KAISER PERMANENTE

PSYCHIATRIC HEALTH FACILITY

SANTA CLARA

CLINICAL STAFF RULES AND REGULATIONS

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INTRODUCTION

The following Rules and Regulations are adopted to become effective upon approval of the Board of Directions of Kaiser Foundation Hospitals, the governing body of Kaiser Permanente Psychiatric Health Facility Santa Clara.

ARTICLE I: ADMISSION AND CARE OF PATIENTS

The Kaiser Permanente Psychiatric Health Facility Santa Clara ("facility") shall admit patients for care and treatment by a member of the Clinical Staff who has been granted admitting privileges and in accordance with these Rules and Regulations and with any official admission policy adopted.

A. Admission

The following conditions shall govern the admission of patients to the facility:

1. Types of Patients: All psychiatric diagnostic categories qualify for admission with the following exceptions:
   a. The referred individual is under the age of 18.
   b. The referred individual has not, in the opinion of the Chief of Clinical Staff, or designee, received adequate Medical Clearance prior to admission.
   c. (Medical Clearance defined as the facility's ability to safely manage a patient in a non-medical facility with minimal nursing intervention).
   d. The referred individual does not have an Axis I psychiatric diagnosis.
   e. The referred individual has on-going medical or self-care needs, which are beyond the capability of the staff to manage safely.
   f. The referred individual has a primary diagnosis of:
      1) substance abuse or dependence
      2) organic mental disorder
      3) Substance intoxication or withdrawal
      4) eating disorder
   g. The referred individual has a communicable disease that requires reporting by Title 17, Code of California Regulations; Section 2500 will be admitted on a case by case basis.
   h. The referred individual convicted of, has entered a plea of guilty or no contest to, or is currently charged with any crime requiring registration pursuant to Section 290 of the California Penal Code. Persons in this category will be evaluated for admission on a case by case basis.
   i. If the only available bed in the facility is in a room that is occupied by a patient of the opposite sex, the facility is unable to adjust room assignments in order to accommodate the referred individual, and there are no scheduled discharges that would allow for the patient's admission.

B. Responsibility for Medical Care

A member of the Clinical Staff who has been granted admitting privileges 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 Clinical Staff member is responsible 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 Clinical Staff member to render patient care if he or she is not available. The attending Clinical Staff member will round on patients at least six days a week.

1. Process of Admission: Appropriate services, whether available in the facility or requiring outside referral, shall be offered to patients based on their clinical need.

    a. Only Clinical Staff members with admitting privileges may admit patients to the facility.
    b. The patient's attending Clinical Staff member who admits the patient shall establish the patient's condition and diagnosis upon admission.
    c. Providing the condition of the patient permits, a physician Clinical Staff member shall perform a complete medical history and physical examination either immediately prior to admission or within twenty-four (24) hours of admission if the patient has been discharged from a facility in excess of thirty days. If a history and physical was performed within 30 days prior to the hospital admission an appropriate physical assessment, including an update of any changes in the patient's current medical status and an update note addressing the patient's current status and/or any changes in the patient's status, must be completed within 24 hours of admission. A copy of the examination findings must be included in the record.
    d. The patient's attending physician Clinical Staff member will complete an admission Psychiatric Evaluation within 24 (twenty-four) hours of admission.
    e. All admitted patients are required to have a tuberculosis screening and assessment (tuberculin test or chest x-ray) when indicated.
    f. A complete blood count, thyroid –stimulating hormone level, comprehensive metabolic panel, pregnancy test (if applicable) and urinalysis are required, unless these tests were performed within seven days of admission and the findings can be documented in the record.
    g. Each patient will be provided with a means of identification upon admission, including at a minimum, the patient's name, the facility admission number, and the facility's name. An exception will be made where the patient's condition will not permit identification.

2. Type of Admission:

    Voluntary: A patient may request voluntary admission if they meet the admission criteria and sign a Request Voluntary Admission and Authorization for Treatment

Involuntary: A patient may be admitted to and detained at the facility involuntarily if he or she meets the criteria in Section 5150, 5250, 5260, or 5300 of the California Welfare and Institutions Code or other applicable law.

C. Suicidal or Dangerous Patients:

All Clinical Staff members 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. Clinical Staff members who admit patients shall be held responsible for giving such information about the patient as may be necessary to protect the patient from self-harm or to protect other patients from injury.

D. Request for Emergency Assistance

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.

E. Prohibition of Splitting Fees

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

F. Utilization Review

The attending Clinical Staff member is required to document the need for admission and continued hospitalization. This documentation should include at a minimum the reason for the need for continued hospitalization, period of time the patient will need to remain in the hospital, and plans for post-hospitalization care.

1. Documentation The attending Clinical Staff member is required to certify the need for hospitalization on admission and every three days thereafter. This documentation must contain: an adequate written record of the reason for continued hospitalization following the facility's admission and continued stay criteria; the estimated period of time the patient will need to remain in the facility; and plans for post-facility care.

2. Long-Term Patients Each patient who remains continuously hospitalized in the facility shall be subject to a chart review by the Executive Committee and Utilization Review staff for the evaluation of proper utilization of facility, at the end of the first thirty (30) day period and at the end of any subsequent thirty (30) day period.

3. Written Justification Upon request of the Executive Committee or Utilization Review staff, the attending Clinical Staff member must provide written justification for the continued hospitalization of any patient. This should include an estimate of the number of additional days of stay and the reasons. This report must be submitted within twenty-four (24) hours of the request.

Failure to comply with Utilization Review documentation requests will be referred to the Executive Committee for review and action as appropriate.

G. Patient Transfer

Notification and Arrangements: 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.

Medical Hazard: No patient shall be transferred to another facility where, in the opinion of the responsible practitioner, the transfer would create medical hazard.

Transfer for Physical Condition: 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. A discharge summary document shall accompany the patient upon transfer to an acute care hospital, skilled nursing or intermediate care facility or other another facility. The discharge summary shall include essential information relative to the patient's diagnosis, facility course, medications, treatments, any relevant dietary requirements and treatment plan. It shall be signed by the attending Clinical Staff member.

H. Patient Discharge

Procedure: Patients shall be discharged only on a written or telephone order of the attending Clinical Staff member or a designee. All telephone orders must be authenticated in the patient's medical record by the responsible practitioner within 48 hours. 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.

ARTICLE II: MEDICAL RECORDS

A. General Provisions:

A medical record shall be kept on each patient admitted or accepted for treatment. The attending Clinical Staff member shall be responsible to assure that a complete, legible, dated, timed and authenticated medical record is prepared for each patient accepted for care by the facility. The record shall be in such form and shall contain as much information as the Executive Committee and Administrator shall jointly prescribe.

All requested medical records (whether originals or reproductions) shall be legible and readily available upon the request of the attending practitioner, any practitioner providing care to the patient in the facility, and any authorized representatives of the facility or its Clinical Staff.

The medical record, including x-ray films and laboratory tests, is the property of the facility and is maintained for the benefit of the patient, the facility, and the Clinical Staff. All medical records shall be safeguarded against loss, defacement, tampering, or use by unauthorized persons.

B. Contents

The medical record of each patient shall contain sufficient information to justify the diagnosis and treatment of the patient, to explain the end results of the patient's hospitalization, and should be sufficiently complete so that another practitioner would be able to assume the case should it be required. All entries shall be signed, timed and dated. Only facility approved symbols may be used.

A medical record is complete when:

1. Contents reflect the patient's condition on arrival, diagnosis, test results, therapy, condition, in-facility progress and condition at discharge.
2. Contents, including any required clinical resume or final progress notes, are assembled and authenticated.
3. All final diagnoses and complications are recorded without the use of symbols or abbreviations.

Specific Requirements for Inpatient Medical Records:

All health records for each patient shall consist of, but are not limited to, the following admission and discharge record identification data:

1. Name
2. Address at time of admission
3. Patient identification number
4. Social Security number
5. Date of birth.
6. Gender
7. Marital status
8. Legal status
9. Religion (optional on part of patient)
10. Date of admission.
11. Date of discharge.
12. Name, address and telephone number of person or agency responsible for patient
13. Initial diagnostic impression
14. Discharge or final diagnosis
15. Disposition (including aftercare arrangements)

The health record for each patient shall consist of the following information with the timeline for completion:

1. Psychiatric evaluation within 24 hours of admission
2. Medical history and physical, within 24 hours of admission
3. Legal authorization for admission, on admission
4. Consultation reports, as indicated
5. Order sheet including medication, treatment and diet orders, beginning at admission

6. Initial Nursing Assessment, within 8 hours of admission
7. Multi-disciplinary Treatment Plan, within 72 hours following admission (Saturdays, Sundays and holidays excepted)
8. Progress notes for each patient contact that indicate provision of, and a patient's response to (as applicable) drug therapy, individual, family, marital, or group therapy, art therapy, recreational therapy, and any specialized therapy.
9. Nurses' notes, each shift
10. Vital signs
11. Reports of all laboratory tests and x-ray examinations performed, as indicated
12. Consent forms, upon admission
13. Informed consent for medication
14. A Psychosocial assessment of the patient, within 72 hours
15. A Rehabilitation assessment of the patient, within 72 hours
16. A discharge summary
17. All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.
18. Records not completed within 14 days of the patient's discharge shall be considered delinquent. Incidents of continued noncompliance will be referred to the Executive Committee for appropriate disciplinary action.

C. Specific Requirements for Entries

Psychiatric Evaluation:

A Psychiatric Evaluation shall be completed within twenty-four (24) hours after a patient has been admitted to the facility by the attending Clinical Staff member. When dictating the psychiatric evaluation, a note shall be entered in the progress notes stating when and by whom the psychiatric evaluation was completed

Progress Notes:

1. Progress notes shall detail the patient's progress in treatment.
2. Only Clinical Staff members are authorized to write practitioner progress notes in the practitioner's section of the medical record.
3. A progress note is made for each patient contact that indicates provision of, and a patient's response to, drug therapy, individual, family, marital, or group therapy, art therapy, recreational therapy, and any specialized therapy.
4. The recording of progress is evidence of individual patient performance. Specifically, the progress notes recorded by the professional staff, or others responsible for the patient's treatment, must give a chronological picture of the patient's progress or lack of progress towards attaining short and long-range goals outlined in the individual treatment plan. Progress notes should relate to the goals of the treatment plan. Notes must be timed, dated and signed (i.e., indicating the signature and title or discipline of the author of the note).
5. The attending practitioner or designee shall write a progress note after each treatment contact at least six days per week.

Multi-disciplinary Treatment Plan:
A written Multi-disciplinary treatment plan shall be developed and implemented by the multi-disciplinary treatment team for each patient as soon as possible after admission but no longer than 72 hours following the patient's admission, Saturdays, Sundays and holidays excepted. The multi-disciplinary treatment plan shall be reviewed and modified as frequently as the patient's condition warrants, but at least weekly.

Nurses' Notes:
Nurses' notes shall contain records of nursing care provided; records of observations of the patient and of the patient's response to treatment; the name, dosage, and time of administration of medications and the site of injections if given other than by oral administration; and a record of any restraints used, including times of application and removal.

Discharge Summary:
A patient's discharge summary contains the outcome of hospitalization, disposition of case, and provisions for follow-up care.

D. Completion of Medical Records:

Completion of Medical Records Following Patient Discharge:
A medical record is considered complete when the required contents, including any required clinical resume or final progress note, are assembled and authenticated and when all final diagnoses and any complications are recorded, without use of symbols or abbreviations. The attending practitioner shall complete a patient's medical record including dictation of the final Discharge Summary within fourteen (14) days of the patient's discharge.

Non-Psychiatric Practitioners:
All non-psychiatric practitioners exercising clinical privileges at the facility are subject to the same basic requirements governing the completion of medical records as psychiatrists. The practitioner will complete and authenticate all required entries to the patient's medical record within fourteen (14) days.

Review of Medical Records: All medical records are reviewed for adherence to requirements every 48 hours and upon discharge by the Continuous Quality Management staff. Regular reports are submitted to the Clinical Staff as part of the Peer Review process.

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

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 related to a previous date and time.

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

Failure to adhere to Rules and Regulations: Any practitioner failing to adhere to any of the above Rules and Regulations in the preceding section may be subject corrective action by the Executive Committee.

E. Patient Access to Medical Records

1. The Psychiatric Health Facility will comply with patient access as set forth in CCR Title 22 §77143 Health Record Availability
2. The Medical Records Department monitors access to patient records.
3. The Medical Records Department notifies the attending physician Clinical Staff member in writing and/or by phone call of the Patient's request for access/inspection of the Medical Record.
4. The Medical Records Department informs the Director of Nursing of the patient's request for access to Medical Records.
5. If the physician Clinical Staff member decides to grant access, he or she must give an order allowing the patient access to the chart.
6. Records are made available for inspection by the patient or the patient's representative within 24 hours of request (excluding weekends and holidays). If that is not possible, the facility will arrange for a mutually convenient time and place for a patient or their representative to inspect the record with a clinical staff member or to obtain copies of the requested health information/records.
7. Access may be denied to a patient or personal representative under specific conditions when access to the patient's records would have a detrimental effect on the patient-physician relationship, or it is reasonably likely that access would endanger the life or physical safety of the individual or another person.
8. If the attending Clinical Staff member denies access to the record, the practitioner must notify the Medical Records Department within three working days following receipt of the request. Otherwise, access will be permitted without his or her authorization.
9. The attending Clinical staff members may furnish a summary or explanation as an alternative to providing access to the actual record, providing that the patient/patient/representative agree in advance to receive a summary and to the fees for such summary or explanation.
10. If the attending Clinical Staff member is on vacation, deceased, or otherwise not available, an ad hoc committee of Clinical Staff will be formed to review these requests and take the appropriate action.

ARTICLE III: PATIENTS' RIGHTS

Written policies regarding patients' rights will be adopted by the Clinical Staff. A list of patients' rights shall be posted in appropriate places within the facility so that such rights may be read by patients.

ARTICLE IV: AVAILABILITY

A. Responsible Practitioner

1. Basic Responsibility: The attending Clinical Staff practitioner is responsible for the diagnosis and care of the patients as well as the direction of the treatment team and:

   a. Admitting orders within 24 hours of the patient's admission to the facility

   b. A psychiatric evaluation of the patient within twenty-four (24) hours of admission

   c. The practitioner initiates a formal treatment plan

   d. To review, approve, sign and date the Multidisciplinary Treatment Plan within 72 hours following admission Saturdays, Sundays and holidays excepted. Treatment Plans will be updated weekly or more frequently if the patient's condition warrants.

   e. To meet with each patient on caseload individually as often as appropriate for the care of the patient, but at least daily six days per week and to document all visits in the progress note of the medical record.

   f. To attend multi-disciplinary treatment planning meetings to discuss the patient and his/her treatment plan at least weekly.

   g. To be "on-call" for his/her patients twenty-four (24) hours a day, seven (7) days a week or provide comparable coverage.

   h. To evaluate the patient and review orders for care and treatment on change of attending physician.

   i. To provide the necessary information for legal documentation in order to implement the Lanterman-Petris-Short laws, (e.g., letters for temporary conservatorship, declarations in lieu of testimony for conservatorship, etc.).

   j. To perform such administrative and teaching duties as assigned by the Chief of Clinical Staff or Administrator from time to time.

NOTE: On–call means immediately available for consultation by telephone and available to be in the facility within thirty (30) minutes if requested to do so. Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code

2. Actions by the Chief of Clinical Staff:

   a. If the attending practitioner fails to see a new admission within twenty-four hours, or fails to respond to telephone messages within four (4) hours, this may constitute an emergency and the nursing staff will so notify the Chief of Clinical Staff or designee, who will take appropriate action. This action may include reassignment of the patient.

b. If the responsible practitioner becomes unavailable, he/she shall ensure that a competent practitioner who is a member of the Clinical Staff of the facility cares for his /her patient. In the event that the attending practitioner fails to obtain a substitute, the Chief of Clinical Staff or designee shall attend to the patient or reassign the patient.

c. The Clinical Staff grants to the Chief of Clinical Staff or designee, the authority to countermand orders of the primary practitioner; to write orders, including the orders to transfer or discharge a patient, when, in the opinion of the Chief of Clinical Staff or designee, an emergency situation exists or the potential for serious harm to the patient exists. The attending practitioner will be notified personally by the Chief of Clinical Staff or designee as soon as possible of the above action.

B. Consultants

If a consultant does not answer a request for consultation within forty-eight (48) hours, the responsible practitioner shall seek another consultation.

ARTICLE V: ORDERS

A. Orders for Treatment

Recording of Orders: All orders for treatment shall be recorded in writing. Any and every entry in the clinical record must be authenticated and dated by the person responsible for making the entry. An order orally transmitted by the practitioner in person or over the telephone must be recorded in the patient's medical record and countersigned by the practitioner within twenty-four (24) hours of transmittal. A person authorized to receive an oral order shall acknowledge receipt of the order by indicating the order, the date and time of transmittal, and the name of the ordering practitioner, and by signing the patient's record.

Recipients of Oral Orders: An oral order for treatment other than medication shall only be given to and transcribed by a registered nurse, a licensed vocational nurse, or a licensed psychiatric technician. An oral order for medication shall only be given to and transcribed by a registered nurse, a licensed psychiatric technician or a licensed pharmacist.

Failure to Countersign Oral Orders: Oral orders not countersigned within twenty-four (24) hours of transmittal will be treated as incomplete portions of the medical record, making the practitioner subject to the sanctions set out in the Clinical Staff Bylaws and in these Rules and Regulations for failure to complete medical records adequately.

B. Medication Orders

Authorized Prescribers: Medication orders shall be written only by authorized prescribers, whose names shall appear on an updated list available in all areas where medications are dispensed.

Selection of Medications: All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or American Medical Association Drug Evaluations. Patients may not use their own medications except under circumstances approved by the patient's attending practitioner and so ordered.

Informed Consent: Informed consent should be obtained from all patients prior to the initiation of psychiatric treatment.

In order to make an informed decision, the patient must be provided with sufficient information by the physician prescribing such medications (in the patient's native language, if possible).

Emergency:

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.

Automatic Stop Orders To ensure the safe and effective use of medication, a specific medications not renewed by the physician will be discontinued automatically as indicated in Policy and Procedure regarding Automatic Stop Orders.

Renewal of Medication Orders The provider must reorder all discontinued medications individually. Orders to "renew all prior meds" are not acceptable.

Non-Customary Drug Usage If, at any time, a medication is prescribed outside the customary usage, the rationale for non-customary usage shall be thoroughly delineated in the practitioner progress notes.

Orders For Non-Formulary Medications Formulary medications are automatically substituted for non-formulary medications by the pharmacy based on the formulary substitution list in Policy and Procedure cod Formulary Procedure.

ARTICLE VI: SPECIAL PROCEDURES: RESTRAINT AND SECLUSION

Practitioner Orders
There shall be written orders for each restraint or exclusion procedure that are timed and dated. The order will be time-limited (not to exceed 24 hours) and will contain the clinical justification for the procedure. Verbal orders can be obtained when emergency restraint and seclusion are necessary and must be signed by the practitioner within twenty–four (24) hours, weekends and holidays excepted.

Practitioner Documentation
Clinical justification of each incident of restraint or seclusion will be clearly documented in the Progress Note by the attending practitioner.

Facility Policies and Procedures covering the use of seclusion and restraint
The needs of the patient will be attended to at least every 15 minutes, especially regarding meals, bathing, and use of the toilet. An order for PRN usage of restraint and/or seclusion is not permissible.

ARTICLE VII: EMERGENCY MEDICAL SERVICES

In a medical emergency, the facility provides patients, staff, and visitors with essential, life-saving treatment and transfer to an acute medical facility as quickly as possible. The facility sends pertinent medical records with the patient and the practitioner in attendance or the nurse supervisor calls the receiving facility. There is regular practitioner review of all medical emergencies by the Chief of Clinical Staff.

ARTICLE VIII: SPECIAL TRAINING

Continuing Education:
All licensed Clinical Staff practitioners are required to participate annually in continuing education courses as required by the appropriate State of California licensing agency.

Orientation
Each practitioner granted clinical privileges shall be oriented to Clinical Staff Bylaws, Clinical Staff Rules and Regulations, Emergency/Disaster Preparedness, Codes, Security, Emergency Evacuation Plan, Tour of the Building, Electronic Medical Record System, Treatment Planning Process, and committee meeting schedules within 90 days of Appointment.

ARTICLE IX: DISASTER ASSIGNMENTS

In a Disaster, the Administrator and Chief of Clinical Staff or designee shall assume charge of the facility and assign practitioners and other medical personnel as needed and available.

ARTICLE X: AUTOPSIES

As appropriate, it shall be the duty of all Clinical Staff members to attempt to secure meaningful autopsies in all deaths which would meet the following criteria as identified by the College of American Pathologists, as follows:

1. Deaths in which autopsy would explain unknown or unanticipated medical complication.
2. Deaths in which the cause is not known with certainty on clinical grounds.
3. Deaths in which an autopsy would allay concerns of reassure the public or family regarding death.
4. Cases of unusual academic interest.

Autopsies will be performed only upon the written consent of a legally authorized person in the form consistent with the applicable statues. In cases within the jurisdiction of the coroner, his or her authorization shall be obtained first.

ARTICLE XI: REGULATORY COMPLIANCE PROGRAM

All Clinical Staff who exercise clinical privileges shall comply with local, state and federal laws and regulations and support and participate in facility regulatory compliance programs.

ARTICLE XII: SIGNIFICANT EVENTS

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

ARTICLE XIII: ADOPTION

These Rules and Regulations of the Clinical Staff shall be adopted effective when approved by the Board of Directors of Kaiser Foundation Hospitals, the Governing Body.

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

_____ _____

DATE Chief of Clinical Staff

The foregoing Rules and Regulations of the Clinical Staff of the Kaiser Permanente Psychiatric Health Facility – Santa Clara are approved effective:

_____ _____

DATE Assistant Secretary
Kaiser Foundation Hospitals

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

10/21/10
DATE

Chief of Clinical Staff

The foregoing Rules and Regulations of the Clinical Staff of the Kaiser Permanente Psychiatric Health Facility – Santa Clara are approved effective:

12/4/10
DATE

Assistant Secretary
Kaiser Foundation Hospitals