

PSYCHIATRY CLINICAL SERVICE
RULES AND REGULATIONS
20162018

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RULES AND REGULATIONS
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I. PSYCHIATRY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The mission of the Psychiatry Clinical Service is to provide the highest quality care to individuals with a variety of mental disorders and psychosocial problems, especially those from ethnic and minority groups, who largely depend on the public sector. In support of this mission and to further the academic collaboration between the City and the University, the Psychiatry Clinical Service is committed to providing training, research and evaluation, and direct patient care that will enhance the treatment of consumers of our services. Scope of Service Statements for specific units/services are maintained in the [SFGHZSFG](#) Psychiatry Clinical Service Policy and Procedures Manual, Section 5.1B.

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of San Francisco General Hospital is a privilege which shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth in [SFGHZSFG](#) Medical Staff Bylaws and Rules and Regulations.

CPR Certification is required for Affiliated Professionals.

C. ORGANIZATION OF PSYCHIATRY CLINICAL SERVICE

1. The Officers of the Psychiatry Clinical Service are:

- a. Chief of Service
- b. Deputy Chief
- c. Director of Administration

2. Chief of Service (refer to APPENDIX G for additional information)

- a. Appointment and review of the Chief of Service will occur by the process specified in the [SFGHZSFG](#) Medical Staff Bylaws.
- b. Responsibilities
 - 1) Overall direction of the clinical, teaching, and research activities for the service.
 - 2) Review and recommendation of all new appointments, requests for privileges and reappointments.
 - 3) Overall direction of the Performance Improvement/Patient Safety and CQI activities for the Service.
 - 4) Appointment of the remaining officers of the service and of service committee members.
 - 5) Financial affairs of the service.
 - 6) Attendance at the Medical Executive Committee, the Chiefs of Service meetings and other meetings as called from time to time by the Executive Administrator or the Chief of Staff.
 - 7) Disciplinary actions as necessary, as set forth in these Rules and Regulations and in the Bylaws and Rules and Regulations of the Medical Staff.

3. Deputy Chief:

- a. Responsibilities: Assists the Chief of Service with the above.

4. Director of Administration:

- a. Responsibilities: Provides overall direction for the budget of the department, human resources, and overall operations of the Service.

5. Attending Responsibilities (Psychiatrists, Psychologists):

Overall direction of clinical care is the responsibility of the supervising attending clinical staff of the Psychiatry Clinical Service. Specific attending job descriptions are maintained in the [SFGH/ZSFG](#) Psychiatry Clinical Service Job Description Manual. (Refer to Appendix C).

II. CREDENTIALING

A. CREDENTIALING OF MEDICAL STAFF AND AFFILIATED PROFESSIONAL STAFF (refer to APPENDIX B)

B. NEW APPOINTMENTS

The process of application for membership to the Medical Staff or Affiliated Professional Staff of [SFGH/ZSFG](#) through the Psychiatry Clinical Service is in accordance with [SFGH/ZSFG](#) Medical Staff Bylaws and the Rules and Regulations.

C. REAPPOINTMENTS

The process of reappointment to the Medical Staff or Affiliated Professional Staff of [SFGH/ZSFG](#) through the Psychiatry Clinical Service is in accordance with [SFGH/ZSFG](#) Bylaws and the Rules and Regulations.

D. PRACTITIONER PERFORMANCE PROFILES

It is the policy of the Psychiatry Clinical Service to certify clinical competence of all medical staff and affiliated professionals, including newly appointed staff members. Information gathered from proctoring, peer review and/or monitoring activities is reviewed by the Chief of the Psychiatry Clinical Service, who then makes appropriate recommendations to continue or revise the status of the staff member. For subsequent reappointment to the medical staff or affiliated professional staff, information gathered from continuous monitoring of the staff member's clinical practice is reviewed by the Chief of the Psychiatry Clinical Service or his/her designee, who makes appropriate recommendations to reappoint or revise the status of the staff member. All materials gathered for evaluation purposes are kept in confidential files in the Psychiatry Clinical Service. Details are outlined in the Psychiatry Clinical Service Credentialing of Medical and Affiliated Professional Staff Policy and Procedure 5.1A (Refer to Appendix B).

E. MODIFICATION OF CLINICAL SERVICE PRIVILEGES

Periodic re-determination of clinical service privileges and the increase in, or curtailment of same, shall be based upon direct observation of care provided, review of records of patients treated in the hospital, review of the records of the Medical Staff which document the evaluation of the member's provision of professional care. Clinical privileges will also be reviewed in the event of a change in job duties/responsibilities to determine that appropriate privileges are assigned. This process for modification of clinical service is in accordance with the [SFGH/ZSFG](#) Bylaws and the Rules and Regulations.

F. STAFF STATUS CHANGE

The process for Staff Status Change for members of the Psychiatry Clinical Service is in accordance with [SFGHZSFG](#) Bylaws and the Rules and Regulations.

G. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of Affiliated Professionals through the Psychiatry Clinical Service is in accordance with [SFGHZSFG](#) Bylaws and the Rules and Regulations, as well as these Clinical Service Rules and Regulations.

H. STAFF CATEGORIES

The Psychiatry Clinical Service staff fall into the same staff categories which are described in the [SFGHZSFG](#) Bylaws and the Rules and Regulations, as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES (refer to APPENDIX A)

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Psychiatry Clinical Service privileges are developed in accordance with [SFGHZSFG](#) Medical Staff Bylaws, and the Rules and Regulations.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Psychiatry Clinical Service Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES

Psychiatry Clinical Service privileges shall be authorized in accordance with the [SFGHZSFG](#) Medical Staff Bylaws and the Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Psychiatry Clinical Service or his/her designee.

1. Privileges to practice in the Psychiatry Clinical Service will be commensurate with clinical training and documentation of an acceptable standard of clinical practice. The specifics of the process are set forth in the Bylaws and the Rules and Regulations of the [SFGHZSFG](#) Medical Staff. Privileges, which will be assigned, are described in detail in the Privileges Request Form for Privileges in Psychiatry Service (Refer to Appendix A).
2. Privileges are delineated by consensus of the Active members of the clinical service, and are approved by the Chief of Service or his/her designee, subject to the approval of the Credentials Committee of the medical staff.
3. Individual privileges are subject to review and revision at an initial appointment, throughout the period of proctoring, at the time of reappointment, at the time as judged necessary by the Chief of Service, or at any time recommended by 2/3s of the clinical service's Active staff.

D. TEMPORARY PRIVILEGES

Temporary Privileges shall be authorized in accordance with the [SFGHZSFG](#) Medical Staff Bylaws and the Rules and Regulations.

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

It is the policy of the Psychiatry Clinical Service, [SFGHZSFG](#), to certify that clinical competence of all medical/affiliated professionals, during the first two years of the initial appointment. Upon completion of the two years, information gathered from proctoring, peer review and/or monitoring activities is reviewed by the Chief of the Psychiatry Clinical Service or his/her designee, who then makes appropriate recommendation to continue or revise the status of the staff member. For subsequent reappointment to the medical/affiliated professionals, information gathered from continuous monitoring of the staff member's clinical practice is reviewed by the Chief of the Psychiatry Clinical Service or his/her designee, who makes appropriate recommendations to reappoint or revise the status of the staff member. All materials gathered for evaluation purposes are kept in confidential files in the Psychiatry Clinical Service. Details are outlined in the Psychiatry Clinical Service Credentialing of Medical Professional Staff Policy and Procedure 5.1A (Refer to Appendix B)

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Psychiatry Clinical Service shall be in accordance with [SFGHZSFG](#) Medical Staff Bylaws and the Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Psychiatry Clinical Service shall be in accordance with [SFGHZSFG](#) Medical Staff Bylaws and the Rules and Regulations.

V. EDUCATION

The Psychiatry Clinical Service serves as a training site for students, interns, and residents in the disciplines of medicine (psychiatry), psychology, nursing, social work, and occupational therapy. Trainees work under the supervision of the Psychiatry Clinical Service faculty and staff who are responsible for monitoring the quality of clinical care provided. Discipline directors are responsible for ensuring that training assignments are properly supervised and are commensurate with the trainee's educational level.

In addition, all Psychiatry Clinical Service members may attend UCSF departmental courses for CME credits.

VI. PSYCHIATRY CLINICAL SERVICE CONSULTATION CRITERIA

The Psychiatry Clinical Service Consultation Criteria ~~are~~ outlined in Appendix H.

VII. EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)

- A. An appropriate medical screening examination shall be provided to all persons who present themselves to the [SFGHZSFG](#) Psychiatry Emergency Service and who request, or have request made on their behalf, for an examination or treatment of a medical condition. In such an event, the Hospital shall not seek authorization from an individual's insurance company until a medical screening examination has been provided and any necessary stabilizing treatment has been initiated. The patient will not be transferred to another facility unless the patient's condition is stabilized or it is in the patient's best interest to be transferred due to the hospital's inability to provide the needed services or level of care.
- B. An appropriate medical screening examination shall be provided to persons, including visitors, who present themselves at an area of the Hospital's main campus other than the Emergency Department if they request, or have a request made on their behalf, for examination or treatment for what may be an emergency medical condition. Where there is no verbal request, a request will nevertheless be considered to exist if a prudent

layperson observer would conclude, based on the person's appearance or behavior, that the person needs emergency examination or treatment.

- C. The medical screening exam must be performed by a physician or other qualified medical personnel as designated by the clinical service.
- D. In the event that a request is made for emergency care in a Hospital department off the Hospital's main campus, such as a Community Primary Care Services Clinic, EMTALA does not apply. The clinic shall provide whatever assistance is within its capability and shall call the local emergency medical services to take the individual to an emergency department.

VIII. DISCIPLINARY ACTION

The San Francisco General Hospital Medical Staff Bylaws and the Rules and Regulations will govern all disciplinary action involving members of the [SFGH/ZSFG](#) Psychiatry Clinical Service.

IX. PERFORMANCE IMPROVEMENT/PATIENT SAFETY (PIPS) & UTILIZATION MANAGEMENT

The Psychiatry Clinical Service is committed to strive towards maintaining the highest possible standard of practice. The Psychiatry Clinical Service PIPS Plan is detailed in APPENDIX E.

A. GOALS and OBJECTIVES

The Psychiatry Clinical Service is committed to strive towards maintaining the highest possible standard of practice. The purpose of the PIPS Program of the Department of Psychiatry is to promote desired patient outcomes by evaluating and improving processes that most affect patient care. The PIPS Program is a multidisciplinary effort, dependent upon the continued commitment and involvement of all staff, including both clinical and administrative, to provide our patients with the highest degree of quality care possible.

B. RESPONSIBILITY

The Psychiatry Department's Executive Committee guides and directs all departmental PIPS activities.

C. REPORTING

All Performance Improvement/Patient Safety activities are reported to the Executive Committee and the [SFGH/ZSFG](#) PIPS Committee through annual reports and presentations. Nursing specific quality improvement activities are also reported to the Nursing Quality Improvement Coordinating Committee. The Assault & Battery Review Board is an important standing multidisciplinary committee that is engaged in PIPS activity. In addition, the ~~Inpatient Steering Committee~~ [Acute and Emergency Services Staff meeting](#) reviews relevant findings to disseminate them to clinical staff. The Department of Psychiatry's PIPS Program is fully integrated into the [SFGH/ZSFG](#) PIPS Program.

D. CLINICAL INDICATORS

The Psychiatry Clinical Service's PIPS Program conducts ongoing monitoring of AWOLS, assaults (including sexual assaults), death/suicide, suicide attempts, seclusion and restraint, patient complaints, code blues, development of disabling or life threatening conditions, and medication errors. (See APPENDIX E for additional information.)

E. CLINICAL SERVICE PRACTITIONER PERFORMANCE PROFILES

Performance improvement and patient care information are collected biannually and are included in the clinical service practitioners' performance profile.

F. MONITORING AND EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

The Psychiatry Clinical Services PIPS Program collects Medical Staff peer reviews and medication monitoring. In addition, the Psychiatry Clinical Service has a Significant Event Program, Patient Complaint and Grievance Process, and a Patient Satisfaction Survey Process. (see APPENDIX E for additional information)

G. DISCHARGE PLAN AND EXIT RECORD

The requirements for discharge plan and exit record are detailed in APPENDIX F

H. INFORMED CONSENT

All decisions for treatment should involve the active participation of the patient when competent, and should be made after appropriate discussions of risks, benefits, and alternatives.

Documentation of "Informed Consent" on medical staff approved forms is required for All Psychiatric Medications.

I. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

1) Physicians

All requirements and details are delineated in APPENDIX F.

2) Housestaff

Details are outlined in the APPENDIX B

3) Affiliated Professionals

Annual UCSF or CCSF Performance Evaluation. Ongoing monitoring requirements and details are delineated in APPENDIX B.

4) ~~SFGH~~ZSFG Employees other than Affiliated Professionals

Annual UCSF or CCSF Performance Evaluation.

J. COMMITTEE STRUCTURE

The Psychiatry Clinical Service will maintain the following committees:

- Executive Committee
- Division Directors Committee
- Acute and Emergency Services Staff Committee
- Assault & Battery Review Board
- Residency Training Committee

X. MEDICAL RECORDS

The members of the service are committed to the maintenance of complete, accurate, and timely medical records.

1. The requirements as set forth in the [SFGH/ZSFG](#) Medical Staff Bylaws and the Rules and Regulations define the minimum standards for records in the service, and
2. Medical Record documentation requirements are detailed in APPENDIX F.

XI. PROTECTION OF PATIENT PRIVACY

- A. Members of the Medical Staff shall comply with the DPH Notice of Privacy Practices, the Hospital Policies and Procedures regarding patient privacy and the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA).
- B. Members of the Medical Staff shall abide by the following:
 1. Protected Health information shall only be accessed, discussed or divulged as required for the performance of job duties;
 2. User IDS and/or passwords shall only be disclosed to Hospital Information Systems staff;
 3. Members shall not log into Hospital information systems or authenticate entries with the user ID or password of another; and
 4. Members shall only install software on Hospital computers that have been appropriately licensed and authorized by Hospital Information Systems staff.
- C. Members agree that violation of this section regarding Protection of Patient Privacy may result in corrective action as set forth in these Bylaws.

XII. PSYCHIATRY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM

It is the policy of the Psychiatry Clinical Service to provide supervision of psychiatric housestaff for their work in the clinical service. Details are outlined in Section 1.15 of the Psychiatric Clinical Policy and Procedures manual (Appendix C). See CHN Intranet Site, Housestaff Competencies link.

The procedure for clinical supervision of residents in the Psychiatry Emergency Service will be as follows:

- a. During the hours of 8:00AM to 5:00PM there will be an attending physician available on-site to provide supervision and consultation to the resident.
- b. During the hours of 5:00PM to 8:00AM and on weekends the resident is instructed to call the PES Medical Director or his/her designate for consultation and problem solving. Should the resident require immediate on-site assistance, there is a Psychiatry Clinical Service Back-Up Physician available 24 hour/day, 7 days/week, who can be contacted by page and who will go to the PES should this additional help be needed. In addition, the resident will discuss with an attending in a morning report all patients they see and evaluate during the hours of 5:00PM to 8:00AM or on weekends.

XIII. MEETING REQUIREMENTS

In accordance with [SFGH/ZSFG](#) Medical Staff Bylaws, all Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings and the annual Medical Staff Meeting.

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

Medical Director, Behavioral Health Center

34.30 SUBSPECIALTY PRIVILEGES (MD/DO)

Note: If you are requesting specialized privileges, you need to request separate Adult Core privileges unless you intend to restrict your practice EXCLUSIVELY to the subspecialty area(s).

In addition to criteria noted in 34.10, psychiatrists must possess training that qualifies them as subspecialists in an area of psychiatry and must provide evidence of qualifications, i.e. certificate of completion of specialized training in a recognized area or subspecialty board

34.31 CHILD PSYCHIATRY

Psychiatric assessment and treatment (see Basic Privileges above) of patients under 19 years of age, including clinical interactions with adult individuals connected to the child, as indicated for the assessment and treatment of the child.

PREREQUISITES: Currently Board-eligible, Board certified, or Re-Certified in Child Psychiatry, or a member of the Clinical Service prior to 10/17/00, or documentation of 2 years or more of applicable clinical experience in Child Psychiatry approved by the Chief of Psychiatry

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

34.32 ADOLESCENT PSYCHIATRY (MD/DO)

Psychiatric assessment and treatment (see Basic Privileges above) of patients from 14 through 18 years of age, including clinical interactions with adult individuals connected to the child, as indicated for the assessment and treatment of the child.

PREREQUISITES: Possess Basic Privileges in Psychiatry; Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology in General Psychiatry who in addition to general psychiatry training has two years or more of documented sufficient, specialized training and experience in working with adolescents and their families approved by the Chief of Psychiatry, and has demonstrated competence to examine and treat adolescents comprehensively, or a member of the Service prior to 10/17/00.

PROCTORING: 5 proctored adolescent cases within the first year.

REAPPOINTMENT: 4 cases in each 2 year period

34.33 ELECTROCONVULSIVE THERAPY (ECT)-ADULT PATIENTS (MD/DO)

Assessment of candidate patients, patient selection; ECT treatment; post-treatment monitoring of patients in collaboration with [SFGHZSFGTC](#) Anesthesia staff.

PREREQUISITES: Possess Basic Privileges in Psychiatry; documentation successful completion of specific ECT training within the past 3 years (if training completed prior to 3 years ago, documentation of ECT clinical activity in good standing with an average of at least 5 cases annually during the prior 3 years), or a member of the Service prior to 10/17/00.

PROCTORING: 5 proctored cases by physician privileged for ECT treatment at

or other institution required prior to independent practice of ECT (i.e. if first 5 treatment cases; if proctored by a staff member of another institution, proctoring must be completed prior to granting of privilege).

REAPPOINTMENT: Peer review of 5 cases in each 2 year period is required for reappointment.

34.40 ADULT (CORE) PRIVILEGES - LICENSED CLINICAL PSYCHOLOGISTS (PhD/PsyD/EdD)

Diagnostic assessment and treatment of psychiatric and substance abuse disorders, including mental status examination, treatment planning, individual psychotherapy, group psychotherapy, family psychotherapy, behavior modification, and cognitive behavioral

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therapy of patients 18 years and older.

PREREQUISITES: Completion of a doctoral degree in psychology from an APA accredited program and licensure by the State of California, Board of Psychology on the basis of the doctoral degree in psychology

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

_____ _____
34.50 SPECIALIZED PRIVILEGES (PhD/PsyD/EdD)

Note: If you are requesting specialized privileges, you need to request separate Adult Core privileges unless you intend to restrict your practice EXCLUSIVELY to the subspecialty

In addition to criteria noted in 34.40, psychologists must apply for each privilege individually and provide documentation indicating appropriate training and proficiency in the activity or technique.

_____ _____
34.51 PSYCHOMETRIC EVALUATION

Testing and measurement of psychological variables including intelligence, aptitude, and personality traits

PREREQUISITES: Minimum of one year of experience (1500 hours) providing psychometric evaluation in a clinical setting, including test administration, scoring, and interpretation, as well as written report. Proficiency in delivering these services in an autonomous fashion

must be verified by a supervisor or prior work setting and approved by the Chief Psychologist.

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

- _____ _____
_____ _____
_____ _____
- a. Along with initialing for privileges 34.51, please initial here to indicate if you are requesting privileges for children and adolescent (under 19 years of age) psychometric evaluation _____
 - b. Along with initialing for privileges 34.51, please initial here to indicate if you are requesting privileges for adult (18 years of age and older) psychometric evaluation _____

_____ _____
34.52 NEUROPSYCHOLOGICAL EVALUATION

NOTE: Neuropsychology privileges subsumes Psychometric Evaluation privileges

Specialized diagnostic assessment of disorders of neurocognitive function.

PREREQUISITES: Completion of the equivalent of a full-time post-doctoral internship in clinical neuropsychology or 2 years of work experience as a clinical neuropsychologist. This experience must be verified by former supervisor or work setting, including the ability to proficiently deliver these services in an autonomous fashion. Experience must be approved by the Chief Psychologist.

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

- _____ _____
_____ _____
_____ _____
- a. Along with initialing for privileges 34.52, please initial here to indicate if you are requesting privileges for children and adolescent (under 19 years of age) psychometric evaluation _____
 - b. Along with initialing for privileges 34.52, please initial here to indicate if you are requesting privileges for adult (18 years of age and older) psychometric evaluation _____

_____ _____
34.53 CHILD AND ADOLESCENT PSYCHOLOGY

Psychological assessment and treatment (see Basic Privileges above for Clinical Psychologists) of patients under 19 years of age, including clinical interactions with adult individuals connected to the child, as indicated for the assessment and treatment of the child.

PREREQUISITES: Documentation of a least one year of didactic instruction and supervised clinical experience in child and adolescent assessment and treatment; approved by Chief Psychologist.

PROCTORING: 5 cases within the first year

APPENDIX B – CREDENTIALING OF MEDICAL AND AFFILIATED STAFF

POLICY:

It is the policy of the Department of Psychiatry, Zuckerberg San Francisco General Hospital, to certify the clinical competence of all medical and affiliated staff, including newly appointed staff. Newly appointed staff are proctored during the initial six months of their appointment, and also undergo continuous monitoring of clinical practice (outlined below). Upon completion of the proctoring process, information gathered from proctoring, peer review and/or monitoring activities is reviewed by the Chief of the Department or his/her designee, who then makes appropriate recommendations to continue or revise the status of the staff member. For subsequent reappointment to the medical staff, information gathered from continuous monitoring of the staff member's clinical practice is reviewed by the Chief of the Department or his/her designee, who then makes appropriate recommendations to reappoint or revise the status of the staff member.

All materials gathered for evaluation purposes are kept in confidential files in the Department of Psychiatry.

PURPOSE:

To ensure that medical and affiliated staff of the Department of Psychiatry are able to demonstrate well-developed skills in the following areas:

- Interview of psychiatric patients
- Diagnosis of psychiatric patients
- Development of appropriate treatment plan
- Use of psychotropic medications (MD/DO/NP only)
- Facility with standard psychological therapies

BASIC QUALIFICATIONS FOR CONSIDERATION OF APPOINTMENT TO THE MEDICAL STAFF:

1. Psychiatrists must have successfully completed an approved ACGME residency training program in Psychiatry, be Board Admissible or Board Certified by the American Board of Psychiatry and Neurology, and possess Medical Licensure from the Medical Board of California. The requirement for Board certification or admissibility may be waived at the discretion of the Chief of Service after careful review of the applicant's qualifications and experience. Such a waiver request shall be put in writing by the Chief of Service to the [SFGHZSFG](#) Credentials Committee, and will outline the applicant's qualifications and experience.
2. Clinical Psychologists must hold a doctorate degree in psychology from an APA-accredited program, and be licensed on the basis of the doctorate degree in psychology by the State of California Board of Psychology. The requirement for an APA accredited training program may be waived at the discretion of the Chief Psychologist after careful review of the applicant's qualifications/experience and verification that the applicant has completed the same number of internship hours as those required by an APA accredited training program and as required by the State of California, Board of Psychology. Such a waiver will be requested in writing by the Chief Psychologist to the [SFGHZSFG](#) Credentials Committee, and will outline the applicant's qualifications and experience.

3. Nurse Practitioners and Physician Assistants must hold the following qualifications:

Nurse Practitioners:

1. Active California Registered Nurse license
2. Successful completion of a Nurse Practitioner program which conforms to the California BRN standards.
3. Certification to practice and prescribe in the state of California as a Nurse Practitioner
4. At least one year of experience as a Registered Nurse or Nurse Practitioner in psychiatry and/or adult health
5. All other requirements listed in the Bylaws and the Rules and Regulations

Commented [JD1]: Mark: should this say something re: having a current "furnishing license"?

Physician Assistants:

1. Active California Physician Assistant license
2. Successful completion of a Physician Assistant Training Program which conforms to California Medical Board standards
3. At least one year of experience as a Physician Assistant in Psychiatry and/or adult health
4. All other requirements listed in the Bylaws and the Rules and Regulations

PROCESS:

- I. Proctoring of Newly Appointed Medical and Affiliated Staff – Divisions will choose who proctors
 - A. A minimum of one proctor is assigned to each newly appointed staff member. The assigned proctor(s) comprise experienced medical staff member(s). It is the responsibility of the proctor(s) to observe the actual practices of the applicant and document their observations. The observations may be made in one of two ways:
 1. On an ad hoc basis, the proctor may concurrently review the clinical care of individual patients and complete the proctoring forms.
 2. The new staff member may serve as a case discussant in a case conference. This involves review by the new staff member of the patient's history, interview of the patient in the presence of other staff members, development of a differential diagnosis and discussion of a treatment plan.
 - B. Each new staff member receives a minimum of six (6) clinical reviews during the initial six months of their appointment, documented on the proctoring form.
 - C. PES On-Call Physicians: Before working independently, PES on-call physicians are reviewed on four clinical assessments upon initial employment. Six months after initial employment, the physician is reviewed on two more clinical assessments. Thus, at the end of the six-month proctoring process, six case reviews have occurred. The proctoring period may be extended in the event that the new staff member is not scheduled for clinical care activities frequently enough

to complete six clinical reviews during the initial six months of employment. Each assessment is carried out by the senior attending psychiatrist on duty in PES at the time the on-call physician is scheduled to work, and is documented on the PES Orientation/Proctoring form. Each assessment includes:

1. One observed interview (more if needed)
2. Clinical assessment
3. Diagnostic formulation
4. Treatment and planning
5. Completion of necessary documentation

- D. Concerns of the proctor regarding a proctored practitioner's performance will be documented and the issue will be brought to the immediate attention of both the Deputy Chief and Service Chief of the Department for necessary action.

II. Continuous Monitoring of Clinical Practice

- A. The clinical practice of all medical and affiliated staff in the Department of Psychiatry is monitored according to the monitoring plan developed by the PIPS Committee, and includes primarily peer review. Examples of unusual or deviant practice are reported to the Department's Chief as provided in this policy and are available for review at the time reappointment to the medical staff.
- B. Clinician-specific information for Ongoing Professional Practice Evaluation (OPPE) related to clinical practice is reviewed by the Chief of the department or his/her designee when the staff member is being considered for reappointment to the medical staff. Appropriate information would include the following:
1. Peer review findings
 2. Medication monitoring findings (inpatient and PES medical staff only)
 3. Antipsychotic polypharmacy prescribing monitoring findings (inpatient only)
 4. Utilization review (inpatient medical staff only)
 5. Risk management
 6. Supervisor and peer recommendations
- C. Performance problems will be reviewed by the Deputy Chief and Service Chief of the Department for necessary action.

III. Credentialing

- A. Licensure/Certification:
All medical and affiliated staff members are required to provide the following information to the Academic Personnel Analyst to ensure that each member's file contains current licensure/certification information:
1. Copies of current licensure/certification, as applicable:

Professional license
DEA Certification (MD^{2s}/~~DO~~/NP^{2s}-only)
Department of Psychiatry PRRT Training Certification (Attending
Psychiatrists/psychologists only on the following services: Inpatient, PES, and C-
L Services)

2. As the above individual licenses/certificates expire, it is the responsibility of the medical staff member to apply for their renewal in a timely manner and provide the Academic Personnel Analyst with a current copy of each prior to or upon expirations.

B. Medical and Affiliated Staff Appointment/Reappointment Paperwork:
All medical staff members are required to complete in full and submit the necessary medical/affiliated staff appointment/reappointment paperwork within the time limit specified by the office requesting the paperwork.

C. Medical Staff Members Assigned as Proctors:
All medical staff members assigned as proctors to junior members are required to complete the necessary proctoring documentation in accordance with the [SFGH/ZSFG](#) Department of Psychiatry Proctoring Policy (see Section II of this policy). It is the responsibility of either the peer reviewer or the individual medical staff member, whichever applies, to ensure that all documentation is completed in full and submitted within the time limit specified by the Quality Management Office.

D. Failure to Meet Documentation/Paperwork Compliance Deadlines:
In the event that the documentation/paperwork summarized in 1, 2 and 3 below is not provided within the time limit specified (as outlined in A, B, C, and D above), per [SFGH/ZSFG](#) Medical Staff Bylaws and the Rules and Regulations, the medical staff member will no longer qualify for medical staff and their appointment and privileges will be terminated.

1. Medical Staff members are responsible for providing the following documentation:
 - a. Licensure/Certification
 - Professional License
 - DEA Certification (MD^{2s}/~~DO~~/NP^{2s}-only)
 - Department of Psychiatry PRRT Training Certification (Attending Psychiatrists/psychologists only on the following services: Inpatient, PES, and C-L Services)
 - b. Appointment/Reappointment Paperwork
2. Proctors are responsible for providing the following documentation:
 - a. Proctoring documentation
3. Supervisors are responsible for arranging and/or providing the following:
 - a. Peer review findings
 - b. Recommendation requests

APPENDIX C – HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. EDUCATION OBJECTIVES

Rotation on the Psychiatry Service at ZSFG is primarily designed to provide the PGY-1 psychiatry resident with a comprehensive experience in the emergency and inpatient treatment of major mental illness. An emphasis is placed upon thorough assessment and diagnosis of the major mental disorders, as well as the major treatment modalities of inpatient psychiatry and emergency psychiatry. Clinical interviewing, crisis stabilization, family intervention, and psychopharmacology are among the important topics of study. Rotations for advanced residents (PGY-2 through PGY-4) focus on outpatient, case management, and consultation liaison psychiatry, with training experiences tailored to provide an in-depth exposure to these different treatment settings and the development of fundamental competencies in these clinical areas.

B. SUPERVISION AND EVALUATION

Residents at ZSFG are supervised and evaluated in an ongoing way via multiple channels.

1. Residents are not members of the medical staff. The clinical and medico-legal responsibility for their patient care activities rests with their supervisors, who are attending level members of the Active and Courtesy medical staff. The routine credentialing processes for medical staff membership permits monitoring of the quality of care provided. The same standards of quality apply as when the supervising attending member of the medical staff is the sole provider. The close involvement of the responsible attending psychiatrist is documented in the patients' medical records by written entries, co-signatures on key documents, treatment plans, discharge forms, diagnosis forms, etc.
2. In the PGY 1 year, residents on the ZSFG Inpatient Psychiatric Units meet at least daily with their on-ward supervisor, who interviews patients with them and directly supervises their work. The on-ward supervisor will also read and make notes in the patient's medical chart. The residents also meet once a week with their off-ward supervisor. (As for evaluation, each of these supervisors is responsible for ongoing feedback as well as a written evaluation at the end of each three-month rotation, which is discussed with the resident. It is the responsibility of the supervisor to provide written evaluations within the deadlines set by the Residency Training Program Office.)
3. In the PGY 1 year, residents rotating on the Psychiatric Emergency Service (PES) are supervised by the PES faculty attending psychiatrist, who interviews patients with them and directly supervises their work. The supervisor will also read and make notes in the patient's medical chart.
4. Residents rotating on the Psychiatric Consultation Liaison Service are supervised by an Attending Psychiatrist in several ways. The Attending Psychiatrist is accessible by pager throughout the work week to review urgent and emergent clinical issues. The resident attends daily general service and team rounds that provide settings for further clinical review. A weekly Case Conference provides a forum for the residents to intensively

review their clinical care of a patient. Finally, each resident meets weekly with their service supervisor to review challenging or problematic clinical issues

5. Advanced UCSF residents working on other services in the Department of Psychiatry are supervised by faculty attending psychiatrists and psychologists assigned to the service. The faculty attendings are responsible for the clinical care provided by the residents.
6. After hours, weekends, and holidays, on-call residents in-house are supervised by the faculty backup attending psychiatrist who is available by pager and able to come to the hospital if clinically indicated. Residents are strongly encouraged to call the faculty back-up for any clinical or administrative question, and are ***required*** to call for the following: new admissions to the Jail Psychiatric Unit, unexpected patient discharges from inpatient psychiatry, new consult requests ***TO*** non-psychiatric services, new consultation requests ***FROM*** non-psychiatric services, any significant changes in medical condition or treatment plan for current psychiatric inpatients, AWOL of a patient on an involuntary psychiatric hold, assault occurring on an inpatient psychiatry unit, administration of involuntary emergency medications, initiation of seclusion or restraint, and any difficult to resolve staff conflicts or system issues. The faculty attending psychiatrist is responsible for all clinical services provided by the on-call resident. In addition, licensed psychiatrists in the Psychiatric Emergency Service are available to the on-call resident for face-to-face consultation.
7. The Site Director meets with each of the PGY 1 residents to review their evaluation and progress in the program midway during their six month rotations. The evaluations and summary of the meetings are then placed in their permanent file.

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APPENDIX D – PSYCHIATRY HOUSESTAFF COMPETENCIES
Refer to CHN Website, House Staff Competencies link

APPENDIX E – PERFORMANCE IMPROVEMENT AND PATIENT SAFETY PLAN

**PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) PLAN
DEPARTMENT OF PSYCHIATRY**

Purpose

The purpose of the PIPS program of the Department of Psychiatry at San Francisco General Hospital is to promote desired patient outcomes by evaluating and improving processes that most affect patient care.

The PIPS program is a multidisciplinary effort, dependent upon the continued commitment and involvement of all staff, including both clinical and administrative, to provide our patients with the highest degree of quality care possible.

Goals

1. Improvement of patient outcomes and patient safety.
2. Improvement of the processes of care.
3. Awareness, understanding and involvement of all staff in quality and performance improvement through the integration of the concepts of quality into daily practice.
4. Coordination and integration of the processes of care between providers.

Objectives

1. To educate all staff in the concepts of performance improvement (PI) and patient safety.
2. To promote responsibility and accountability for the performance improvement process by each member of the staff.
3. To evaluate the quality and appropriateness of care through ongoing monitoring and evaluation activities specific to the Department of Psychiatry.
4. To design new processes that are effective, consistent with the organization's mission, that consider staff and patient needs, ideas, and expectations, and that are based on up to date information.
5. To identify and study processes/issues from a variety of data sources including: patient surveys, staff meetings, committee reports, PI reports, audits, infection control data, risk management, patient complaint data.
6. To determine trends or patterns that warrant further evaluation.
7. To conduct monitoring activities designed to evaluate processes that are high risk, high volume and problem prone.
8. To utilize the information obtained through surveys and identify the needs and expectations of patients and others; e.g. staff, providers.

9. To take corrective action on problems identified or processes that could be improved.
10. To re-evaluate the corrective actions taken and monitor the response.
11. To facilitate the collaboration of all PI groups and committees to identify and resolve intradepartmental and interdepartmental problems.
12. To recognize and support staff participation in unit and program based performance improvement and patient safety activities.

Authority and Accountability

- A. All performance improvement and patient safety activities are reported to the Department of Psychiatry Executive Committee, and the [SFGH/ZSFG](#) PIPS Committee. Nursing-specific performance improvement and patient safety activities are also reported to the Nursing Quality Improvement Coordination Committee. In addition, the [Inpatient Steering Committee Acute and Emergency Staff meeting](#), Medical Staff Meeting and Psychiatric Nursing Executive Committee review relevant findings in order to apply to clinical practice. **Inpatient and PES PIPS Activities**
The Inpatient Units and PES are integral parts of the department's PIPS Program. All units are involved in ongoing PI monitoring activities and unit staff participate in Department wide PIPS task forces. PIPS information is disseminated to the units through leadership meetings, [Inpatient Steering Committee Acute and Emergency Staff meeting](#), Medical Staff meetings and the Nursing QI Coordinating Committee.

In addition, Nursing reports to the Psychiatry Nursing QI Coordinating Committee. The purpose of this committee is to coordinate and provide continuity from a nursing perspective. [See Department of Nursing QI Plan for description.]

- B. **Department of Psychiatry Executive Committee**
The Department of Psychiatry Executive Committee guides and directs all departmental performance improvement and patient safety activities

1. Objectives
 - a. Plan and implement the department wide PIPS program.
 - b. Development and approval of the PIPS plan.
 - c. Selection of topics for department wide projects, and approval of PIPS outcome monitors and projects.
 - d. Review and discussion of the findings of PIPS studies and projects. When applicable initiation of plans of action to improve patient care using data gathered from Sentinel Event Reviews, Drug Usage Evaluations and PI monitoring activities and projects.
 - e. Identification of opportunities to improve care and reduce barriers to quality patient care.
 - f. Approval and implementation of recommendations for quality of care improvements.
 - g. Allocation of resources to facilitate the development, implementation, monitoring, evaluation and follow up of performance improvement activities.

- h. Assessment of the effectiveness of the PIPS program, at least annually, to determine its impact on patient care and service delivery.
 - i. Support the design and evaluation of new processes using the CQI process.
2. Committee Membership
- The Executive Committee meets monthly. Standing committee members include:
- Chief of Psychiatry, [committee chairperson]
 - Deputy Chief of Psychiatry
 - ~~Medical~~ Director of Psychiatry Emergency Services,
 - Director of Psychiatry Residency Training
 - ~~Director of Psychiatry Consult/Liaison Service~~
 - Nursing Director for Acute Psychiatry
 - Clinical Director for the Division of Substance Abuse and Addiction Medicine
 - Director of Citywide ~~Community Focus~~
 - ~~Director of Psychiatry Emergency Services~~
 - Division Director of Infant Child and Adolescence
 - ~~Director of Social Work~~
 - Director of Psychiatry Administration
 - Director of Alliance Health Project
 - Director of Trauma Recovery Services
 - ~~Director of Behavioral Health and Neuropsychology~~

A. Departmental/Program Monitoring and Activities

Through continuous monitoring and evaluation, the patient focused functions and organizational functions are improved. Indicators based on the scope of service and important aspects of care are generated and studied at the departmental, unit, or service level. Both outcomes and processes are monitored and when an improvement opportunity is identified an action plan designed to improve the function or process is developed and implemented.

1. Peer Review and Medication Monitoring – Evaluation of the adequacy and appropriateness of care is monitored annually through the Peer Review and Medication Monitoring processes. Medication monitoring processes measured include prescribing and ordering, preparing and dispensing, administration and monitoring the medications effects on patients. Peer review criteria, primarily documentation based, are reviewed by Medical Staff for compliance to documentation standards. When non-compliance is noted, staff are counseled regarding specific means of meeting the criteria. Results from Peer Review and Medication Monitoring are quantified annually, and reviewed by the administrative leadership.

Sentinel Event (SE) Review/Root Cause Analysis (RCA) – All unusual occurrences which meet Level I and Level II criteria are addressed. This process includes in-depth investigation of the incident, a determination of whether standards of care were met and, when appropriate, a SE Level I Review and Root Cause Analysis. The significant event reviews are designed to identify opportunities to improve processes, staff performance and the quality of patient care outcomes. These reviews are conducted with the oversight of the [SFGHZSFG](#) Risk Management Committee.

2. Drug Usage Evaluations – Standards relating to the ongoing evaluation of drug usage are applied using specific criteria to measure appropriateness and effectiveness of medications used in the Department of Psychiatry. Criteria based studies are conducted that focus on frequently prescribed medications [high volume], medication that carries with it a significant degree of risk for the patient [high risk and/or drugs that are used for a specific diagnosis or condition. Results of Drug Usage Evaluations include the mechanisms for improvement in the use of the medication and are disseminated to the Medical Staff, Executive Committee and PIPS Committees.
3. Patient Complaint/Grievance- The department is committed to providing quality care and service in accordance with our patients needs and desires. When a patient or a patient’s significant other(s) is dissatisfied with any aspect of care provided within the psychiatry department, Quality Improvement will be notified and an investigation will be conducted. The Quality Improvement Coordinator will collaboratively work with the patients and the treatment team to resolve all patient complaints. All complaints received will be tracked and reported annually to the Patient Concern Subcommittee of the [SFGHZSFG](#) Performance Improvement and Patient Safety Committee (PIPS) [See Department of Psychiatry Patient Complaint Policy #8.2]

Reporting of PIPS Activities

The activities of each committee are documented. This provides a way to monitor problems that are identified in the PIPS forum and to insure implementation of improvements. Priority is given to those aspects of patient care that are high risk, high volume and/or problem prone.

All departmental PIPS activities are reported to the [SFGHZSFG](#) PIPS through annual reports and presentations. The Department of Psychiatry program is fully integrated into the [SFGHZSFG](#) PIPS program.

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EFFECTIVE DATE: MARCH 2002
REVISED: May 2012
May, 2014
August 2016
November 2018

CROSS REFERENCE: Unusual Occurrence: Significant Event Management
Significant Event Review Program
Patient Complaint Policy

Approved By:

Chief, Department of Psychiatry

Date

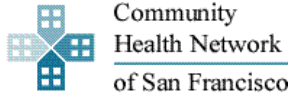
Director of Administration, Psychiatry

Date

Director, Psychiatric Nursing Division

Date

APPENDIX F – MEDICAL RECORDS DOCUMENTATION



*The Integrated Delivery System
Of San Francisco's Department of
Public Health*

DEPARTMENT OF PSYCHIATRY

5.3A

TITLE: Medical Record Documentation Policy - Medical Staff

POLICY: It is the policy of the San Francisco General Hospital Department of Psychiatry that medical services provided to patients are documented in accordance with the procedure as stated in this document.

PURPOSE: To ensure adequate and consistent standards of medical records charting in the Department of Psychiatry.

PROCEDURE:

A) Medical Staff Psychiatric Emergency Service (PES):

PES is responsible for initiating the following:

- psychiatric service record
- PES intake evaluation form/initial assessment (including medical history)
- admission orders
- [SEGHZSFG](#) registration and admission forms
- voluntary admission/patient consent for medication, or, 5150/5150 advisement forms
- informed consent/medication advisement forms
- medical screening exam

The inpatient attending physician is responsible for evaluating the patient and documenting an Initial Psychiatric Assessment and Treatment Plan within 24 hours of inpatient admission. Inpatient attending physician progress notes shall be completed on all inpatients deemed by Utilization Management to be receiving an acute level of care.

Medical Staff- Consultation/Liaison Service (C/L):

The Consultation/Liaison (C/L) staff is responsible for completing the following documentation:

- consultation report
- daily follow up notes on patients held on 5150 involuntary holds, and others as clinically appropriate
- PSR form
- Attending or Resident transfer note if admitted to Inpatient Psychiatry
- Medication consents (as appropriate) and legal status documents

If a patient is admitted after 4:30 p.m., C/L is responsible for completing the admission orders to inpatient psychiatry. If a patient is admitted between 8:00 a.m. and 4:30 p.m., the inpatient unit staff is responsible for completing the admission orders.

B) Medical Staff - Jail Psychiatric Services (JPS):

For patients admitted from JPS to 7B or 7L, JPS is responsible for completing the following forms. These forms must accompany the patient upon transfer.

JPS evaluation form
5150

For admissions between 8:30 a.m. and 4:30 p.m., the inpatient unit staff is responsible for the following:

- patient evaluation
- PSR
- Inpatient admission orders
- physical exam
- Initial Psychiatric Assessment and Treatment Plan
- [SFGHZSFG](#) registration and admission forms
- voluntary admission/patient consent for medication forms or 5150/5150 advisement forms (if appropriate)

Medication consent forms for night and weekend admissions from JPS, the on-call resident and attending faculty back- up assume the above responsibilities. The responsibilities of the inpatient resident and attending physician are as previously outlined.

C) Medical Staff Inpatient Unit:

A. Admission Orders: Review admission orders from PES and revise as indicated.

B. Admission Note:

The initial psychiatric assessment is completed and placed in the database section of the chart and includes the following categories:

- chief complaint

- history of present illness
- pertinent medical, psychiatric, substance abuse, alcohol withdrawal, family, educational, occupational and social history
- active medical problems/findings
- TB screening status
- Physical exam status
- patient's personal strengths
- patient's level of function
- mental status examination
- [DSM-IV-TR-ICD-10](#) diagnosis initial plan of care with goals/rationale
- treatment interventions
- disposition plan
- indication of patient's level of involvement in the plan, and signature if obtainable
- Attending physician signature with name and CHN# in legible fashion

C. Physical Examination and Review of Systems: See P&P #2.11.01

D. Interdisciplinary Plan of Care:

The Treatment Team will review and update the Interdisciplinary Plan of Care every four days.

E. Progress Notes:

Progress notes are written each day (7 days/week) by the psychiatry attending for all patients deemed by Utilization Management to be receiving acute care. These notes should address the current mental status; assessment (including documentation of medical necessity for acute care), disposition and treatment plan specifically addressing problems outlined in the initial and subsequent plans. Rationale for medication order changes (including dose and type) must be documented.

F. Discharge Plan and Exit Record:

The Patient Discharge Summary (GAF Ratings, [DSM-IV-TR-ICD-10](#), and Post-hospital care referral) must be completed at the time of discharge.

- a. A clinician to clinician discussion of the patient's medical care needs is required for patients who are being discharged to another hospital or jail.
- b. Written Discharge Summary: The attending physician certifies oversight and responsibility for the patient's hospital course by signing the written discharge summary.

Discharge Plan:

1. Identifying information:

- Patient's name, B#, Date of Birth (if possible, use addressograph stamp)
- Admission/Discharge dates
- Admission/Discharge units
- Admission/Discharge legal status

2. Treatment Information:

- a. Multiaxial diagnosis (ICD-10) (The first diagnosis listed on Axis I is the principal diagnosis)
- b. Medication upon discharge (and amount given at discharge)
- c. Brief summary of hospitalization - include the following:
 - reasons for admission
 - mental status
 - course of treatment
 - medication response
 - complications
 - suicidal and assaultive behavior/ideation
 - abnormal physical exam and lab data
- 3. Resident physician's signature (if completed by Resident physician)
- 4. Attending physician's signature.

G. Signatures:

When documenting in the patient's medical record, each entry must include the staff person's name, ID #, training status, current date and signature in legible form.

Each database form must be signed and dated by the attending physician with the CHN# and name in legible form. An attending co-signature must accompany medical student documentation.

H. Monitoring:

The Attending Psychiatrist is responsible for reviewing and ensuring the completeness of medical staff, resident, and medical student documentation

Revised: June, 1995
May, 1999
May, 2000
March, 2002
August 2004
May, 2010
May, 2012
May, 2014
May, 2016

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November, 2018

Approved:



Mark Leary, MD
Interim Chief, Department of Psychiatry

San Francisco General Hospital
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APPENDIX G – CHIEF PSYCHIATRY CLINICAL SERVICE JOB DESCRIPTION

CHIEF OF PSYCHIATRY CLINICAL SERVICE JOB DESCRIPTION

Position Summary:

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

Reporting Relationships:

The Chief of the Psychiatry Clinical Service reports directly to the Associate Dean and the University of California, San Francisco (UCSF) Department Chair. The Chief is reviewed not less than every five years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Associate Dean, the UCSF Department Chair, and the [SFGHZSFG](#) Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.

Position Qualifications:

The Chief of the Psychiatry Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at [SFGHZSFG](#).

Major Responsibilities:

The major responsibilities of the Chief of the Psychiatry Clinical Service include the following:

Providing the necessary vision and leadership to effectively motivate and direct the Service in developing and achieving goals and objectives that are congruous with the values, mission, and strategic plan of [SFGHZSFG](#) and the DPH;

In collaboration with the Executive Administrator and other ZSFG leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement, reviewing and approving Service policies and procedures, identifying new clinical services that need to be implemented, and supporting clinical services provided by the Department;

In collaboration with the Executive Administrator and other [SFGHZSFG](#) leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of Service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and

Performing all other duties and functions spelled out in the [SFGHZSFG](#) Medical Staff Bylaws.

APPENDIX H -

**PSYCHIATRIC CONSULTATION SERVICE
DIVISION OF Acute and Emergency Services/ ZSFG DEPARTMENT OF PSYCHIATRY**

The mission of the Consultation Services is to assist the clinical staff to identify, evaluate and intervene with acute management difficulties of patients who are emotionally impaired or mentally disordered.

1. *Referral Criterion*

- Medically admitted adults at [SFGHZSFG](#)

2. *Service Priorities*

High

- Patients currently on a legal psychiatric hold (5150, 5250 and TCon)
- Patients immediately at risk for suicidal behavior
- Patients with a mental disorder and immediate risk for assaultive behavior
- Patients with severely disorganized or chaotic behavior

Routine

- Evaluation for psychiatric diagnosis
- Evaluation for non-emergent psychiatric intervention
- Evaluation for psychiatric aftercare
- Advisory opinion regarding informed consent
- Patients in whom a mental disorder may significantly influence cooperation with staff or treatment
- Enhancement of the provider/patient relationship
- Patients transferred down from Psychiatry

3. *To Refer*

Monday - Friday, 8:00 a.m. - 5:00 p.m. - 327-9058

Other hours throughout the week - 327-9058 - **(Emergency / Urgent Cases Only)**

4. *Please provide the following information:*

- Patient name
- Medical Record Number
- Service
- Attending Physician
- Patient Location
- Brief description of patient and referral question

5. Please leave a consultation request that includes the name of the attending physician in front of the chart.

6. Please inform the patient that you have asked us to see him/her.

Please Note: We are able to optimize our assistance and coordination of services when we are contacted early in the day and as early in the week as possible. We must see all patients admitted on psychiatric holds at least once.