INTRODUCTION

It is the goal of Langley Porter Psychiatric Hospital and Clinics ("the Hospital") at the University of California, San Francisco to serve the community by providing psychiatric/psychological care and, in so doing, to enrich our general and special training programs. Institutions and professions licensed by the State of California conduct their activities within a framework of law and government regulations that define standards of practice and institutional operation. The following Rules and Regulations augment such descriptions of good clinical practice and are designed to maintain the best possible interactions with patients and referring providers. Specific information about legal requirements or interpretations is available through the Director of Clinical Services of the Hospital or his/her designee.

PROFESSIONAL AFFAIRS

I. REFERRAL COMMUNICATION STANDARDS AND PROCEDURES

The following minimum communication standards apply to Medical Staff Members for all treatment provided at the Hospital.

A. As appropriate, a patient's written or documented verbal consent to release information is required for communication with referring and/or primary clinicians external to UCSF clinical enterprise.

B. Communications with referring and/or primary clinicians should be clear, complete and timely. In addition to providing information, communication should seek to involve the referring clinician in all major decisions concerning the care of the patient.

C. For inpatient and partial hospitalization programs, communications with referring and/or primary clinicians should be conducted by Attending Medical Staff Members whenever possible. The referring clinician should always be provided with the name and telephone number of the responsible Attending Medical Staff Member.

D. In the event of unanticipated inpatient and partial program admissions, the admitting physician should immediately contact the referring and/or primary clinician when admission is desired; this communication should include at least the following:

1. How the patient presented to the Hospital (if self-referred); the patient's current condition, indications for admission and treatment plan.

2. An understanding of the preferences of the referring and/or primary clinician regarding the patient's future care.

3. The name and telephone number of the Attending Physician (or senior House Officer) and expectations regarding future communication.

E. During treatment, communication should occur whenever there is a significant change in the patient's clinical status or in the treatment plan. For hospitalizations, communication should occur at regular (weekly) intervals.

F. Prior to discharge, the Attending Physician or their designee should telephone the referring provider and/or the next provider of care to communicate at least the following:

1. Patient's condition and principal diagnosis at time of discharge.

2. Plans for follow-up care including the anticipated role of the Hospital providers (when applicable) and the referring and/or primary clinician.

3. Expectations for communication during the follow-up including the name and telephone number of responsible Hospital providers.

4. At the point of discharge a written discharge plan detailing the patient's medication list and follow-up care will be faxed or sent directly to the next provider of care. Additionally, the Attending Physician will request that Health Information Management Service (HIMS) forward a written Discharge Summary, to the next providers of care including the primary care physician if appropriate.

G. Self-referred patients without a primary clinician will be referred for follow-up to an appropriate clinician, clinic or practice. These referral arrangements will include the communications outlined in section F. above.

II. MEDICAL COVERAGE OF HOSPITAL

There is a licensed House Staff member on-site at all times. House Staff are supervised by an Attending Physician at all times.

III. FACULTY PRACTICE COVERAGE

Faculty Medical Staff Members are responsible for the coverage of their individual patients at all times, unless otherwise determined by the President of the Medical Staff.

For all types of leave, faculty are required to arrange coverage by another faculty member. The name and contact information for the covering faculty member must at minimum be stated on the outgoing voicemail of the faculty member on leave.

It is expected that appropriate clinical information is communicated at the point of hand-off between the faculty member and the covering colleague.

III. SENIOR OFFICER OF THE DAY

Senior officers of the day (OD) assume medical coverage responsibility for the hospital on weekdays from 5:00 PM to 8:00 AM, on weekends from 5:00PM on Friday to 8:00am on Monday, and for 24 hours on all holidays.

Senior OD is required to:

A. Pick up the senior OD pager before 5:00pm at the Langley Porter front desk on the Monday of your call week.

B. Return the senior OD pager to the front desk no later than 10:00am on the Monday after your call week.

C. Use the Langley Porter senior OD pager while on call (443-1333). There are two senior OD pagers both programmed to 443-1333. If the senior OD is unable to be at Langley Porter on a Monday morning of the day their call starts to pick up the pager, the senior OD must pick up the 2nd pager the week prior, and then turn it on beginning Monday at 5 PM of their call week.

D. Make sure the pager is functioning and the battery is fresh (a battery icon will appear on the upper right corner of the display if battery is low or out). Senior OD should page the number 443-1333 to test the pager.

E. Check in with the resident OD between 5:00-8:00pm every weekday and every Sunday evening and before 10:00am every weekend day. (The resident OD on Sunday AMs is different from the OD on Sunday evenings, so both need to be called for check insurance. The on call resident can be paged at 443-1743. (An alternative is to call the front desk Hospital Assistant at 476-7296).

F. Understand the following guidelines for when the On-Call Resident is expected to contact the senior OD:

   1. Whenever the on-call resident has a question

   2. When patients judged to be at moderate to high risk of violence or suicide are being discharged

   3. When unplanned patient discharges occur from the Adult Inpatient Program

G. Return calls from the on-call resident within 15 minutes. Residents will report delays in response the following morning at sign out.

H. Failure to comply with any of the above rules and regulations may result in the senior OD being assigned one extra week of senior OD service.

1. Occurrences of failure to comply will be reported in writing to the Chair of the Credentials Committee. Excuses such as the pager being inadvertently turned off or a dead battery are not acceptable since it is expected that faculty check the pager to ensure it is functioning.

2. The Credentials Committee will investigate the alleged failure to comply. The Credentials Committee will report their findings and make recommendations to the Executive Committee of the Medical Staff. The Executive Committee of the Medical Staff will review the recommendations of the Credentials Committee. The President of the Medical Staff will inform the Medical Staff member if an extra week of senior OD service has been assigned.

3. The Credential Committee's report as well as a report of the actions taken by the Executive Committee of the Medical Staff will be forwarded to the Peer Review Committee.

IV. HOUSE STAFF

Residents of the University of California, San Francisco who are rotating through the Hospital are not eligible for Medical Staff membership. They shall abide by the Bylaws and Rules and Regulations of the Medical Staff to the extent these are applicable to their clinical performance, training, and education. Residents will be provided with a copy of the Bylaws and Rules and Regulations of the Medical Staff and informed of their responsibilities.

A. The Director of Clinical Services delegates oversight of clinical care provided by the house staff to Medical Staff members. In providing oversight, the Medical Staff member shall consider the resident's level of training.

B. The oversight responsibility of the supervising Member is to monitor the clinical activity of the resident. He/she shall review the medical records of the patients assigned to the resident and shall clinically assess the resident's actions. The supervising Member is accountable for the clinical care and documentation of the resident.

C. The rotation and assignment of residents shall be subject to the policies of the University and the Hospital.

V. CONSULTATIONS

The purpose of a consultation is to provide prompt and expert specialty evaluation, management advice, and a disposition that benefits the patient and meets the expectation of both the patient and requesting physician. It is expected that all clinicians will seek consultation from specialists regarding patients with a degree of complexity that extends beyond their identified area of expertise.

A. The attending physician determines the need for and authorizes consultations with other services concerning patients under her/his direct care pursuant to the following criteria:

1. Where the diagnosis remains obscure after ordinary diagnostic procedures have been completed

2. Where there are significant differences of opinion as to the best choice of treatment

3. In unusually complicated or high risk situations where specific skills of other practitioners may be helpful

4. For patients with underlying chronic problems where the consultation might reasonably be expected to assist in the patient's continuing care

5. When expert advice or services are necessary for the care of a specific patient and are outside the scope of basic services provided under the standard care of the Hospital

B. Medical staff members of UCSF Medical Center who are fully credentialed by their respective departments and approved for active medical staff privileges at UCSF Medical Center will be allowed to consult at Langley Porter Psychiatric Hospital and Clinics in the area(s) of their clinical specialty as defined by their privileges.

C. It is the responsibility of the Attending Physician to determine the need for and authorize consultations with specialists concerning patients under her/his direct care. Although a House Officer or fellow may prepare the consultant request, the consultation must be reviewed, confirmed, and the note countersigned by the participating consulting Medical Staff member who has examined the patient.

VI. ROLES AND RESPONSIBILITIES OF MEDICAL STAFF MEMBERS, RESIDENCY TRAINING AND TRAINEES

The roles and responsibilities of supervisees and trainees must be clear to ensure the safe and proper care of patients in situations where clinical trainees are educated.

SCOPE

These rules apply to all clinical supervisors who are involved in the guidance, observation, and assessment of clinical trainees enrolled in postgraduate medical programs at Department of Psychiatry , UCSF and to the clinical trainees, themselves.

DEFINITIONS

Clinical Trainees ("trainees" or “residents”) are doctors who hold a degree in Medicine and are continuing in specialist education in psychiatry. They are bound by the policies and procedures of Langley Porter Psychiatric Institute’s Adult and Child Residency Training Programs (https://moodle.ucsf.edu/course/view.php?id=1241)

The Clinic Attending is the physician or clinician who has final responsibility and is accountable for the clinical care of a patient.

Community Advisors, Modality-Specific Case Advisors and the APC Advisors are clinical teachers who are delegated by their respective training programs to guide, observe and assess the educational activities of the trainees. [1]

PRINCIPLES

The rules and regulations regarding the roles and responsibilities of Medical Staff, Residency Training and trainees are based on the following principles:

A. Appropriate care of the patient is central to the training endeavor.

B. Proper training, which respects the autonomy and personal dignity of both patient and trainee, optimizes patient care as well as the educational experience.

C. In order to obtain the best results from the educational experience, there should be joint decision-making and exchange of information between supervisor and trainee.

D. Trainees must actively participate in the provision of psychiatric care in order to receive the training they require for future independent practice; that is, they must have hands-on experience in a system of delegated and graded responsibility. By doing, as well as observing, trainees learn how to question, examine, diagnose, manage, and treat patients, and adopt the

[1] In the context of a training program, residents or fellows often serve in the role of clinical teachers, but do not act as most responsible physician for patient care.

necessary attitudes towards patients and their relatives, colleagues and other members of the health care team.

E. In collaboration with Residency Training, the Medical Staff defines and oversees the clinical activity of trainees to ensure quality of care.

RULES AND REGULATIONS REGARDING THE ROLES AND RESPONSIBILITIES OF MEDICAL STAFF MEMBERS, RESIDENCY TRAINING AND TRAINEES

These rules and regulations focus on professional responsibilities in the following aspects of medical education:

A. Supervision and Training

B. Evaluation and Promotion

C. Professional Relationships

D. Clinical Responsibilities

E. Reporting Responsibilities

F. Respecting Patient Rights and Consent to Treatment

G. Role in the Provision and Improvement of Quality Patient Care

A. SUPERVISION AND TRAINING

One clinician must always be designated the most responsible clinician for the patient's care.

The clinical supervisor must provide appropriate supervision to the trainee.

This includes:

1. being willing and able to see patients under his or her care when action is required or when requested;

2. ensuring that trainees to whom he or she is delegating have the appropriate knowledge, skill and judgment to perform the delegated act such that the patient is not put in jeopardy;

3. allowing trainees the responsibility appropriate to their level of training, commensurate with their ability and applicable regulations;

4. ensuring ongoing evaluation to determine the trainee's clinical competence and educational requirements;

5. meeting regularly with the trainee to discuss the trainee's assessment, management, and documentation of patient care;

6. ensuring that all relevant clinical information is made available for the best care of the patient.

The trainee should:

1. be willing and able to see patients and to report information to the supervisor and/or most responsible physician according to any guidelines laid down by the postgraduate program and clinical placement setting;

2. communicate with the supervisor and/or most responsible physician:

3. when a patient has a change in level of care;

4. when there is a significant change in a patient's condition;

5. prior to the patient's discharge;

6. when the patient or substitute decision-maker and family has significant concerns; and

7. in any emergency;

8. ensure that the supervisor and/or most responsible clinician is aware of the trainee's level of competence and educational requirements;

9. document his/her findings and management plans in the medical record and discuss these with the supervisor and/or most responsible physician.

B. EVALUATION AND PROMOTION

Clinical supervisors assess trainees' competencies on an ongoing basis. Communication about learning needs and performance occurs formally and informally throughout the academic year.

Supervisors submit formal written evaluations of resident trainees to Residency Training semi-annually. The Director of Residency Training or their delegate reports the promotion of trainees annually to the Medical Staff.

See Residency Training's Promotion Policy,
http://lpintra.ucsf.edu/p_and_p/Promotion.pdf

Resident trainees complete confidential evaluations of supervisors annually.

C. PROFESSIONAL RELATIONSHIPS

The most responsible clinician, clinical supervisor, and trainee should:

1. maintain an ethical approach to the care of patients;

2. maintain a professional supervisor-trainee relationship at all times, which includes:

    a. not exploiting the power differential that is inherent in the supervisor-trainee relationship;

    b. not becoming involved in situations involving conflicts of interest;

    c. not intimidating or harassing one another emotionally, physically or sexually;

3. maintain an appropriate professional relationship with all other colleagues, which includes not intimidating or harassing them emotionally, physically or sexually.

In addition, the most responsible physician/supervisor is responsible for providing a model of appropriate and compassionate care.

D. CLINICIAL AND EDUCATIONAL RESPONSIBILITIES

The specific training program in collaboration with the Medical Staff is responsible for defining the required educational experiences for trainees. Residency training in collaboration with the Medical Staff is required to provide the educational experience so that residents can demonstrate the following:

1. **Patient care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

2. **Medical knowledge** about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care

3. **Practice-based learning** and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

4. **Interpersonal and communication skills** that result in effective information exchange and teaming with patients, their families, and other health professionals

5. **Professionalism,** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

6. **Systems-based practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.

Additionally, Residency Training in collaboration with the Medical Staff must ensure that residents

1. develop a personal program of learning to foster continued professional growth with guidance from the teaching staff;

2. participate fully in the educational and scholarly activities of their program and, as required, assume responsibility for teaching and supervising other residents and students;

3. have the opportunity to participate on appropriate institutional and departmental committees and councils whose actions affect their education and /or patient care;

4. participate in an educational program regarding physician impairment, including substance abuse.

E. REPORTING RESPONSIBILITIES

1. Legal Reporting:

   Supervising clinicians and trainees are required to abide by all hospital and clinics reporting requirements as described in the Hospital Administrative Manual. Specific attention is directed to the following Hospital Administrative Policies and Procedures:

   #510 Tarasoff: Communication of Serious Threats of Physical Violence;

   #511 Assaults or Threats to Faculty, Staff and/or Trainees' Safety;

   #515 Abuse, Neglect, Child, Dependent Adult/Elder and Domestic Violence, Physical Assault, Rape, or Molestation: Identification and Reporting Of

2. Ethical Reporting:

   The Medical Staff and Residency Training affirms that the ethical clinician will contact both parties if another clinician exhibits behavior that would suggest incompetence or incapacity that compromises his/her ability to care for patients. This applies to the most responsible physician, clinical supervisor, or trainee.

3. Adverse Event and Error Reporting

   The Medical Staff and Residency Training affirm that clinicians will report all adverse events, errors or systems issues that may create an error. It is the understanding of the Medical Staff and Residency Training that the purpose of this reporting is to improve and protect the quality of care for patients and staff. See Hospital Administrative Policy and Procedure #107, Sentinel Event Management.

F. RESPECTING PATIENT RIGHTS AND CONSENT TO TREATMENT

Patients have the right to be fully informed about, and to refuse to participate in, medical education; however, alternative care arrangements may be required if a patient refuses treatment in a clinical teaching setting. The most responsible clinical supervisor and trainee are jointly responsible for trying to ensure that patients are aware of their rights in this context, and that such rights are respected.

Consent:

Patients must consent to treatment except in emergency situations or those in which LPS holds or court rulings apply. Patients entering teaching facilities will be notified of the educational nature of the patient care to be provided.

Special Situations

Incapable Patients:

When the patient is incapable of consenting to treatment, consent should be obtained from the appropriate substitute decision-maker as delineated by applicable laws.

Examination and Clinical Demonstration Solely For Educational Purposes:

When patient participation is purely for educational reasons, the patient must be notified and must provide consent. The most responsible physician and/or supervisor should ensure that the proposed examination or clinical demonstration is not detrimental to the patient, either physically or psychologically. An explanation of the educational purpose behind the proposed examination or clinical demonstration must be provided to the patient when obtaining the patient's informed consent.

G. ROLE IN QUALITY PATIENT CARE AND EDUCATION

Quality patient care is the cornerstone of quality education.

The Medical Staff, trainees and Residency Training have a shared responsibility in the maintenance and promotion of quality patient care which requires participation in performance improvement and adherence to evidence-based

medicine practices. It also requires adherence to reporting requirements (see Section E, #3).

Performance Improvement may be defined as the body of knowledge, attitudes and skills necessary to efficiently lead and continuously improve the multiple elements of care delivery within a medical practice. Evidenced Based Medicine has been defined as the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

Medical staff members are responsible for fostering attitudes which encompass the following:

a. A willingness to work on teams tasked with improvement initiatives

b. An awareness and positive attitude toward improving health care delivery

c. An understanding that performance improvement tools and methods can improve the care delivered.

All medical staff members are clinically responsible for identifying and communicating:

a. the best evidence available for the diagnosis and treatment of each clinical issue identified

All medical staff members must be able to define, weigh and provide education about various outcomes including:

a. Physical- the measurable physical outcomes of the patient as a result of health care provided

b. Service- access to care and patient satisfaction with care provided

c. Cost- appropriate use of resources and subsequent affect on costs in the care provided

PATIENT AFFAIRS

I. INPATIENT AND PARTIAL HOSPITALIZATON ADMISSIONS, DISCHARGES, AND TRANSFERS

A. Admissions

1. Eligible Patients

   Patients may be admitted to the Hospital by inpatient physicians or psychologists of the Medical Staff. Admissions will be arranged consistent with the Hospital's and assessment of level of care policies and procedures. Patients are informed of their anticipated financial liability upon admission or whenever practical thereafter.

2. Appropriateness of Higher Levels of Care

   Provision of the plan for utilization management including admissions and medical care is the responsibility of the Quality Council under its utilization review function. Patients must meet level of care criteria to be admitted to the inpatient or partial hospital programs. Day to day operations of utilization review is delegated to the Director of Patient Care Services.

3. Provisional Diagnosis and Other Admitting Information

   Patients admitted to the inpatient or PHP must have a diagnosis explaining the need for admission and a record of additional diagnoses which could affect the length of treatment. At the time of admission, the admitting physician must provide a brief treatment plan, estimated length of stay, name of referring (or primary) physician, and general demographic information.

4. Payers Requiring Prior Approval

   a. Admissions of patients with insurance requiring approval for elective admissions must be preauthorized under established procedures. Such admissions will be deferred until authorization is obtained.

   b. Prior authorization is not needed for an emergent admission. The insurance company will be contacted immediately following admission**, subject to the availability of insurance information and access to the insurance company by phone**. At this time, the admitting physician or their designee shall furnish the following information to an insurance company: the nature of the emergency, patient's condition, and the reason services were immediately necessary. An attempt at notification and documentation of the effort shall be documented on a 7 day per week/24 hour basis.

5. Education Programs

Physicians and the Patient Registration Staff shall inform patients that, while receiving care at the Hospital, all patients participate in the teaching programs of the University of California, San Francisco. This communication may occur via the Hospital terms and conditions form.

6. Admission Orders

There are no standard admission orders. Admission orders are individualized according to identified patient needs.

B. Discharges

1. Discharge Planning

The Discharge Planning Policy (Hospital Administrative Policy and Procedure #330) shall be followed for each patient.

a. Discharge planning should begin at or before the day of admission.

b. A preliminary discharge plan is formulated within 24 hours of admission and documented.

c. Problems related to implementation of the plan are documented in the medical record.

2. After Care Plan

A written after care plan is completed prior to discharge from inpatient status and is given to the patient, family, or other person designated by the patient on the day of discharge. With patient consent, a copy is forwarded to the next providers of care.

3. Discharge Summary

A written discharge summary is completed within 14 days of discharge from the inpatient or partial hospitalization programs. With patient consent, the discharge summary is routinely provided to the next provider of care. Refer to Section Three I.B.3.g for content requirements.

II. COMPLETE PHYSICAL

A. Patients will be screened for the need for a physical on admission.

B. Inpatients are required to have a complete physical exam on admission, unless they have a current and complete physical documented.

C. Physicals will be considered current if these have been completed within the last 30 days. A brief update is required if the documented physical exam has occurred in the last 30 days.

D. Physicals will be considered complete if these meet all Hospital criteria for a complete history and physical.

E. Physicals performed elsewhere must be made available via copy of fax at the time the patient presents for admission or will need to be repeated.

F. Incomplete physicals performed elsewhere must be completed and documented by the physician responsible for completing the physical.

G. Recent physicals for medically unstable patients or patients presenting with an altered mental status shall be repeated on admission.

H. There must be a comment on the physical exam form about whether or not exams were done and, if not, there must be a complete, accurate documentation as to why.

I. Admission orders. There must also be, within the medical record, a signed consent form for every psychotropic medication ordered for every patient.

J. Completion of consultation requests (e.g., chest, X-ray, EKG, etc.).

K. Patients who are unable to tolerate a complete physical exam on admission shall receive a heart and lung exam prior to the initiation of medication, unless they are unable to tolerate this also. In this case, medication may be administered if, in the opinion of the prescribing physician, the potential for risk due to lack of a physical exam is outweighed by the potential for benefit to the patient. Further attempts to complete the physical shall be made and documented daily.

III. COMMUNICABLE DISEASES AND INFECTION CONTROL

Each member of the Medical Staff has a personal responsibility and an opportunity to prevent the development and the transmission of infection in the patients and staff of the Hospital. Basic infection control practices, in particular hand washing, are an integral part of this process and should be practiced and encouraged by everyone. Medical Staff members are required to follow recommendations by the Occupational Health Service and/or Infection Control Service regarding coming to work sick, immunizations and related procedures. Failure to do so may result in restriction or loss of medical staff privileges.

Specific infection control policies and procedures are as follows:

A. Hand washing or use of alcohol gel as indicated is required before contact with each patient. Hand washing with antimicrobial soap and water is required if hands are visibly soiled.

   Aseptic technique is required for patient care procedures in which there is contact with blood or mucous membrane.

   Staff members with infections (e.g., any lesion draining purulent material, flu-like illness, varicella-zoster virus infection) are to refrain from patient contact to prevent transmission to patients and staff. If mild upper respiratory infection is present, hand washing is required before touching patient care items, and after coughing or sneezing.

B. Infection control procedures listed in the Infection Control Manual (available online and the inpatient nursing station) are to be followed by all staff members.

C. Patients with communicable infections must be placed on isolation or precautions, and appropriate procedures are to be followed.

D. Isolation or precautions, when appropriate, should be initiated as soon as the likelihood of infection (e.g., infectious diarrhea, lesion draining purulent material, or infection with resistant organism) is apparent.

E. Patients with varicella-zoster infections or measles are not to be housed on patient care units with immunologically incompetent patients. They are cared for in Airborne Precautions in a negative pressure room by staff that are immune to the patient's disease (verified by serum antibody titer or had 2 doses of varicella vaccine.

F. Patients with pulmonary tuberculosis are cared for in Airborne/AFB precautions in a negative pressure room and staff caring for the patient will wear a fit-tested N-95 respirator or powered air purifying respirator.

G. Patients with communicable diseases listed under, Reportable Diseases and Conditions, of the Infection Control Manual are to be reported to the San Francisco Health Department.

H. Blood and body fluid precautions shall be followed for all patients, regardless of risk category or diagnosis.

I. After a point exposure (such as needlestick, mucosal or conjunctival splash, open wound or skin abrasion), a health care worker, on a voluntary basis, will be followed and tested for HIV antibody according to a pre-arranged schedule.

J. Blood and body fluid precautions shall be observed in the hospital; additional measures shall be taken to minimize sharp instrument exposure.

IV. CONSENT FOR ORGAN AND TISSUE DONATION

A. Definition of Brain Death

An individual, who has sustained irreversible cessation of all functions of the entire brain, including the brain stem, as determined by accepted medical standards, is dead. There shall be independent confirmation of the death by another physician. Neither the physician making the determination of death nor the physician making the independent confirmation shall participate in the procedures for removing or transplanting a part (California Health and Safety Code, Sections 7180-7182).

B. Procedure

Within one hour after death is declared, the California Transplant Donor Network must be informed. The California Transplant Donor Network can be reached 24 hours daily at 1-800-55-DONOR. The California Transplant Donor Network will inform the Tissue Bank, which will contact Langley Porter to determine the deceased individual's suitability for tissue donation. The Tissue Bank will make any family contact. The Tissue Donation Policy (Hospital Administrative Policy and Procedure #611) shall be followed for a patient death.

V. CALIFORNIA NATURAL DEATH ACT/DURABLE POWER OF ATTORNEY FOR HEALTH CARE

A. The Medical Staff of the Hospital recognizes the rights of patients in the determination of their health care and the dignity and privacy which patients have a right to expect. California law provides that a patient,

while competent, may designate another to make decisions on his/her behalf should he/she become mentally incompetent (Durable Power of Attorney for Health Care). A patient may also execute an advanced directive to the physician giving instructions regarding treatment (California Natural Death Act). In those cases where a valid directive has been executed and the patient's condition is within the defined limits of the Act, the Medical Staff is prepared to honor the directive or otherwise comply with the law. In the absence of a directive, the Medical Staff will continue to respect the patient's rights, dignity, and privacy and will render appropriate treatment consonant with the wishes and needs of the patient as well as the best standards of medical practice.

B. Information about the California Natural Death Act and the Durable Power of Attorney for Health Care (California Civil Code, Sections 2410-2443) is made available to inpatients on admission or when clinically appropriate.

1. A copy of the California Natural Death Act and explanatory material prepared by the California Hospital Association will be given to patients upon request.

2. Information about Durable Power of Attorney for Health Care and appropriate documents provided by the California Medical Association will be made available to patients upon request.

C. If a patient presents a directive under the California Natural Death Act or a Durable Power of Attorney for Health Care, the physician must discuss the meaning and intent of the document with the patient. Since the Durable Power of Attorney for Health Care transfers authority for decision making about health care from the patient to his/her designee when the patient is no longer able to make such decisions, the significance of this decision should be reviewed with the patient.

D. When a patient presents a validly executed directive, the original of the directive will be placed in the patient's medical record and a copy of the directive will be given to the patient.

E. Medical Staff shall be aware of the contents of the California Natural Death Act and the Durable Power of Attorney for Health Care.

F. No Medical Staff Member may be a witness to a directive relating to delivery of health care services.

G. If a directive under the California Natural Death Act or Durable Power of Attorney for Health Care is revoked, the time, date and place of the revocation will be recorded in the patient's medical record. The attending physician must be notified of such revocation.

VI. PATIENT RIGHTS IN CALIFORNIA

All patients in acute psychiatric hospitals, whether voluntary or involuntary, have basic rights that must be maintained. In accordance with Title 22, Section 70707 of the California Administrative Code, the Hospital and the Medical Staff have adopted the following list of patient rights:

A. Exercise these rights without regard to ***race, color, national origin, religion, gender, physical or mental disability, medical condition, ancestry, marital status, age, sexual orientation, gender identity, citizenship, or status as a covered veteran (special disabled veteran, Vietnam era veteran, or any other veteran who served on active duty during a war or campaign or expedition for which a campaign badge has been authorized))*** *or by source of payment, subject to state and federal laws and regulations.*

B. Considerate and respectful care.

C. Knowledge of the name of the physician who has primary responsibility for coordinating the care and the names and professional relationships of other physicians and non-physicians who will see the patient.

D. Receive information from the physician about the illness, the course of treatment, and the prospects for recovery in terms that the patient can understand.

E. Receive as much information about any proposed treatment or the procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate course of treatment or nontreatment and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.

F. To be informed of outcomes of care, including unanticipated outcomes.

G. Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment.

H. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.

I. Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care.

J. Reasonable responses to any reasonable requests made for service.

K. Leave the hospital even against the advice of physicians except when treatment is being administered involuntarily under California Code.

L. Reasonable continuity of care and to know in advance the time and location of appointment as well as the identity of persons providing the care.

M. Be advised if hospital/personal physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects.

N. Be informed of continuing health care requirements following discharge from the hospital.

O. Examine and receive an explanation of the bill regardless of source of payment.

P. Know which of the Hospital rules and policies apply to the patient's conduct while a patient.

Q. Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

R. Additional Rights for Mental Health Inpatients under California Code:

1. To wear your own clothes.

2. To keep your personal possessions.

3. To keep and be allowed to spend a reasonable sum of your own money for small purchases.

4. To have ready access to letter writing materials, including stamps.

5. To use the phone.

6. To see visitors.

7. To receive unopened mail.

8. To have private storage space.

9. To see and receive the services of a Patient Advocate who has no direct or indirect clinical or administrative responsibility for treatment.

VII. DENIAL OF RIGHTS

A. Mental health patients' rights can only be denied for good cause.

B. Only an authorized member of the Medical or Nursing staff can make a denial.

C. All denials and justification for denials must be noted in the medical record.

D. Rights must be restored as soon as the cause for denial no longer exists.

PATIENT CARE DELIVERY

I. MEDICAL RECORDS

A. Definition, Ownership, Control

1. Medical records are legal documents and are the property of the Hospital. Medical Records are under the custody of the Health Information Management Service (HIMS).

2. Medical records contain valuable and confidential information and are to be safeguarded against loss, defacement, tampering, or use by unauthorized persons. Nothing shall be removed or deleted from a medical record, and no irrelevant or facetious notations may be made in them.

3. Information may not be released from the medical record nor copies made thereof except by designated individuals following written guidelines (see the Hospital Administrative Manual, HIMS Manual and California Hospital Association Consent Manual). Patient's questions, while in treatment, about the content of records should be referred to the attending physician or attending clinical psychologist. Following discharge, patient’s questions about records are referred to HIMS.

4. Medical records are to be in HIMS or at the site of patient care service. Medical records may be used outside the HIMS for specific occasions, such as conferences and meetings. Persons with records checked out to them must always have them immediately available for patient care. Records are not to leave the Hospital except pursuant to a court order, subpoena, or statute.

5. Medical records may be borrowed only by authorized borrowers, who must adhere strictly to established guidelines for request and return of records as stipulated in the Hospital's Policies and Procedures Manual.

6. Medical records requested by outpatient staff must be returned within twenty-four hours. Medical records requested by PHP or AIP staff may remain on the service for the duration of the patient’s stay.

7. Use of medical records for research shall be governed by procedures adopted by the Executive Committee of the Medical

Staff, fulfilling its role in oversight of HIMS function of the Quality Council. The following are criteria for research review:

a. Approval must be obtained from the UCSF Committee on Human Research if the researcher plans to contact the review patient related material or contact the patient directly.

b. Record must be requested from Medical Records with 72 hours advance notification.

d. No more than 25 at a time may be requested.

B. Content of Medical Records

1. Complete and accurate medical records are indispensable for the proper care of patients, and are the focal point of communication among Hospital personnel. See HIMS Policy & Procedures for complete listing of chart contents by service area.

Documentation of Medical Care

2. Medical records must be signed, legible, and up-to-date. Documentation must be completed within one business day of the date of service.

a. Unless identified by physician number, all entries shall include an appropriate title (Clinical Nurse II, Social Worker II, Pharmacist) and printed name in addition to the signature and date.

b. “Do Not Use” abbreviations are not be used in any written patient care communications including orders. For a complete list of “Do Not Use” abbreviations see HIMS Policy and Procedure Manual.

C. Completion of Medical Records

1. Medical record documentation serves as a primary method of the communication of patient care information and documents the services provided to the patient. To this end, it is expected that documentation be completed in a timely manner that facilitates the care of the patient and demonstrates the nature and depth of services provided to the patient.

2. All patient care documentation should be completed within 24 hours or within the guidelines specified by the specific clinical service and state/federal regulation.

3. Notes and entries made in the medical record should always include the date and time they were made and the clinician's signature. Thus the date of an entry reflecting a correction should be the date the correction was made, not the date the error was made, with a line through the corrected information with the initials of the writer. Any appropriate cross-referencing should be placed in the record when necessary to explain the correction.

4. The Attending Physician or Clinical Supervisor is responsible for the completion of records of his or her patients or the records of the trainees he/she supervises.

5. It is the responsibility of the Chief of Service to see that medical records are completed by members of their services according to the established Hospital and Clinic guidelines and policies.

5. HIMS routinely monitors the accuracy, completeness and timeliness of medical staff member documentation.

6. Failure to complete medical record documentation within the specified guidelines may result in loss of privileges for the Attending Physician, Psychologist or Allied Health Member.

II. PHYSICIAN ORDERS

A. General Policy

Orders must be written and signed by the Attending or House Staff Physician responsible for the patient's care.

C. Written and Verbal Orders

Treatments, diagnostic procedures, and administration of medications are carried out by a nurse upon written order of the Medical Staff. When a written order is indicated but cannot be made, a verbal order may be accepted by a registered nurse. A verbal order for medication may be accepted by a registered nurse or licensed pharmacist. All verbal orders must be transcribed, dated, timed and signed by the authorized recipient

in the patient's medical record, and must be countersigned by a licensed physician within the shift, whenever possible. Verbal orders must be countersigned within 24 hours. The one exception to this time frame is Special Treatment Procedures (refer to section VIII).

E. Medical Students' Orders

Medical student orders will not be taken off until they are co-signed by the responsible House Staff member or Attending Physician.

F. Review and Countersignatures

The Attending Physician shall write a note in the chart of each patient approving, correcting, or supplementing the recorded workup of the resident.

G. Medication Orders

1. Medications are available through a hospital formulary system.

2. Drugs required for appropriate treatment that are not listed in the Formulary may be ordered with a Non-Formulary Request. This request may be approved by the chief pharmacist or designee.

3. Approval (in the form of a co-signed order) from an Attending Physician is necessary for out-of-range dosages and for novel use of medication. Novel use of medication refers to unstudied and unreported use in the medical literature. Documentation of rationale for out-of-range dosing and for novel use of medication must be entered into the progress notes of the medical record.

4. PRN orders need specific behavioral criteria or target symptoms for their administration and must have a specified total dose amount for a 24-hour period.

5. No psychiatric medication will be passed by the nursing staff until there is a signed consent form specifying the medication and the dose range except in emergency situations.

H. Psychoactive Medication Consents

1. Each prescriber has the primary responsibility of giving patients specific written medication information.

2. A written medication consent must be completed with all inpatients for each psychoactive medication. The consent process must be implemented by the prescriber and may not be delegated.

3. All inpatients, whether voluntary or involuntary, shall be treated with psychoactive medications only after such person or legally authorized representative has been informed of the right to accept or refuse such medications and has consented to the administration of such medication.

4. The only exceptions are cases of specifically defined emergencies.

5. A consent form must be completed for each therapeutic class of medication ordered.

6. Guidelines for content of consent forms are provided in the Hospital's Administrative Policy and Procedure Manual #430.

7. If the patient signs with an "X" or other mark, the mark must be witnessed by a member of the treatment staff as the patient's mark.

8. If the patient refuses to sign the consent form but is willing to give verbal consent, the physician must document the verbal consent on the consent form and must have the form witnessed by another staff member who saw the patient give verbal consent.

9. Patients who fail to give consent, either in writing or verbally, cannot be medicated except:

   a. In emergencies, or

   b. When adjudicated to receive involuntary medication treatment (Riese).

I. Orders Not to Resuscitate (Guidelines for Foregoing Life-Sustaining Treatment)

1. Policy

   a. The policy of the Hospital is to provide high quality medical care to its patients to sustain life. The Hospital has a standing order to initiate cardiopulmonary resuscitation for any patient who suffers cardiac or respiratory arrest. In the absence of an order not to resuscitate, cardiopulmonary resuscitation must be initiated.

b. Any exception to this standing order constitutes an order not to resuscitate.

(1) The refusal of life-sustaining treatment by a competent and adequately informed adult should be respected.

(2) When it is the judgment of the Attending Physician that the patient is suffering from an incurable, irreversible disease and that the patient's death is imminent, life-sustaining treatment may be withheld. The patient should be so informed, unless the physician determines that such disclosure would be harmful to the patient.

(3) A patient may not compel a physician to provide any treatment that in the professional judgment of the physician is unlikely to provide the patient with significant benefit.

(4) If the attending physician judges that life-sustaining treatment should be withheld and the patient is unwilling to forego such treatment, consultation is required. The attending physician will obtain consultation from another physician not previously involved in the patient's care. The attending physician will request an ethics consultation by contacting the President of the Medical Staff, the Director of Clinical Services or the Ethics Committee.

(5) When a patient suffers from mental impairment that makes consent impossible, a patient surrogate should be consulted regarding the order not to resuscitate. The patient surrogate may be the patient's next-of-kin or a health care agent designated by a Durable Power of Attorney for Health Care. When a patient has transferred authority for health care decisions in accord with the Durable Power of Attorney Act, that agent acts as if she/he were the patient.

(6) Orders not to resuscitate may be written for minors when it is the judgment of the Attending physician that the patient is suffering from an incurable, irreversible disease and that the patient's death is imminent. Permission should be granted from the patient's parents or legal guardians.

2. Procedures

a. When it is determined that a particular life-sustaining procedure is to be foregone and the above procedures have been followed, an order not to resuscitate must be written into the patient's medical record by the Attending Physician or a designate as directed by the Attending Physician. A verbal communication from the Attending Physician to a resident physician can be entered in the order sheet, but must be signed by the Attending Physician within 24 hours. Such verbal communication must be witnessed by at least one other witness. The medical reasons for the order, the circumstances regarding consent and discussions with the family and all consultations must be recorded in the progress notes.

b. When an order not to resuscitate is entered in the order sheet, this should be communicated to all relevant providers of care, including consultants involved in the care of the patient.

c. All other care shall be continued unless specific directives to discontinue are given or the patient is declared dead. This would include continuation of ventilator support, cardiac support, and administration of medications as needed.

d. The circumstances justifying an order not to resuscitate shall be reevaluated as the clinical situation changes. The results of the reevaluation should be documented in the progress notes.

e. The order not to resuscitate shall stand unless explicitly rescinded by the Attending Physician or by the patient.

III. CONSENTS, PERMITS, AND LEGAL AFFAIRS

A. Consents and Permits

1. General Consent

General consent to treatment must be signed when patients are admitted for treatment in the Hospital. It provides a record of consent to routine services and medical treatment and informs the patient of participation in the educational programs of the Hospital.

A general consent cannot be used as a consent for specific procedures.

2. Special Consent

   a. Obtaining a patient's informed consent for medical procedures is the responsibility of the Attending Physician. An alternate (licensed) physician may be designated to obtain the patient's consent and signature on the proper form if, in the opinion of the Attending Physician, the alternate (licensed) physician is knowledgeable of the benefits and inherent risks of the procedure and alternative procedures. In the event that the consent and signature are obtained by a designated alternate licensed physician, he/she will be responsible for advising the patient and specifying on the form the name of the physician who will perform the procedure, or inserting a statement that the procedure will be performed (supervised) by a member of the Attending staff. The patient's consent and signature attesting to the consent must be obtained before beginning any medical or surgical procedure which involves special risk to a patient.

   b. It is the responsibility of the physician who is to perform the procedure (or his designated alternate, licensed physician) to fully inform the patient about the procedure, the alternative methods, and the complications or risks (and to assure that the patient's signature is on the proper consent form), and to make an appropriate entry in the medical record.

   c. Any questions as to the necessity of obtaining a special consent from patients should be resolved in favor of obtaining consent.

   d. Examples of situations in which special consents must be obtained follow.

      (1) All non-operative procedures which involve more than a slight risk of harm to patients, or which involve the risk of a change in patients' body structures.

      (2) Release of information to the press or media and the taking of photographs, films, or published images or recordings teaching or research purposes.

      (3) Participation in clinical research protocols.

(4) Administration of investigational drugs.

(5) The next of kin of any patient who dies while under inpatient care will be approached by the attending physician to obtain consent for autopsy.

3. Implied Consent in Medical Emergencies

In an emergency that threatens the life or health of a patient, treatment without a written consent is authorized by law under the doctrine of implied consent. This is based on the theory that if the patient were able to, or if a legal representative were present, such consent would be given. Proceed as follows:

a. Determine whether the treatment is required immediately and is necessary to prevent deterioration or aggravation of the patient's condition.

b. Assess the possibilities of obtaining the necessary written consent, weighed against the possibility that delay would jeopardize the health of the psychiatric patient.

c. Obtain medical consultation to determine whether or not an emergency exists. Two physicians must sign the authorization attesting to the existence of an emergency when the patient is unable to sign.

4. Involuntary Psychiatric Hospitalization

a. At each phase of the involuntary procedure, the same criteria must be met. The patient is mentally ill and due to the mental illness, the patient is a danger to himself and/or to others and/or is gravely disabled (defined as the inability to provide food, clothing, or shelter for himself or herself).

b. Involuntary Hospitalization (Types)

(1) 5150 (72 hour evaluation)

(2) 5250 (Certification for a fourteen-day intensive treatment)

(3) 5260 (Post certification Proceedings for Persons Deemed a Danger to Self)

(4) Conservatorship for Gravely Disabled Persons

c. Hearings

(1) Probable Cause Hearings: Involuntary patients who are served a 5250 must be notified that they have a right to a hearing. The purpose of the hearing is to have a court appointed hearing officer determine if the hospital has grounds for the 5250 certification. The hearing officer makes a determination based on probable cause for danger to self, others and/or grave disability. Testimony is given by the primary therapist, and each patient also has an attorney who represents him or her. If the finding of the hearing officer is that there is no probable cause for further involuntary treatment, patients may be offered voluntary hospitalization. However, if the patient so chooses, he/she has the right to leave the hospital.

(2) Writ of Habeas Corpus: Following the probable cause hearing, the patient, if probable cause has been found, may elect to request a writ of habeas corpus and have a hearing in the superior court. Any patient, stating that he/she desires to leave the hospital MUST be told that he/she has a right to a writ hearing. The patient contacts the San Francisco Public Defender's office to request the hearing. If the patient is unable to do so, the staff assists the patient to complete the call. The Superior Court will determine if the patient can be held involuntarily. The patient will either be released by the Court or returned to the Hospital to continue involuntary treatment.

5. Involuntary Psychotropic Medication Treatment

a. Non-emergency Situations:

Involuntary patients, who are competent, have the right to refuse psychotropic medications. If the treatment team believes that the patient needs psychotropic medications and that the patient is not competent to make a decision about medications, a Reise hearing (competency hearing) is requested. The Hearing Officer will determine if the patient is competent to refuse psychotropic medications. If the patient is deemed not competent to refuse psychotropic medications, the staff is authorized to administer these medications to the patient. If the patient is deemed to be

competent, the staff may not administer medication (absent an emergency).

b. Emergency Situations

Emergency medications can be administered to patients who are judged to be in imminent danger to themselves or others. Medication must be limited to that which is required to end the emergency. Medication that may result in serious, life threatening side effects resulting from sudden discontinuation, may be tapered.

6. Patient Refusing to Take Medical Advice

Patients not meeting involuntary criteria may not be detained without consent to treatment. All patients leaving against medical advice must be asked to sign a special release form. Notation should also be made in the medical record of the A.M.A. discharge and of the patient's condition at discharge.

B. Other Legal Affairs

1. Legal Documents

The following certificates are required by law:

a. Death (details available in the Morgue Pack). A licensed physician completes and signs the Death Certificate. The physician in charge of the patient notifies the family.

b. Autopsy Permit

(1) It is essential that all persons concerned with the care of a dying patient give their whole-hearted cooperation toward securing permission for a post-mortem examination.

(2) If a family is unwilling to consent to a complete autopsy, a limited autopsy may be suggested.

(3) A family's wishes regarding an autopsy must be respected except in Coroner's cases

2. Unusual Incident

a. An unusual incident is any event which will, could or did harm a patient or visitor. Incidents will be reported within 24 hours by a nurse, physician, or other staff member witnessing the incident via the Hospital online incident reporting system (\\lpdocsrv\clinical\incident reporting).

b. Failure to report incidents may be grounds for disciplinary action by the Executive Committee of the Medical Staff.

c. The attending physician or his/her designee shall inform the patient or patient's representative about outcomes of medical treatment and procedures whenever those outcomes differ

outcomes differ significantly from the anticipated outcome. In the event of an unanticipated outcome resulting in harm to the patient, Risk Management may be consulted prior to discussion with the patient or family.

d. All adverse events as outlined in the Hospital Administrative Policy and Procedure Manual, Sentinel Event Management Policy #107, will be reviewed according to policy. The purpose of the review is to prevent similar adverse events from occurring in the future.

3. Service of Legal Papers

Members of the Medical Staff are served any legal paper concerning their clinical activities at the Hospital, they should immediately notify the Director of Clinical Services, Director of Patient Care Services and the Office of Risk Management.

4. Contact by Investigator

A physician contacted by any government or private investigator regarding patient care activities within the Hospital should contact the office of the Director of Clinical Services and the Director of Patient Care Services before submitting to questioning.

5. Findings Reportable to Government Agencies

Physicians are responsible for reporting a variety of diseases and crime-related wounds and injuries to the police, coroner, or other government agencies. Specific requirements are enumerated in Hospital Policies and Procedures Manual.

IV. EMERGENCY SERVICES

A. There are no Emergency Services available at the Hospital.

B. Patients requiring emergency service will be attended via emergency consultation or service at the Moffitt-Long Emergency Room at UCSF Medical Center.

C. Disaster Plan

Members of the Medical Staff shall be familiar with the Hospital Disaster Plan and the Campus Emergency Operations Plan. Medical Staff Members shall be prepared to assume critical roles in disaster drills or in a real disaster.

V. ASSESSMENT AND MANAGEMENT OF POTENTIAL SUICIDES

Ongoing assessment, management, and documentation of potential suicidal behavior is a shared responsibility of all disciplines. The Attending Physician with the aid of the House Staff is responsible for the evaluation and documentation of suicide risk and decision as to action to be taken, if any. This evaluation should be carried out without delay. Risk evaluation should be repeated as frequently as the patient's condition dictates. Detailed procedures appear in the Hospital Policy and Procedures Manual.

VI. SPECIAL TREATMENT PROCEDURES

A. Definitions:

1. Seclusion: The involuntary confinement of a patient locked alone in a room and thereby physically prevented from leaving the room. Seclusion occurs for any period of time in order to protect the patient/others from injury.

2. Restraint: Use of a physical or mechanical device to involuntarily restrain the movement of the whole or a portion of a patient's body as a means of controlling his/her activities in order to protect him/her/others from injury. This includes restraints applied for postural support/fall prevention (precautionary restraint) and for behavioral control.

3. Chemical Restraint: Use of a sedating psychotropic medication, not otherwise part of the patient’s treatment plan, to manage or control behavior.

B. Physician Orders:

1. Seclusion and/or restraints require a specific physician's orders which must be time limited and written for a specific episode that demonstrates the need for protection from injury to patient/and/or

others. Each order must include specific behavioral criteria for release.

2. The order must specify the type of restraint to be used (i.e., 4-point locking geriatric chair)).

3. Each order must be time-limited not to exceed 4 hours for patients 18 years or older and 2 hours for patients 16 to 17 years old.

4. Any pre-existing conditions or physical disabilities that would place the patient at greater risk during seclusion and restraint, as well as any history of physical or sexual abuse, is documented in the medical record.

5. The ordering physician must see and assess the patient and document the patient's condition in the medical record within one hour of the initiation of seclusion and/or the application of restraint.

6. Nursing staff may initiate the use of seclusion and/or restraints in the case of emergency with patients who have not responded to less restrictive alternatives, to be followed by a physician order and face-to-face physician assessment within 1 hour.

7. Nursing staff will debrief with the patient as soon as appropriate but no longer than 24 hours after the incident.

8. When an order for seclusion and/or restraint expires and the patient continues to require seclusion and/or restraint, a new, specific physician order is required.

9. A patient who continues to require seclusion and/or restraint must be evaluated in person by a physician every 8 hours for individuals 18 years of age or older and every 4 hours for individuals 16 to 17 years old.

10. Patients who are secluded and/or restrained shall be placed on an involuntary detention EXCEPT when restrained for postural support and/or prevention of falls.

11. Patients, who are secluded, whether or not they are restrained, shall be considered to have all their rights denied and this will be specified in the physician's order for seclusion. The denial of rights associated with seclusion will be continued only as long as the patient is secluded. All rights will be restored upon release from seclusion. Patients who are restrained but not secluded will not be considered to have any rights denied by the fact of their restraint;

need for the denial of any specific right will be individually assessed and ordered if clinically indicated.

VII. SMOKING IN THE HOSPITAL

There shall be no smoking within the Hospital.

VIII. NAMETAGS

While on the premises and in contact with patients, Medical Staff Members are required to wear a name tag that clearly state their name and position.

IX. RELEASE OF PATIENT INFORMATION TO PRESS/MEDIA

The UCSF Public Relations is responsible for initiating and handling all press/media inquiries about patients, clinical developments, research and all other campus matters. All staff members should consult with this department prior to any press contact. The Hospital abides by the guidelines and procedures of UCSF Public Relations. If you are contacted by the media, contact UCSF Public Relations at 415-502-NEWS (6397).