THE RULES AND REGULATIONS OF THE CLINICAL STAFF

KAISER PERMANENTE PSYCHIATRIC HEALTH FACILITY – SANTA CLARA

2020

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OF KAISER PERMANENTE PSYCHIATRIC HEALTH FACILITY - SANTA CLARA
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INTRODUCTION

Pursuant to Section I-1-a, the Bylaws of the Clinical Staff of Kaiser Permanente Psychiatric Health Facility - Santa Clara, the following Rules and Regulations are adopted to become effective upon approval of the Board of Directors of Kaiser Foundation Hospital.

ARTICLE I: ADMISSION AND CARE OF PATIENTS

SECTION I-A. ADMISSION AND PROVISIONAL DIAGNOSIS.

A patient shall be admitted to the Facility only by a member of the Clinical Staff with admitting privileges. A provisional diagnosis shall be stated for each patient upon admission to the Facility.

1. The types of patients admitted shall be all psychiatric diagnostic categories with exceptions defined in policy and procedure.
2. Admissions may be voluntary if admission criteria is met and they sign a Request Voluntary Admission and Authorization for Treatment or
3. Involuntary, if the patient is admitted or detained at the facility and meets the criteria in Section 5150, 5250, 5260 or 5300 of the California Welfare and Institutions Code or other applicable law.

SECTION I-B. RESPONSIBILITY FOR MEDICAL, PSYCHIATRIC AND PSYCHOLOGICAL CARE

A member of the Clinical Staff shall be responsible for the care and treatment of each patient in the facility, for the timeliness, completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to the patient and/or relatives of the patient.

The attending physician has the responsibility for the complete and continuing care of his or her patients. He or she is required to keep appropriate facility personnel informed as to where he or she can be reached in case of emergency and shall designate at least one physician or render emergency or other necessary patient care if he or she is not available. It shall be the responsibility of the Executive Committee to establish policies and procedures regarding minimum requirements for rounding by the attending Clinical Staff.

SECTION I-C. PROTECTION OF PATIENTS.

All practitioners responsible for admitting patients to the Facility shall obtain and furnish, to all Facility personnel concerned, such information as is readily available and may be reasonable required for the protection of the patient from self-harm and for the protection of others from patients who are a source of danger.

SECTION I-D. PROVISION OF SERVICES.

Appropriate services, whether available in the facility or requiring outside referral, shall be offered to patients based on their clinical need, including patients who are mentally ill, who become mentally ill while in the facility, or who suffer from the effects of alcohol or other substances.

SECTION I-E. PROVISION OF PATIENT CARE.

Medically indigent patients who are admitted to the Facility shall be attended by members of the Clinical Staff.

SECTION I-F. TRANSFER OF PATIENTS.

A patient shall be transferred to another facility only when such transfer is authorized by the attending physician and has been agreed upon by an accepting physician and facility. The patient or the patient's legal representative, when he or she is reasonably available, shall consent to the transfer. When transferring a patient to another facility, arrangements are made in advance, the patient is notified of transfer or the person legally responsible for the patient (conservator) has been notified or unsuccessful attempts at notification have been documented over a twenty-four (24) hour period. The patient or the patient's legal representative, when he or she is reasonably available, shall consent to the transfer.

No patient shall be transferred to another facility where, in the opinion of the responsible practitioner, the transfer would be contraindicated.

Clinically unstable patients shall not be transferred unless: a) the patient is being transferred to a higher level of care and the risks of transferring the patient are outweighed by the benefits of the transfer; b) the patient insists on such transfer after being fully informed of the risks associated with the transfer.

A transfer summary shall accompany the patient upon transfer to another health facility. The transfer summary shall include information relative to the patient's diagnosis, known residual behaviors or symptoms of mental disorder, medications, treatments, dietary requirements, rehabilitation potential, and known allergies and shall be signed by the clinical director or the clinical director's designee

SECTION I-G. DISCHARGE OF PATIENTS.

Patients shall be discharged only upon the order of the attending practitioner or designated member of the Clinical Staff. When transferring a patient to another facility for treatment of a physical condition that requires more than routine care on an outpatient basis, the patient shall be discharged from the facility prior to the transfer. Should a patient leave the facility against the advice of the attending Clinical Staff member, or by elopement, a notation of the incident shall be made in the patient's medical record and the attending Clinical Staff member immediately notified. If the patient has left by elopement and does not return within 6 hours of the incident, the patient would be deemed to be discharged against medical advice.

SECTION I-H. ATTENDANCE OF PATIENTS IN EMERGENCY SITUATIONS.

Emergency services and care shall be provided to any person in danger of loss of life or serious injury or illness whenever there are qualified personnel available to provide such services or care. Such emergency services and care shall be provided without regard to the patient's race, color, ethnicity, sexual orientation, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental disability, insurance status, economic status, or ability to pay for clinical services, except to the extent such circumstances is clinically significant to the provision of appropriate care to the patient.

In the event that a member of the Clinical Staff requests another member of the Clinical Staff to respond to a patient or an emergency, the Clinical Staff member shall render appropriate

emergency care within his or her scope of practice and/or advice and shall assist in contacting the patient's attending Clinical Staff member.

The Chief of Clinical Staff shall establish policies and duty rosters of physicians, including physicians who serve on an "on call" basis, to provide coverage in emergency cases. In emergency situations, Clinical Staff members are required to attend patients until appropriately relieved.

SECTION I-I. QUESTIONING OF ORDERS.

Physician orders may be questioned by nurse and other personnel in accordance with professional practice standards and established facility and Clinical Staff policies.

SECTION I-J. RESOURCE REVIEW AND MANAGEMENT.

The attending practitioner is required to document the need for admission and continued hospitalization after specific periods of facility stay as identified and approved by the Executive Committee. This documentation must contain:

1. An adequate written record of the reason for admission or continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
2. The estimated period of time the patient will need to remain in the facility.
3. Plans for post facility care.

Upon the request of the Executive Committee, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient, including an estimate of the number of additional days of stay and the reasons therefor. This report shall be submitted promptly, within twenty-four (24) hours of receipt of such request. Failure of compliance with this policy will be referred to the Executive Committee for appropriate action.

SECTION I-K. REQUEST FOR EMERGENCY ASSISTANCE.

In the event that a member of the nursing staff requests a member of the Clinical Staff to respond to a patient or an emergency, the Clinical Staff member shall render appropriate emergency care and/or advice and shall assist in contacting the patient's attending physician.

The physician may take appropriate action in an emergency when there is a sudden marked change in the patient's condition so that action is immediately necessary for the preservation of the life or the prevention of serious bodily harm to the patient or others, and it is impracticable to obtain consent first. If psychoactive medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient. In such cases, the patient's consent to treatment shall be implied.

SECTION I-L. PROHIBITION OF SPLITTING OF FEES

The practice of dividing or splitting of fees, or offering, paying, soliciting or receiving remuneration as an enticement for the referral of patients for care services is prohibited.

ARTICLE II: MEDICAL RECORDS

SECTION II-A. GENERAL PROVISIONS.

1. Complete Medical Record: The attending practitioner(s) shall be responsible to assure that a complete, legible, dated and authenticated medical record is prepared for each patient accepted for care by the Facility. This record shall be in such form and shall contain such information as the Executive Committee and Facility Administrator shall jointly prescribe. Entries in the medical record may be electronic or hard copy. A medical record is complete when:

   a. its contents reflect the patient's condition on arrival, diagnosis, test results, therapy, condition and in-facility progress, and condition at discharge

   b. its contents, including any required clinical resume or final progress notes, are assembled and authenticated; and

   c. all final diagnoses and complications are recorded.

   The following minimum information shall be included, to the extent applicable:

   i. Identification data

   ii. Consent forms, on admission

   iii. History and Physical (within 24 hours of admission)

      a. Medical complaint(s)

      b. History of present illness

      c. Past medical history

      d. Allergy history, including allergies noted during facility stay

      e. Family history

      f. Social history

      g. Review of systems

      h. Physical examination

      i. Special reports covering all consultations, clinical laboratory examinations, x-ray examinations and similar information

      j. Provisional diagnosis

   iv. Psychiatric evaluation (within 24 hours of admission)

   v. A psychosocial assessment of the patient (within 72 hours)

   vi. A Rehabilitation assessment of the patient, within 72 hours

   vii. Multi-disciplinary Treatment Plan within 72 hours of admission (Saturdays, Sundays and holidays excepted)

   viii. Referrals to other providers and agencies

   ix. Evidence of informed consent

x. Medications, assessments, diet and treatments ordered

xi. Legal status of patients and authorization if applicable

xii. Emergency care provided to the patient prior to arrival, if any

xiii. Evidence of known advance directives

xiv. Consultation reports

xv. Clinical treatment recommended and carried out

xvi. Progress notes

xvii. Condition on discharge

xviii. Discharge summary

xix. Discharge instructions

xx. Post discharge plan

xxi. At the time of discharge, final diagnosis.

2. Timely Completion: After discharge of the patient from the Facility, records shall be promptly completed. No medical record shall be filed until it is complete, except at the direction of the Executive Committee. Records not completed within 14 days of the patient's discharge shall be considered delinquent. The Executive Committee shall make recommendations regarding handling of delinquent records and appropriate disciplinary action.

3. Signature and Authentication: As used in these rules and regulations, requirements for Practitioner signature may be met through handwritten signatures, signature stamps, or electronic signature. When a signature stamp or electronic signature is used, a statement shall be on file with the facility to the effect that the person whose name is on the stamp or electronic signature is the only person who has access to and will use the stamp or electronic signature.

   Each entry in the medical record shall be signed by the person making the entry, dated, and the time shall be noted. The date and time shall be the date and time the entry is made regardless of whether the contents of the note relate to a previous date and time.

4. Symbols and Abbreviations: A list of symbols and abbreviations which may not be used in the medical record shall be approved by the Executive Committee

5. Progress Notes: Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity and transfer of care. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be recorded by the responsible practitioner(s) not less frequently than daily or more often when warranted by the patient's condition.

SECTION II-B. PROTECTION OF MEDICAL RECORDS.

All medical records and other records, whether in hard copy or electronic form relating to the admission, care and discharge of a patient are the property of the Facility. The original documents shall not be removed from control by the Facility except as required by statue, subpoena, or court order. For purposes of this section, documents are to be considered under the control of the Facility if

in the possession of The Permanente Medical Group or at the corporate offices of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, Inc. or their respective attorneys. Medical record information may be released when authorized by the patient, his or her guardian, conservator, the administrator of the patient's estate, or when required by law. Bona fide clinical researchers may have access to medical records, providing they assure preservation of confidentiality of patient identity.

SECTION II-C. PATIENT CARE ORDERS.

Ordinarily, orders for patient care are communicated in writing. All written orders shall be dated, timed and signed. A written order may be hardcopy or in electronic form. Verbal orders may be given by a Practitioner with clinical privileges to a registered nurse, pharmacist, licensed vocational nurse, physical therapist or a respiratory therapist (within the lawful scope of their activities) and others as determined by the law and as authorized by the Facility Administrator. The person receiving the verbal order shall document the order and the name of the ordering practitioner in the medical record and date, time and sign the entry with his or her own name and title. The ordering practitioner, or another practitioner responsible for the patient's care, shall review and sign verbal orders within 48 hours, unless earlier review and signature is otherwise required by law or facility policy and procedure.

Whenever there is a significant change in the level of a patient's care, after appropriate evaluation, patient care orders shall be reviewed and revised.

SECTION II-D. SUPERVISION OF HOUSE STAFF

House staff shall be supervised in accordance with the Facility's policies and procedures. The attending physician shall document his or her involvement with the supervision of House Staff by complying with supervision documentation requirements, including, but not limited to, countersigning clinical reports, consultation, discharge summaries and history and physical examination reports and by reviewing and correcting medical record entries made by House Staff.

SECTION II-E. CONSENT.

The competent patient is entitled to be informed about the nature of the proposed therapeutic procedures, possible benefits, risks, reasonable alternatives to the proposed care or treatment, side effects related to the alternatives, risks of not receiving the proposed care, and potential complications. It is the Clinical Staff member's responsibility to convey the necessary information appropriate to the patient and the circumstances, in language which the patient is likely to understand, and to document this discussion in a separate entry in the medical record.

Except in emergencies, no patient shall be subjected to any therapeutic procedure that involves a significant risk of bodily harm unless informed consent is obtained from the patient or his or her legally recognized representative and all other persons, if any, from whom consent is required by law. The medical record should indicate the emergent reason for not obtaining consent.

In exceptional cases where the patient asks not to be informed, and/or where discussion of the risks or complications might, in the opinion of the Clinical staff member, cause greater harm to the patient than is warranted, the Clinical Staff member shall discuss the risks, complications, benefits and alternative treatments, if any, with individuals who would be an appropriate decision maker if the patient lacked capacity to make health care decision. Such a situation should be noted in the patient's medical record.

In cases where a patient is unconscious such condition will be documented in the medical record.

Special consents may be required, such as for patient photographs, or for educational purposes, and will be identified by the Executive Committee consistent with legal requirements. All such consents shall become part of the medical record.

SECTION II-F. DISCHARGE SUMMARIES/DISCHARGE NOTES.

A concise discharge summary shall be included in the medical records at discharge which contains: the reason for the hospitalization; significant findings; procedures performed and treatment rendered; the patient's condition at discharge; and instruction to the patients hospitalized for less than 48 hours with minor problems, a progress note that includes the above elements may substitute for the discharge summary. For the purpose of this section, a minor problem or intervention is a problem or intervention which does not pose a significant hazard to the patient.

ARTICLE III: CONSULTATION

SECTION III-A. CRITERIA FOR CONSULTATION

Except when consultation is precluded by emergency circumstances or is otherwise not indicated, the attending Practitioner shall consult with another qualified Clinical Staff member in the following cases:

1. when the diagnosis is obscure after ordinary diagnostic procedures have been completed;
2. when there is doubt as to the choice of therapeutic measures to be used;
3. in situations where specific skills of other physicians may be needed;
4. when other required by the Clinical Staff or Facility rules.

ARTICLE IV: MISCELLANEOUS PROVISIONS

SECTION IV-A. DUPLICATION OF LABORATORY PROCEDURES.

Laboratory testing done prior to Facility admission need not be repeated following admission if the tests have been carried out recently enough to be pertinent to the condition of the patient. A copy of the results of such reports shall be made a part of the facility medical record.

SECTION IV-B. EMERGENCY PREPAREDNESS.

In preparation for possible catastrophes and disasters, the Facility Administrator and Chief of Clinical Staff shall jointly be responsible for the establishment of an Emergency Operations Plan. The scope of this plan will relate to situations arising within the Facility and the community surrounding it. The operational aspects of the plan will be designed to coordinate to the greatest degree possible with area-wide disaster planning.

When the Emergency Operations Plan is activated, members of the Clinical Staff are to report to the Facility and will be required to participate consistent with the Emergency Operations Plan. Practitioners may provide services consistent with the scope of their respective facility privileges and

will be assigned to appropriate tasks during the emergency situation. The Emergency Operations Plan should be rehearsed at least twice a year, preferably as a part of a coordinated drill in which other community emergency service agencies participate. There shall be a written report and evaluation of all drills, which is prepared for and reviewed by Facility Administration and the Executive Committee.

SECTION IV-C. REGULATORY COMPLIANCE PROGRAM

All Clinical Staff members and practitioners who exercise clinical privileges shall comply with local, state and federal laws and regulations, accreditation standards and the Principles of Responsibility, and shall support and participate in the Regulatory Compliance Program.

SECTION IV-D. PATIENT SAFETY & SIGNIFICANT EVENTS

All Clinical Staff members and practitioners who exercise clinical privileges shall support and participate in the identification, reporting and investigation of suspected Significant Events and other patient safety improvement and risk reduction activities.

The foregoing Rules and Regulations of the Clinical Staff of
Kaiser Permanente Psychiatric Health Facility - Santa Clara, were adopted by the Active Clinical Staff effective:

10/12/20

Date

Chief of Clinical Staff

The Rules and Regulations of the Clinical Staff of Kaiser Permanente Psychiatric Health Facility - Santa Clara were approved by the Board of Directors effective:

5/14/2021

Date

Assistant Secretary

KAISER FOUNDATION HOSPITALS

CERTIFICATE

I, Bernice Gould, do hereby certify that:

1. I am the duly elected Assistant Secretary of Kaiser Foundation Hospitals, a California nonprofit public benefit corporation ("Corporation"); and

2. As Assistant Secretary of the Corporation, I have custody of the corporate records; and

3. Set forth below is a full, true, and correct copy of a resolution, which was adopted by the Quality and Health Improvement Committee ("Committee") of the Board of Directors of the Corporation at a meeting duly called and held on May 14, 2021.

RESOLVED, that the proposed amendments to the Bylaws and Rules and Regulations of the Clinical Staff of Kaiser Permanente Psychiatric Health Facility – Santa Clara are approved by the Quality and Health Improvement Committee on behalf of the Board of Directors of Kaiser Foundation Hospitals, effective May 14, 2021.

4. The foregoing resolution has not been amended, modified, superseded or repealed, and is, as of the date of this Certificate, in full force and effect; and

5. Attached hereto as Exhibit A is a full, true and correct copy of the Bylaws and Rules and Regulations of the Clinical Staff of Kaiser Permanente Psychiatric Health Facility – Santa Clara which were approved by the aforementioned resolution of the Committee.

IN WITNESS WHEREOF, the undersigned has signed her name this 14th day of May 2021.

Bernice Gould
Assistant Secretary

Exhibit A

Bylaws and Rules and Regulations of the Clinical Staff of Kaiser Permanente Psychiatric Health Facility – Santa Clara