UCLA Resnick Neuropsychiatric Hospital

RULES AND REGULATIONS

OF THE

PROFESSIONAL STAFF

2020

SECTION 1. ADMISSIONS

A. No patients shall be denied admission to the Stewart and Lynda Resnick Neuropsychiatric Hospital (R-NPH) based on gender, race, creed, disability or national origin.

B. Patients shall be admitted only upon written order of a physician.

C. Except in an emergency, no patient shall be admitted to the R-NPH until a provisional diagnosis has been stated. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.

D. Practitioners who refer private patients for admission to the R-NPH shall be held responsible for giving information necessary to assure the protection of those patients, or of other persons if the referred patients are in any way a source of danger.

E. A medical history, physical examination, mental status examination, and initial treatment plan shall, in all cases, be written in the medical record within 24 hours of admission of the patient. All entries in the medical record shall be dated and signed or otherwise authenticated.

F. The procedure for admission to the R-NPH shall be formulated by the respective Clinical Divisions, subject to approval by the Professional Staff Executive Committee.

G. Admission to the R-NPH will include, but not be limited to, patients suffering from all types of neurological or psychiatric illnesses.

H. All patient care is the responsibility of the Professional Staff. Patient care provided by residents, interns, and medical students shall be under the supervision of Attending Staff. Such care shall be in accordance with the provisions of a program approved by and in conformity with the Accreditation Council on Graduate Medical Education of the American Medical Association, and residency or training programs of the respective specialty boards.

I. Each inpatient shall be reviewed regularly by the Attending Physician or by his or her designated alternate. In addition, either the Attending Physician or his or her alternate shall be available on call 24 hours per day to meet the needs of the patient.

J. Consistent with community standards for optimal inpatient care, the attending physician, or designated alternate, must contact the patient's outside physician within 24 hours of admission, or for holidays/weekends, the first regular business day. The fact of and major themes of discussion must be documented in the patient's medical record. Where efforts to contact outside treaters fail, messages left, and additional attempts to contact the physician must be documented as well.

SECTION 2. DISCHARGE

Patients shall be discharged only upon written order of a physician. At the time of discharge/transfer, the record shall contain a principal diagnosis, discharge note, and physician's signature. The discharge/transfer summary shall include complete diagnoses and clinical resume. The resume will mention:

A. significant findings;
B. course and progress;
C. clinical treatment;
D. condition of patient, including physical and function status; and
E. arrangements for aftercare including medication, future treatment and disposition.

Discontinuation of Involuntary Holds

Discontinuation of involuntary holds on inpatients, whenever possible, should be ordered by the attending physician who evaluated the patient that day. In the event that the attending physician cannot enter an order in a timely manner, and the patient is ready to be safely discharged, discontinuation of the hold may be ordered by the on duty resident who has evaluated the patient and discussed the case with the attending physician. The on duty resident shall document evaluation of the patient and discussion with the attending physician. Such events are anticipated to be infrequent and to occur only when there is no reasonable alternative.

SECTION 3. TREATMENT

A. All patients shall be attended by a physician member of the Professional Staff and shall be assigned to the appropriate Clinical Division or Service concerned with the treatment of the illness or condition, which necessitated admission.

B. The authority for involuntary detention of patients under Welfare and Institutions Code, Section 5150, shall be granted to clinicians who meet all the requirements of State law and regulation and the Los Angeles County Department of Mental Health for LPS designation, including current licensure, approval by the Chief of Staff, attendance at an LPS Designation Class required by the LA County Department of Mental Health (DMH), and successful demonstration of competence on a test administered by DMH.

C. Post-Discharge Laboratory Results: Reports of laboratory results are sometimes received after the patient has been discharged. When such late results are abnormal and could constitute or indicate the potential for clinically significant risk to the patient and/or to others, proper follow-up advisement is required. In such cases the house officer should notify the patient by mail or by telephone of the result and should advise the patient to consult with his/her physician concerning follow-up care. Alternatively, the physician who is responsible for the patient's continuing care post-discharge may be advised of the result by letter or telephone. Letters should be countersigned by the patient's attending physician and a copy of the letter should be routed to the patient's chart. If advisement is made by telephone, the specifics thereof should be documented in a note in the patient's chart.

D. All orders for treatment shall be in writing, except in cases of emergency. Telephone orders and verbal orders to authorized registered nurses, licensed pharmacists, staff respiratory therapists, physical therapists and occupational therapists shall be accepted as appropriate and be written by the respective staff. All telephone orders must be authenticated by the responsible physician as soon as possible, within 48 hours.

E. Orders shall be the responsibility of the Professional Staff member, but writing them may be delegated.

F. As far as possible, the use of proprietary remedies shall be avoided. Patient's personal dietary supplements may not be used while the patient is in the hospital.

G. All Schedule II narcotic drug orders must be rewritten every seven 7 days except when a specific number of days is indicated by the prescriber.

H. All Schedule III-V narcotics must be rewritten every seven 7 days, except when a specific number of days is indicated by the prescriber.

I. All orders for CNS stimulants, anticoagulants, and antibiotics must be rewritten every seven- (7) days, except when a specific number of days is indicated by the prescriber.

J. All orders for hypnotic medications must be rewritten every seven- (7) days, except when a specific number of days is indicated by the prescriber. Orders for hypnotic drugs used for non-hypnotic uses (e.g., as a single dose sedation prior to a diagnostic procedure, as an antiemetic, as anticonvulsant therapy) are not included in this rule.

K. All orders from medical students must be read, approved and countersigned by a registered or licensed resident or attending physician before they are acted upon.

L. Medications brought by or with the patient to the R-NPH shall be held at the appropriate nursing station, and shall not be administered to the patient unless the following conditions are met:

1. The medications are specifically ordered by the patient's attending physician or designee, and the order entered in the patient's medical record. The order must include the medication name, strength, frequency, prescription number, and Community pharmacy that dispensed it.

2. The medications have been positively identified and examined for lack of deterioration by the pharmacist and have been re-labeled, if necessary, by the pharmacist to provide adequate identification for those responsible for administering the medication.

M. Medication errors and adverse reactions to medication shall be reported in accordance with written procedures. Documentation of the medication administered and/or the untoward reaction shall be properly recorded in the patient's medical record.

N. The Human Subjects Protection Committee shall review and approve all investigational medications and experimental procedures.

O. When hospitalization at R-NPH leads to changes in longstanding diagnoses, it is of particular importance for R-NPH physicians to include documentation of the basis for such changes. Under such circumstances it is also incumbent upon the R-NPH physicians to articulate the basis for the changed diagnosis to the outside treaters, and to document the content of that discussion with the outside physician.

SECTION 4. MEDICAL RECORDS

A. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identifying data; presenting complaint; personal history; family history; history of present illness; physical and mental status examinations; initial treatment plan and subsequent modification; special reports such as consultations, clinical laboratory, x-ray, and others; provisional diagnosis; medical or surgical treatment; pathological findings; progress notes; principal diagnosis; condition on discharge; follow-up; and autopsy report when available. No medical record shall be filed until it is complete, except on order of an appropriate committee. The medical record for each patient must be completed and filed within 14 days from the date of discharge. Every record shall contain written evidence of a critical review of the patient and the medical record by a member of the attending staff.

B. The medical record will not be considered complete until the encounter for that episode of care has been closed by the attending physician in CareConnect.

C. Health System Policy 1377 “Unapproved Medication Abbreviations” identifies abbreviations, acronyms and symbols that must not be used when documenting medications. No abbreviations are permitted in the final principal diagnosis and procedures.

D. In case of readmission of a patient, all previous records shall be available for the use of the attending physician.

E. Physicians shall cooperate in the timely preparation, completion, submission and maintenance of all medical records and reports. A physician who fails or refuses to complete or maintain medical records as requested may be subject to one or more of the following: formal reprimand; notification of failure to complete medical records being made a part of the physician's credentials files; denial of privileges until the records are complete; suspension or dismissal. Non-completion of medical records by a physician may result in termination of appointment or other disciplinary measures.

F. All original records are the property of the R-NPH and shall not be removed from R-NPH without a court order, on advice of University Counsel, or the written permission of the Chief of Staff.

G. Whenever possible the physician dictating notes for the medical records will sign such notes personally. The Division Chief or his/her designee may sign and authenticate notes in the absence of the dictating physician.

H. All medical students and unlicensed physicians, writing in the medical record, will indicate their year in training (MS I-IV or PG 1-7). Other mental health trainees will similarly provide an indication of their level of experience (predoctoral fellow, postdoctoral fellow, etc.).

I. On all services, the attending physician will write an admission note containing:

1. historical findings;
2. examination findings;
3. agreement or disagreement with significant findings described by the house officer;
4. the attending's conclusions, and
5. the attending's recommendations.

This note will be written and signed within 1 day of admission or transfer to the attending's service.

I. Adequate progress, therapy, treatment or continuation notes shall be written by the physician to progress therapy and treatment. Student notes do not suffice for adequate notes unless countersigned by the attending or house officer. For patients on all inpatient units, notes will be written as often as required by the severity of the illness and rapidity of change with the patient, but not less often than three (3) times per week.

J. The Director of Medical Records shall have the authority to administratively declare any medical record closed for the purpose of filing. The Medical Records Director can take action on any record that remains incomplete longer than ninety (90) days and for which no other method of compliance for valid clinical completion can be identified.

K. Clinician ID numbers should be used routinely with all clinician’s signatures.

L. Entries in the medical record must be legible, complete, dated, timed, and signed (including credentials).

M. Members of the House Staff may write patient care orders.

SECTION 5. CONSULTATIONS

In order to insure the most informed and timely management of patients and to utilize the variety of special expertise at the University of California, Los Angeles, Medical Center, consultations are encouraged. Consultations are recommended in all cases where the diagnosis is obscure or where there is doubt as to the best therapeutic measure to be utilized. Consultations should be obtained on high risk patients or those patients with underlying chronic problems, whenever the consultation

might reasonably be expected to assist in the patient's continuing care. All Consultations requested require an order in the patient's medical record.

SECTION 6. AUTOPSIES

A. In all R-NPH deaths, an autopsy shall be requested either from the family or by the Coroner's Office.

B. The Medical Director, or his designee, will notify the medical staff, specifically the attending physician and when applicable the psychologist, of the hospital's intent to obtain an autopsy and/or an autopsy report.

C. The certifying physician shall notify the Medical Director and coroner of any death of an R-NPH inpatient.

D. The certifying physician must report any death of any secluded or restrained psychiatric patient or of any patient without a previously known and potentially fatal physical condition.

E. Documentation of the basis for determining and confirming death, as well as the signed Report of Death and Permission for Postmortem Examination Form must be kept in the patient's medical record.

F. The physician shall notify the patient's family and ascertain if they wish to view the body on the unit within a specified time period.

G. A physician shall write an order to transport body to the morgue.

H. All inpatient deaths shall be reviewed by the Peer Review Committee, and, if more in depth review is recommended, by the Special Incident Committee.

APPROVAL:

Professional Staff Executive Committee:	09/25/2020
Professional Staff:	09/30/2020
Governing Body:	09/30/2020