per month unless prior arrangements are made with the Chief, Emergency Department.
  - Part-time faculty must work 1/3 of their shifts as nights and 1/3 as weekends unless special arrangements are made with the Chief, Emergency Department.
  - Faculty may not work more than 12 consecutive hours or have less than 8 hours between shifts.
  - Full-time faculty must submit their schedule requests by the due date and note on their schedule request reasons for days off (i.e., personal, reason for work related business).
  - Full time faculty must request approval for 7 or more consecutive days off in a row at least 2 weeks before schedule requests are due. Approval of requested time off will be granted depending on the ability of the department to accommodate the schedule requirements.

### **C. SICK CALLS AND MISSED SHIFTS**

1. Medical students and house staff must call the attending physician in the clinical area to which they are assigned when unable to work a scheduled shift.
  - The attending in charge will redistribute personnel as necessary.
  - Students and house staff may be required to make up missed shifts as determined necessary by the Director of Medical Education.
  
2. Attendings unable to attend a shift should the on-call physician for coverage of the shift.
  - An On-Call system exists to provide coverage in the event that an attending physician is unable to attend a shift.

- The Chief or Medical Director of Emergency Department should be paged if the on-call physician cannot be reached.

#### **D. SIGN-OUT ROUNDS**

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

1. Confidentiality must be maintained at all times.
  - The discussion of patients should be quiet and held several feet away from the patients so that confidentiality is maintained.
2. Attendings should sign-out any pending transfers and current diversion status.
3. At the conclusion of each case discussion, a plan for further therapy and diagnostic evaluation must be outlined. The end points for admission or discharge must also be discussed.

#### **F. DIVERSION**

1. E.D. diversion is carried out as outlined in the administrative policy “Ambulance Diversion Criteria” (ZSFG Administrative Policy 4.05)
  - Patients, nursing staff and medical staff should be redistributed as the need arises to attempt to avoid total E.D. diversion.
  - If it becomes apparent that the E.D. is unable to provide the standard of care for incoming patients, the charge nurse, attending in charge and AOD should confer regarding the need for total E.D. diversion which must occur before the decision is made to go on diversion.
  - It should be recognized that total E.D. diversion does not divert ambulances with patients for whom the E.D. is a special receiving facility (Level 1 trauma patients, EMSA defined specialty care triage criteria – i.e STAR, STEMI, Burns, Reimplantation, Obstetrics, Acute medical pediatrics, ZSFG campus clinic patients, incarcerated or police custody patients)

#### **G. AVAILABILITY**

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

- 1.. The Chief or Medical Director (Vice Chief) should be called for any significant risk management issues.

2. The Chief or Medical Director (Vice Chief) can be called to facilitate disputes between the E.D. and a potential admitting service attending or between admitting service attendings regarding the need for admitting a particular patient.
3. The Chief or Medical Director (Vice Chief) should be called when an attending is unable to work a shift in the acute area of the E.D.
4. The Chief or Medical Director (Vice Chief) should be called when there are significant conflicts between medical and nursing staff in the E.D.
5. The Chief or Medical Director (Vice Chief) should be called whenever there is an activation of the hospital's disaster plan.

#### **H. APPROPRIATE DRESS**

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

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

#### **IX. DISCIPLINARY ACTION**

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

#### **X. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY**

##### **A. CLINICAL INDICATORS**

Clinical indicators include but are not limited to deaths in the E.D., 7 days revisit admissions, deaths, procedural sedation, patients leaving AWOL or AMA, and airway intubation.

##### **B. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES**

The Director of PIPS prepares an annual report for the organization and department summarizing the performance of the department based on these clinical indicators.

**C. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES**

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

**D. MONITORING & EVALUATION OF APPROPRIATENESS OF PROFESSIONAL PERFORMANCE**

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

**XI. CLINICAL ISSUES**

**A. EVALUATION OF PATIENTS**

1. Patients seen in the E.D. may be seen initially by students, interns, residents, nurse practitioners or attending. The attending should remain available to hear presentations of new cases and be available to consult on potential admissions or discharge.
2. All patients seen by a resident or medical student must be staffed by an attending before they leave the ED.

**B. DOCUMENTATION**

1. Before seeing the patient, the intern/resident clicks their initials in the appropriate box in EPIC that notes the time that the evaluation of the patient is initiated.
2. Attending physicians, at the time of admission or discharge, are responsible for ensuring that all appropriate documentation is present on the medical record.

3. The pertinent history is documented. This includes but is not limited to all pertinent positive and negative history:
  - Appropriate timing of the onset of illness or injury.
  - Pertinent past medical history and review of symptoms.
  - Identification of the patient's Primary Care provider (PCP) and or usual source of care.
  - Results of attempt to contact PCP must be documented.
4. Appropriate Physical Exam is documented:
  - The patient's general appearance is noted.
  - Wounds are described in terms of size and location.
  - When appropriate, detailed Neurologic exams are documented including gait (this may require serial examinations as patient's mental status improves).
5. Procedures:
  - All procedures are carefully documented, including prep, anesthetic and extent of procedure in the appropriate procedure template.
  - The results of procedure, including complications, are documented.
6. Orders will be documented:
  - This includes all orders for IV, medications, restraints, oxygen, laboratory test, EKG's, cardiac monitoring x-rays, diet, neurological checks and vital signs.
  - All orders are time stamped in EPIC at the time they are written
  - Before discharge, any verbal orders documented by the nursing staff must be signed by physicians.
7. Patients whose clinical condition changes should have their reassessments documented in the appropriate section on the chart. Examples include:
  - Any discussion with friends or family should be documented here
  - Attendings leaving at the end of a shift should write a note in this section for complicated patients whose disposition has not been decided upon.
8. At the time of discharge the following must be completed:
  - Discharge diagnosis, must be specific and should include all pertinent diagnosis present in the E.D. (i.e. "multiple contusion", "alcoholism", "alcohol withdrawal", etc.)
  - Mechanism of injury may be a diagnosis but should never be the only diagnosis
  - Instructions to patients, especially those symptoms necessitating

- immediate return to the E.D. must be carefully documented.
- The clinics to which the patient is being referred and the time frame requested for follow-up must be documented.
9. Attending signature with date and time stamp must be completed within the agreed upon time frame from date of service by the Chief of the Emergency Department.
  10. An attending note should be completed for all admitted and discharged patients. This must include:
    - A brief description of exceptions from and/or additions to the intern/resident note and the most pertinent findings
    - A review of pertinent lab and diagnostic data
    - The attending's presence for all procedures performed in the E.D.
    - The diagnosis(es)
    - The plan for the patient's follow-up or admission.
    - The time and date of discharge must be documented
    - Attending signature with date and time stamp must be completed within the agreed upon time frame from date of service by the Chief of the Emergency Department

### **C. ADMISSIONS**

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

1. When it is recognized that a patient requires admission to the hospital, the admission disposition should be made in EPIC as soon as this is known. The admitting diagnosis, service, and admitting resident as well as the need for special precautions like isolation should be entered into the admission disposition request.
2. The admitting service should be notified when a patient requires admission to their service. A patient cannot be sent upstairs without approval of the admitting service. Disagreements should be immediately discussed by the attending physician on the admitting service and the emergency department attending physician. Continued disagreements should be referred to the Medical Director or Chief of Emergency Department.
3. Patients requiring admission who have out of network insurance will be identified by the transfer center. If patients are deemed stable by the attending physician, they can be transferred to an accepting institution. (See XI.E below)



4. All ICU admissions require calling the ICU resident for admission to an ICU bed.
5. The following rules also apply to admissions:
  - Prisoners with chest X-ray consistent with tuberculosis must be admitted unless active tuberculosis can be ruled out
  - An admitting team may only discharge an admitted patient from the E.D. after discussion with the attending physician on the admitting service and requires a note from the inpatient attending physician of record.

#### **D. TRANSFER INTO EMERGENCY DEPARTMENT**

Transfer into and out of the Emergency Department is only approved and arranged by attending physician (See ZSFG Administrative Policy 20.07)

1. All non-trauma transfers from other hospitals into the Emergency Department are first screened by the transfer coordinator for eligibility and availability of beds. If patients are deemed eligible and ZSFG beds are available, the transfer coordinator notifies the Emergency Department Attending who will then contact the referring physician. Patients are only accepted if they are then deemed stable for transfer.
  - Patients who are obviously a direct admission should not be accepted to Emergency Department. The referring physician should be referred to the admitting physician of the admitting service.
  - Patients from Laguna Honda Hospital and City Clinics should always be accepted unless there is no bed available for potential admission, the patient is in critical condition (in which case the patient will be transported by paramedics to the nearest appropriate receiving facility), or, ZSFG is on diversion.
2. Patients who meet trauma center criteria from San Francisco hospitals should always be accepted for transfer. These calls need not go through the coordinator.
3. Patients who meet trauma criteria from hospitals outside of San Francisco should be referred to the attending physician on the trauma service for acceptance of transfer.
4. Whenever a transfer is accepted, the triage nurse should be notified of the incoming transfer as well as the residents and attending in the area to which the patient will be triaged.

## **E. TRANSFER OUT OF EMERGENCY DEPARTMENT**

Transfer out of the Emergency Department may only be *authorized* by an attending physician in the ED (See ZSFG Administration Policy 20.05)

1. Stable patients who either require a transfer or in whom a transfer is required because of insurance purposes may be transferred with their consent.
2. Unstable patients in whose transfers are required in order to provide appropriate care may be transferred with patient's consent. If the patient is unable to consent these patients may also be transferred.
3. The process for arranging a transfer is as follows:
  - The attending physician asks the charge nurse to have the transfer coordinator verify the patient's eligibility.
  - Upon verification of the patient's eligibility the transfer coordinator notifies the attending physician of the patient's insurance coverage.
  - The attending physician or resident speaks to the appropriate physician to accept transfer.
  - The appropriate physician at the receiving institution should be called to accept the transfer.
  - Once an accepting physician has been identified the ZSFG E.D. attending physician or resident should notify the charge nurse that the transfer has been accepted and document the acceptance on the E.D. medical record
  - The charge nurse should then request the transfer coordinator to prepare necessary transfer documents, copy x-rays and provide transportation (as requested by the attending physician) for transfer.
  - The transfer coordinator shall ensure that the appropriate transfer forms are filled out and provides copies of the medical records, x-rays and EKG's.

## **F. DISCHARGE AND FOLLOW-UP**

1. Patients with Primary Care Providers (PCP's) who can provide necessary follow-up should be referred to these physicians.
2. Out of county patients should be referred to their PCP or the County hospital in which they reside.
3. Every effort should be made to refer San Francisco patients without PCP to primary care clinics in the Department of Public Health. Only those patients requiring specialty care should be referred to specialty clinics.
4. Discharge plans should be discussed with relatives or friends accompanying the patient whenever possible and appropriate.

5. All patients should be instructed in the signs and symptoms which may require their immediate return to the E.D. and these instructions must be documented.
6. Upon discharge, patients are provided with *a copy* of their E.D., prescriptions, instruction sheets, and if necessary, bus tokens or taxi vouchers to ensure their safe transport home.
7. Homeless patients and those patients requiring the services of a social worker should receive a consultation from the social worker prior to discharge.

## **XII. RISK MANAGEMENT**

### **A. AVAILABILITY**

The Risk Manager for the University of California is available 24 hours per day on pager (415-327-9543). The Chief of Emergency Department, or designee, is also available 24 hours per day.

For any questions that may have medical legal implications (see below) the UC Risk Management and Chief, Emergency Department, should be paged.

1. The Unusual Occurrence reporting system does not negate the need to page the UC Risk Manager and Chief, Emergency Department.
2. Requests for information from attorneys or investigators must go through the UC Risk Management.

### **B. LEAVING AGAINST MEDICAL ADVICE (AMA)**

(Refer to ZSFG Administrative Policy 1.10)

1. Patients must be able to understand the consequences of leaving against medical advice before leaving AMA.
2. Patients leaving against medical advice must be interviewed by the attending physician prior to leaving.
3. Patients leaving against medical advice must be informed of the risks of leaving.
4. Patients leaving against medical advice should be given discharge instructions, medications and follow-up as any other patient would receive.
5. Patients leaving against medical advice should be informed as to the conditions which would require immediate return to the E.D.
6. Patients leaving against medical advice should have the above-mentioned discussions documented in their chart.

7. Patients leaving against medical advice should be asked to sign the AMA form. If they refuse *this should be noted and it* should be made a part of the permanent medical record.
8. Patients leaving AMA who are considered “At Risk” before an attending assessment is made should be detained by SFSD until the attending evaluation is completed.

### C. RESTRAINTS

(Refer to, “Restraint\Seclusion” ZSFG Administrative Policy 18.09).

1. Patients may be restrained for either safety or behavioral reasons.
  - Patients on 5150’s may be placed in restraints if necessary to avoid elopement.
  - Patients at risk for falling or otherwise hurting themselves may be placed in restraints.
2. Physicians and nurses should review each patient’s status before removing restraints.

3. A restraint order must be placed prior to application

-Orders involving restraint of extremities must specify laterality.

-Restraints for *non-violent, non self-destructive (medical safety)* purposes must be renewed as needed at least **every 24 hours**.

-Restraints for *violent\self-destructive purposes (behavioral safety)* must be renewed as needed at least **every 4 hours** and require face to face assessment by a physician within an hour of initiation and reapplication.

4. If a patient is taken out of restraints prior to the time ordered for restraints to be discontinued; an order to discontinue restraints should be written.

### D. CONSENT

(See ZSFG Administrative Policy 3.09)

1. Patients registered into the E.D., if able, sign a consent which permits evaluation and emergency treatment in the E.D.
2. If procedures need to be performed which are not emergent in nature and the patient is unable to consent, then consent should be obtained from a surrogate decision-maker.

3. Patients unable to consent at registration may have an emergency procedure performed if, “implied consent” applies. The concept of “implied consent” means that a patient with severely impaired ability to understand the consequences of refusing care would, if able to understand the situation, consent to necessary evaluation and treatment.
  - Any necessary treatment should be performed in these cases.
  - The reason for invoking “implied consent” must be carefully documented.

Examples:

- a. A patient with a gun shot wound to the abdomen may not be able to understand the consequence of leaving because of severe anger or fear and may be held because of the high likelihood of death or permanent disability.
  - b. A patient with a scalp laceration due to a fall who is mildly intoxicated and has been observed for several hours may not be permitted to leave, based on the severity of head injury and degree of intoxication.
  - c. A severely demented patient with a paronychia who is somewhat combative may be held until evaluation of the infection has been completed because of severe impairment in ability to understand the consequence of leaving.
4. Blood transfusions in the E.D. always require completion of the Blood Transfusion Consent form.
  5. Consent for surgery or other procedures to be performed outside of the E.D. should be obtained by the admitting service.

**E. DO NOT RESUSCITATE ORDERS AND DEATH IN EMERGENCY DEPARTMENT**

1. Only attending physicians may write do not resuscitate orders in the chart.
  - The order should state reason for the order.
  - Any contact with the family should be noted.
  - The order should specify what procedures may or may not be performed (intubation, defibrillation and use of medications).
  - These orders do not apply to admitted patients outside the E.D.
2. All deaths in the E.D. must be reported to the Medical Examiner’s office (see E.D. Policy D, “Death in the ED”)
  - Attending physicians do not sign the death certificates

- The Medical Examiner may choose to take the patient or sign the patient out to a private physician who will then sign the death certificate.
- The death registry form should be completed by the E.D. attending physician.
- No devices (tubes, catheters etc.) are to be removed from a deceased patient in the ED.

#### **F. UNIVERSAL PRECAUTIONS**

(Refer to E.D Policy E. “Exposures to Blood and Body Fluids”)

1. Part of all orientations will include discussion of the use of universal precautions
2. Any exposure to blood or body fluid by medical staff shall report to the Charge Nurse
3. Further treatment and prophylaxis will be determined by the physician in concordance with the needlestick hotline.
4. The attending physician will fill out the report of injury.

#### **G. USE OF INTERPRETERS**

1. Medical staff should not rely on anything less than fluency in patient’s language to interpret for their patients.
2. The use of hospital interpreters and the AT&T interpreter line should be used whenever possible.
3. Family members should not be used to interpret for patients
4. The use of an interpreter and AT&T line as an interpreter should be noted in the chart.

### **XIII. MEETING REQUIREMENTS**

In accordance with ZSFG Medical Staff Bylaws, all active members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings and the annual Medical Staff Meeting.

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

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

**A. EMERGENCY DEPARTMENT STAFF MEETINGS**

1. Emergency Department staff meetings are held on the 2nd Tuesday of each month at 2:30 pm

The Emergency Department staff meeting will consist of:

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

2. Full-time faculty are required to attend 50% of medical staff meetings.
3. Part-time medical staff are required to read the minutes of the medical staff meetings and are held accountable for all information contained in these minutes.
4. Attendance and participation in the Departments weekly Residency Teaching conferences is determined by the Residency Program Director in consultation with the Department of Emergency Medicine Steering committee.

**XIV. ADOPTION AND AMENDMENT**

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

## ATTACHMENT A - EMERGENCY DEPARTMENT PRIVILEGE FORM

### Privileges for San Francisco General Hospital

Requested

Applicant: Please initial the privileges you are requesting in the Requested column.

Service Chief: Please initial the privileges you are approving in the Approved column.

#### ED EMERGENCY MEDICINE 2021

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

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#### 12.10 Core Privileges

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

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine.

PROCTORING: 5 observed cases

REAPPOINTMENT: Review of a minimum of 50 cases

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#### 12.20 Procedural Sedation

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

PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.08 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine and has completed at least one of the following:

- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year in the preceding 2 years or
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association

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

REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and has completed at least one of the following:

- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year for the preceding 2



years or,

·Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association

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### 12.30 Acute Trauma Care

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

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine.

1. Completion of ACGME-approved residency with Board certification/eligibility in Emergency Medicine, Internal Medicine, or Family Practice

2. Availability, clinical performance and continuing medical education consistent with current standards for Emergency Medicine physicians at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgery

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 5 cases

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### 12.31 Limited Privileges for Resuscitative Thoracotomy

Perform antero-lateral resuscitative thoracotomy for trauma, limited to the following circumstances:

\*When there is direct communication by phone between the Surgery and ED attendings (or Surgery fellow if the Surgery attending is unavailable).

\*The procedure must be performed by a member of the active or courtesy medical staff and not by a trainee.

PREREQUISITES: Current privileges in Actue Trauma Care

PROCTORING: One procedure satisfactorily performed in a thoracotomy cadaver training session within the previous three (3) years or equivalent.

REAPPOINTMENT: One procedure satisfactorily performed in a thoracotomy cadaver training session within the previous three (3) years or equivalent.

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### 12.40 Airway Management

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

PREREQUISITES: Currently Board Admissible, Board Certified, or e-Certified by the American Board of Emergency Medicine.

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

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

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### 12.50 Medical Toxicology

Evaluate, diagnose and provide consultative services to adult, adolescent and pediatric patients with clinical pharmacological and toxicological problems in the ambulatory and inpatient settings.

PREREQUISITES: Currently certificate eligible, certified or re-certified in Medical Toxicology

as authorized by a primary board of the American Board of Medical Specialties.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

**12.60 Ultrasound**

12.61 FAST (Focused Abdominal Sonography in Trauma)

Detection of pericardial or peritoneal fluid

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation of 25 studies. If evidence of 25 documented and reviewed studies from residency or another institution with completion of proctoring is provided, then

the requirement is documentation and review of 3 studies at [SFGHZSFG](#)

PEER REVIEW: Documentation and review of 3 studies

12.62 Pregnancy

Detection of intrauterine pregnancy or peritoneal fluid

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

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

documentation and review of 3 studies at [SFGHZSFG](#)

PEER REVIEW: Documentation and review of 3 studies

12.63 Focused Echocardiography

Detection of pericardial effusion, detection of any cardiac activity, and evaluation of global left ventricular systolic function.

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

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

documentation and review of 3 studies at [SFGHZSFG](#)

PEER REVIEW: Documentation and review of 3 studies

12.64 Aorta

Detection of abdominal aortic aneurysm

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

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

documentation and review of 3 studies at [SFGHZSFG](#)

PEER REVIEW: Documentation and review of 3 studies

12.65 Abdomen Right Upper Quadrant

Detection of gallstones, sonographic Murphy's Sign, pericholecystic fluid and gallbladder wall thickening

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

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

PEER REVIEW: Documentation and review of 3 studies

12.66 Renal

Detection of hydronephrosis and intrarenal calculi

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

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

PEER REVIEW: Documentation and review of 3 studies

12.67 Deep Venous Thrombosis

Detection of compressibility in the common femoral and popliteal veins

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

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

PEER REVIEW: Documentation and review of 3 studies

12.68 Pneumothorax

Detection of pneumothorax

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

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

is documentation and review of 3 studies at [SFGHZSFG](#)

PEER REVIEW: Documentation and review of 3 studies

**12.70 Waived Testing**

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges, providers satisfy competency expectations for waived testing by The Joint Commission.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology, or General Surgery.

PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.

REAPPOINTMENT: Renewal of privileges requires every two years

documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.

- A. Fecal Occult Blood Testing (Hemoccult)
- B. Vaginal pH Testing (pH Paper)
- C. Urine Chemistrip Testing
- D. Urine Pregnancy Test (SP Brand Rapid Test)

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**12.80 Evoked Potentials**

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified By the American Board of Emergency Medicine. At initial request of this privilege, mandatory training and minimum of 12 CME hours by the American Society of Electroencephalographic Technicians (ASET) or the American Academy of Audiology.  
PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with evoked potential privileges.  
REAPPOINTMENT: Review of 3 cases.

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**13.00 PEDIATRIC EMERGENCY MEDICINE**

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**13.10 Core Privileges**

Responsible for preventive medical services and medical care of patients under the age of 21. Provides patient management, including H&Ps and diagnostic and therapeutic treatments, as well as procedures and interventions, including the areas described below and similar activities.

Supervises house staff and students.

PREREQUISITES: Currently Board Admissible, Board Certified or Re-certified in Pediatric Emergency Medicine by the American Board of Pediatrics or American Board of Emergency Medicine.

PROCTORING: 5 observed cases

REAPPOINTMENT: Current demonstrated competence and documentation of successful treatment of a minimum of 50 patients for the past 24 months based on the result of quality assessment – improvement activities and outcomes.

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**13.20 Procedural Sedation**

Provides procedural sedation of all forms for pediatric patients under the age of 21, undergoing procedures in Emergency Services.

PREREQUISITES: Physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.08 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified or Re-certified in Pediatric Emergency Medicine by the American Board of Pediatrics or American Board of Emergency Medicine. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine, American Board of Pediatrics or Anesthesia or,

- Management of 10 airways via BVM or ETT per year in the preceding 2 years or,

-Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association.

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

REAPPOINTMENT: Completion of procedural sedation test as evidenced by a satisfactory score on the examination and has completed at least one of the

following:

- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine, American Board of Pediatrics or Anesthesia or,
- Management of 10 airways via BVM or ETT per year in the preceding 2 years or,
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association.

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### 13.30 Acute Trauma Care

Comprehensive emergency management of the acutely injured pediatric trauma patient up to age 15, providing initial resuscitation and management of acutely injured pediatric trauma patients

PREREQUISITES: Currently Board Admissible, Board Certified or Re-certified in Pediatric Emergency Medicine by the American Board of Pediatrics or American Board of Emergency Medicine. Availability, clinical performance and continuing medical education consistent with current standards for Pediatric Emergency Medicine physicians at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgery

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 5 cases

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### 13.40 Airway Management

Comprehensive management to control, protect and intubate the airway including medications, adjuncts and cricothyroidotomy in pediatric patients under the age of 21

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or American Board of Emergency Medicine.

PROCTORING AND REAPPOINTMENT: Physician will be assessed for proficiency by an expert in pediatric emergency airways. Demonstration of proficiency will occur by intubation of a standardized model or a patient and performance of the Seldinger technique for emergency cricothyroidotomy on a standardized model. This assessment should occur twice over the span of two years. Expert is defined as an individual who meets any of the following:

\*Serves as an instructor at a difficult airway course, including simulation labs conducted by the Department of Emergency Medicine

\*Serves on an advisory committee for a national body (ACEP, AAP, etc.) on topics related to emergency airways.

\*Requirements for one supervised intubation can be met by successful completion of one intubation on a pediatric patient.

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### 13.60 Ultrasound

Perform ultrasound in pediatric patients under the age of 21 as follows:

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#### 13.61 FAST (Focused Abdominal Sonography in Trauma)

Detection of pericardial or peritoneal fluid

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation of 25 studies. If evidence of 25 documented and reviewed studies from residency or another institution with completion of proctoring is provided, then the requirement is documentation and review of 3 studies at [SFGHZSFG](#)  
PEER REVIEW: Documentation and review of 3 studies

13.62 Pregnancy

Detection of intrauterine pregnancy or peritoneal fluid  
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours  
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at [SFGHZSFG](#)  
PEER REVIEW: Documentation and review of 3 studies

13.63 Focused Echocardiography

Detection of pericardial effusion, detection of any cardiac activity, and evaluation of global left ventricular systolic function.  
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours  
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at [SFGHZSFG](#)  
PEER REVIEW: Documentation and review of 3 studies

13.64 Aorta

Detection of abdominal aortic aneurysm  
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours  
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at [SFGHZSFG](#)  
PEER REVIEW: Documentation and review of 3 studies

13.65 Abdomen Right Upper Quadrant

Detection of gallstones, sonographic Murphy's Sign, pericholecystic fluid and gallbladder wall thickening  
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours  
PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution with completion of proctoring, then requirement is documentation and review of 3 studies at [SFGHZSFG](#)  
PEER REVIEW: Documentation and review of 3 studies

13.66 Renal

Detection of hydronephrosis and intrarenal calculi  
PREREQUISITES: Currently board admissible, certified or recertified by

the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

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

PEER REVIEW: Documentation and review of 3 studies

13.67 Deep Venous Thrombosis

Detection of compressibility in the common femoral and popliteal veins  
PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

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

PEER REVIEW: Documentation and review of 3 studies

13.68 Pneumothorax

Detection of pneumothorax

PREREQUISITES: Currently board admissible, certified or recertified by the American Board of Emergency Medicine and didactic instruction in ultrasound technology and imaging 16 hours

PROCTORING: Documentation and review of 25 studies is required. If evidence of 25 documented and reviewed studies from residency or at another institution, then requirement is documentation and review of 3 studies at [SFGHZSFG](#)

PEER REVIEW: Documentation and review of 3 studies

**13.70 Waived Testing (Under the age of 21)**

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care in pediatric patients under the age of 21. By obtaining and maintaining waived testing privileges, providers satisfy competency expectations for waived testing by The Joint Commission.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology, or General Surgery.

PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.

REAPPOINTMENT: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.

- A. Fecal Occult Blood Testing (Hemoccult)
- B. Vaginal pH Testing (pH Paper)
- C. Urine Chemistrip Testing
- D. Urine Pregnancy Test (SP Brand Rapid Test)

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**13.80 CTSI (Clinical and Translational Science Institute) - Clinical Research**

Admit and follow adult patients for the purposes of clinical investigation in the inpatient and ambulatory CTSI Clinical Research Center settings.

Prerequisites: Currently Board Admissible, Certified, or Re-Certified by one of the boards of the American Board of Medical Specialties. Approval of the Director of the CTSI (below) is required for all applicants.

Proctoring: All OPPE metrics acceptable

Reappointment: All OPPE metrics acceptable

\_\_\_\_\_  
CTSI Medical Director

\_\_\_\_\_  
Date

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

Department Chief signature: \_\_\_\_\_ Date: \_\_\_\_\_



**ATTACHMENT B - EMERGENCY DEPARTMENT POLICIES**

**Please refer to policies maintained in Clinical Service Office**

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

**Please refer to policies maintained in Clinical Service Office**

## **ATTACHMENT D - EMERGENCY DEPARTMENT HOUSE STAFF MANUAL**

**Please refer to policies maintained in Clinical Service Office**