

ATTACHMENT I
Documents Relied Upon

Available under the heading "DPH-05-010, Scope of Practice in Licensed Health Facilities" at

<http://ww2.cdph.ca.gov/services/DPOPP/regs/Pages/ProposedRegulations.aspx>

- A. November 8, 2004, Petition from Psychology Shield
- B. November 22, 2004, California Department of Health Services acknowledgement of receipt of November 8, 2004, petition
- C. April 26, 2005, California Department of Health Services response to the November 8, 2004 petition

ATTACHMENT 1-A

PSYCHOLOGY SHIELD

Committed to improving quality
and access to treatment in
state health facilities

November 8, 2004

Ms. Sandra Shewry
Director Department of Health Services
1501 Capitol, Room 600
Sacramento, CA 95814

RE: DEPARTMENT OF HEALTH SERVICES REGULATIONS TO
IMPLEMENT HEALTH AND SAFETY CODE SECTION 1316.5
and CAPP v. Rank

Dear Ms. Shewry:

In your recent testimony to the Senate Rules Committee you indicated that the Department of Health Services is willing to draft regulations pursuant to Rule 100, which would fully implement Health & Safety Code §1316.5 ("§1316.5") and its interpretation by the California State Supreme court in *CAPP v Rank*¹. We very much appreciate the priority that you have given to this important and long-standing concern both of the State Legislature and of the Supreme Court. We also would like to extend our appreciation to you and your staff for taking the first steps in achieving full enforcement of State law that governs the practice of psychology in California.

The purpose of this letter is to provide you with a brief history of the legislature's efforts to implement the law and to provide you with the background and the language that will be needed to formulate the new regulations and enforcement strategies.

In 1978, the State Legislature enacted California Health & Safety Code §1316.5 ("~~§1316.5~~") based upon its explicit findings that broader, more cost effective treatment options would be achieved if qualified psychologists were allowed to assume responsibility for the care of patients in health facilities. Instead of implementing this statute, the DHS issued illegal, discriminatory regulations that required a physician to be "Captain of the Ship," i.e., assume overall responsibility for care of all institutionalized patients. The California Supreme Court, in the 1990 *CAPP v Rank* decision, reviewed the actions of DHS and affirmed a trial court order compelling the Department of Health Services to enforce the law and issue non-discriminatory regulations.

¹ 51 Cal. 3d. 1 (1990).

Despite the Supreme Court decision and the clear language of §1316.5, DHS failed to (i) enforce the law, or (ii) amend its discriminatory regulations; and instead allowed discriminatory treatment of psychologists to continue in health facilities. Responding to the continuing discrimination in state-owned and operated health facilities, in overwhelming bipartisan actions, the Legislature strengthened §1316.5 in 1996 (AB3141) and again in 1998 (AB 947). The second bill was clearly understood as a strong legislative reaction to the failure to implement the law. The amendments to §1316.5 strengthened the anti-discrimination provisions and mandated health facility rules and medical staff by-laws that provide for full clinical privileges for psychologists within the scope of their licensure in all state owned and operated health facilities

Many years of implementation failures have blocked the improvements in patient care and relief for the California taxpayers that the Legislature was seeking. Accordingly, the following issues must now be addressed aggressively, within the letter and spirit of the law and as mandated by legislative and court directives.

- DHS regulations still unlawfully restrict psychologists from performing services that the Legislature and the Supreme Court have specifically stated psychologists and psychiatrists should perform "without discrimination."
- DHS facilitates discrimination against psychology services in health facilities both by enforcing regulations that compel the discrimination specifically proscribed by the Legislature and Supreme Court and by using ambiguous regulations that are exploited by interests in health facilities that resist implementing the law in good faith.

To resolve these problems of implementation, we strongly recommend that you consider the following:

1. Compliance with the *CAPP* trial court order, as affirmed by the Supreme Court, requires issuance of regulations that do not permit the kinds of discrimination against psychologists that is occurring in health facilities. These regulations must be clear and specify that psychologists are the protected class of practitioners under 1316.5, the relevant law that is specific to psychologists. (There is no prohibition in law against a health facility discriminating against health providers who are not members of the medical staff. Accordingly, the determination of scope of practice to enforce

nondiscrimination is relevant only to psychologists. Regulatory language relevant to scope of practice of psychologists that is drafted too broadly so it applies to non-psychologists is inappropriate because only psychologists are the protected class on the medical staff in 1316.5. None of the practitioners in health facilities who are not on the medical staff have any protection against discrimination in statute or *CAPP v. Rank*.) Specific clarity in the regulations are also needed to assure that DHS surveyors and health facilities can and will identify discrimination as defined by *CAPP* and 1316.5. Because discrimination is also institutionalized within DHS, regulations must also make clear that, for the first time, 1316.5 and *CAPP v. Rank*

enforcement is a part of the job description of those individuals that DHS relies upon to enforce state law in health facilities.

2. Regulations that clearly and faithfully implement California law require that psychologists be specifically identified as having authority to provide services without physician supervision. According to State law, physicians are not always "Captain of the Ship." The services to which I refer include, but are not limited to, the following:

Serving as attending clinicians for patients with a diagnosis of mental or emotional disorder;

Providing and order care and consultations for patients;

Ordering restraint and seclusion,

Assuming overall care of patients;

Approving patient care plans;

Providing the diagnosis of record;

Assessing patient's competency to consent to medical treatment;

Assessing the effects/side effects of psychotropic medications and the indications for those medications;

Assuming primary responsibility for mental health treatment/team leadership;

Initiating or accepting patient admissions including intake evaluations;

Writing orders for discharge;

~~Writing transfer orders;~~

Diagnosing mental disorders;

Issuing orders to nursing and other staff;

Writing orders for audiological consultations;

Writing orders for speech consultations;

Writing orders for psychological consultations;

Writing orders for educational consultations;

Writing orders for grounds privileges;

Writing orders for home passes;

Practice of individual psychotherapy;

Practice of group therapy;

Practice of behavioral assessment;

Practice of behavior therapy;

Practice of family therapy;

Practice of psychological assessment;

Practice of biofeedback;

Practice of hypnotherapy;

Practice of neuropsychological assessment;

Writing orders for suicide watch;

Participation in medical staff governance/administration;

3. Educate DHS surveyors that it is not the job of the health facilities, the physicians, surveyors of health facilities, or the DHS to determine what is within or not within psychologists' scope of practice. The surveyors are only to apply the definitions that have been provided to them. The Legislature has decided, and the Supreme Court in *CAPP* confirmed, that psychologists are on an equal footing with physicians except psychologists may not prescribe medication, perform surgery, administer electroconvulsive therapy or use biofeedback instruments that pierce or cut the skin.

DHS has an obligation to recognize and enforce violations of state law. Moreover, because DHS has in the past fostered and continues to actively discriminate in the licensing and certification programs, DHS now has an obligation to mitigate the current institutionalization of illegal discrimination. There are obvious indicators of discrimination. For example, if there were no discrimination against psychologists in health facilities, psychologists would be well represented throughout the health facility in clinical decision-making roles. Instead, the major clinical management and policy roles

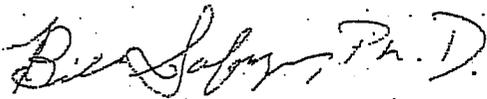
are. by formal and informal health facility policy, predominantly filled by physicians because of "Captain of the Ship" policies. Those in management who are not physicians are there because they have tacitly agreed to continue the discriminatory Captain of the Ship policies. To enforce the mandated nondiscrimination in health facilities, DHS must provide in regulations a clear template for health facilities and DHS surveyors to use to identify discrimination, formal and informal, by its results.

Further, those who report discrimination and violations of public policy must be protected in regulation from retaliation by the health facility. Surveyors need to have sources of information within health facilities that include information from psychologists if there is going to be effective enforcement of policies that prohibit discrimination against psychologists.

Finally, the health facilities that have been discriminating against psychologists for 25 years with only a wink and a nod from DHS may not quickly understand that continued stalling is not going to be tolerated. To make there is compliance with the law, DHS must also establish a deadline for health facilities' compliance with 1316.5 since stalling is the most effective tactic that has been used to avoid implementing the law.

Thank you for your continued courtesy, cooperation, and anticipated prompt response. Enclosed is a list of current regulations which violate the law and which must be changed, along with suggestions of language which would bring the regulations into compliance with the law. (While this list is intended to be comprehensive, it is possible that other regulations might also have to be changed.) If you need any additional information, please do not hesitate to contact me.

Sincerely,



Bill Safarjan, Ph.D.

Cc: The Honorable Judy Chu
California Psychological Association

WordPerfect Document Compare Summary

Original document: ::ODMA\WORLDOXT\NEWLIT\21437\17002\ARC4685.WPD

Revised document: ::ODMA\WORLDOXT\NEWLIT\21437\17002\ARC4698.WPD

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Insertions are shown with the following attributes and color:

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ILLEGAL REGULATIONS - REVISED

GENERAL ACUTE CARE HOSPITALS (CHAPTER 1; §§ 70001 to 70923)

22 CCR §70101. Inspection of Hospitals

(a) The Department shall inspect and license hospitals.

(b) Any officer, employee or agent of the Department may, upon presentation of proper identification, enter and inspect any building or premises at any reasonable time to secure compliance with, or to prevent a violation of, any provision of these regulations.

(c) All hospitals for which a license has been issued shall be inspected periodically by a representative or representatives appointed by the Department. Inspections shall be conducted as frequently as necessary, but not less than once every two years, to assure that quality care is being provided. During the inspection, the representative or representatives of the Department shall offer such advice and assistance to the hospital as is appropriate. For hospitals of 100 licensed bed capacity or more, the inspection team shall include at least a physician, psychologist, registered nurse and persons experienced in hospital administration and sanitary inspections.

(d) The Department may provide consulting services upon request to any hospital to assist in the identification or correction of deficiencies or the upgrading of the quality of care provided by the hospital.

(e) The Department shall notify the hospital of all deficiencies of compliance with these regulations and the hospital shall agree with the Department upon a plan of corrections which shall give the hospital a reasonable time to correct such deficiencies. If at the end of the allotted time, as revealed by repeat inspection, the hospital has failed to correct the deficiencies, the Director may take action to revoke or suspend the license.

(f) Reports on the results of each inspection of a hospital shall be prepared by the inspector or inspection team and shall be kept on file in the Department along with the plan of correction and hospital comments. The inspection report may include a recommendation for reinspection. All inspection reports, lists of deficiencies and plans of correction shall be open to public inspection without regard to which body performs the inspection.

(g) The Department shall have the authority to contract for outside personnel to perform inspections of hospitals as the need arises. The Department, when feasible, shall contract with nonprofit, professional organizations which have demonstrated the ability to carry out the provisions of this section. Such organizations shall include, but not be limited to, the California Medical Association Committee on Medical Staff Surveys, the California Psychological Association, the California Dental Association, the California Dental Association and participants in the Consolidated Hospital Survey Program.

22 CCR §70577. Psychiatric Unit General Requirements

(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

(b) The responsibility and the accountability of the psychiatric service to the medical staff and administration shall be defined.

(c) The psychiatric unit shall be used for patients with the diagnosis of a mental disorder requiring hospital care. For purposes of these regulations "mental disorder" is defined as any psychiatric illness or disease, whether functional or of organic origin.

(d) Medical services.

(1) Psychiatrists or clinical psychologists within the scope of their licensure and subject to the rules of the facility, shall be responsible for the diagnostic formulation for their patients and the development and implementation of each patient's treatment plan.

(2) Medical examinations shall be performed as often as indicated by the medical needs of the patient as determined by the patient's attending psychiatrist or psychologist. Reports of all medical examinations shall be on file in the patient's medical record.

(3) A psychiatrist or psychologist shall be available at all times for psychiatric emergencies.

(4) An appropriate committee of the medical services shall:

(A) Identify and recommend to administration the equipment and supplies necessary for emergency medical problems.

(B) Develop a plan for handling and/or referral of patients with emergency medical problems.

(C) Determine the circumstances under which electroconvulsive therapy may be administered.

(D) Develop guidelines for the administration of a drug when given in unusually high dosages or for purposes other than those for which the drug is customarily used.

(e) Psychological services shall be provided by clinical psychologists within the scope of their licensure and subject to the provisions of Section 1316.5 of the Health and Safety Code

(1) Facilities which permit clinical psychologists to admit patients shall do so only if there are arrangements to have staff physicians who will provide the necessary medical care to the patients.

(2) Only staff physicians shall assume responsibility for those aspects of patient care which may be provided only by physicians.

(f) Provision shall be made for the rendering of social services by social workers at the

request of a patient's attending physician or psychologist.

(g) Therapeutic activity program.

(1) Every unit shall provide and conduct organized programs of therapeutic activities in accordance with the interests, abilities and needs of the patients.

(2) Individual evaluation and treatment plans which are correlated with the total therapeutic program shall be developed and recorded for each patient.

(h) Education.

(1) No hospital shall accept children of school age who are educable or trainable and who are expected to be a patient in the unit for one month or longer unless an educational or training program can be made available for such children in accordance with their needs and conditions.

(2) Educational programs provided in the facility shall follow those programs established by law, and shall be under the direction of teachers with California teaching credentials.

(3) If children attend community schools, supervision to and from school shall be provided in accordance with the needs and conditions of the patients.

(4) Transportation to and from school shall be provided where indicated.

(i) The medical records of all patients admitted to the unit shall contain a legal authorization for admission. Release of information or medical records concerning any patient shall be only as authorized under the provisions contained in Article 7 (commencing with Section 5325; and Section 5328 in particular) Part 1, Division 5 of the Welfare and Institutions Code.

(j) Restraint of patients.

(1) Restraint shall be used only when alternative methods are not sufficient to protect the patient or others from injury.

(2) Patients shall be placed in restraint only on the written order of the physician or psychologist. This order shall include the reason for restraint and the type of restraint to be used. In a clear case of emergency, a patient may be placed in restraint at the discretion of a registered nurse and a verbal or written order obtained thereafter. If a verbal order is obtained it shall be recorded in the patient's medical record and be signed by the physician or psychologist on his next visit.

(3) Patients in restraint by seclusion or mechanical means shall be observed at intervals not greater than 15 minutes.

(4) Restraints shall be easily removable in the event of fire or other emergency.

(5) Record of type of restraint including time of application and removal shall be in the patient's medical record.

(k) Patients' rights.

(1) All patients shall have rights which include, but are not limited to, the following:

(A) To wear his own clothes, to keep and use his own personal possessions including his toilet articles; and to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases.

(B) To have access to individual storage space for his private use.

(C) To see visitors each day.

(D) To have reasonable access to telephones, both to make and receive confidential calls.

(E) To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.

(F) To refuse shock treatment.

(G) To refuse lobotomy.

(H) To be informed of the provisions of law regarding complaints and of procedures for registering complaints confidentially, including but not limited to, the address and telephone number of the complaint receiving unit of the Department.

(I) All other rights as provided by law or regulations.

(2) The physician or psychologist who has overall responsibility for the unit or his designee, may for good cause, deny a person any of the rights specified in (1) above, except those rights specified in subsections (F), (G) and (I) above and the rights under subsection (F) may be denied only under the conditions specified in Section 5326.4, Welfare and Institutions Code. The denial, and the reasons therefor, shall be entered in the patient's medical record.

(3) These rights, written in English and Spanish, shall be prominently posted.

(l) Psychiatric unit staff shall be involved in orientation and in-service training of hospital employees.

(m) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.

22 CCR §70s-79. Psychiatric Unit Staff

(a) If a psychiatrist is not the administrative director of the psychiatric unit, a psychiatrist who is certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology, shall be responsible for the medical care and services of the unit, including all those acts of diagnosis, treatment, or prescribing or ordering of drugs which may only be performed by a licensed physician.

(b) A clinical psychologist shall be available on a full-time, part-time or consulting basis. The clinical psychologist shall function on such terms and conditions as the facility shall

establish.

(c) A registered nurse with two years experience in psychiatric nursing shall be responsible for the nursing care and nursing management of the psychiatric unit.

(d) There shall be registered nurses with training and experience in psychiatric nursing on duty in the unit at all times.

(e) There shall be sufficient nursing staff, including registered nurses, licensed vocational nurses, licensed psychiatric technicians and mental health workers to meet the needs of the patients.

(f) A qualified therapist should be employed to conduct the therapeutic activity program. Therapists that may be involved in the program include occupational, music, art, dance and recreation therapist.

(g) A social worker shall be employed on a full-time, regular part-time or consulting basis.

22 CCR §70703. Organized Medical Staff

(a) Each hospital shall have an organized medical staff responsible to the governing body for the adequacy and quality of the medical care rendered to patients in the hospital.

(1) The medical staff shall be composed of physicians, psychologist and, where dental or podiatric services are provided, dentists or podiatrists.

~~(2) Where clinical psychological services are provided, clinical psychologists may be appointed to the medical staff subject to the by-laws, rules and regulation of the hospital.~~

(b) The medical staff, by vote of the members and with the approval of the governing body, shall adopt written by-laws which provide formal procedures for the evaluation of staff applications and credentials; appointments, reappointments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate. The medical staff shall abide by and establish a means of enforcement of its by-laws. Medical staff by-laws, rules and regulations shall not deny or restrict within the scope of their licensure, the voting right of staff members or assign staff members to any special class or category of staff membership, based upon whether such staff members hold an M.D., D.O., D.P.M., OR D.D.S. degree or clinical psychology license.

(c) The medical staff shall meet regularly. Minutes of each meeting shall be retained and filed at the hospital.

(d) The medical staff by-laws, rules, and regulations shall include, but shall not be limited to, provision for the performance of the following functions: executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting the medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. These functions may be performed by individual committees, or when appropriate, all functions or more than one function may be performed by a

single committee. Reports of activities and recommendations relating to these functions shall be made to the executive committee and the governing body as frequently as necessary and at least quarterly.

(e) The medical staff shall provide in its by-laws, rules and regulations for appropriate practices and procedures to be observed in the various departments of the hospital. In this connection the practice of division of fees, under any guise whatsoever, shall be prohibited and any such division of fees shall be cause for exclusion from the staff.

(f) The medical staff shall provide for availability of staff physician for emergencies among the in-hospital population in the event that the attending physician or psychologist or his alternate is not available.

(g) The medical staff shall participate in a continuing program of professional education. The results of retrospective medical care evaluation shall be used to determine the continuing education needs. Evidence of participation in such programs shall be available.

(h) The medical staff shall develop criteria under which consultation will be required. These criteria shall not preclude the requirement for consultations on any patient when the director of the service, chairman of a department or the chief of staff determines a patient will benefit from such consultation.

22 CCR §70706. Interdisciplinary Practice and Responsibility for Patient Care

(a) In any facility where registered nurses will perform functions requiring standardized procedures pursuant to Section 2725 of the Business and Professions Code, or in which licensed or certified healing arts professionals who are not members of the medical staff will be granted privileges pursuant to Section 70706.1 there shall be a Committee on Interdisciplinary Practice established by and accountable to the Governing Body, for establishing policies and procedures for interdisciplinary medical practice.

(b) The Committee on Interdisciplinary Practice shall include, as a minimum, the director of nursing, the administrator or designee and an equal number of physicians or psychologists appointed by the Executive Committee of the medical staff, and registered nurses appointed by the director of nursing. Licensed or certified health professionals other than registered nurses who are performing or will perform functions as in (a) above shall be included in the Committee.

(c) The Committee on Interdisciplinary Practice shall establish written policies and procedures for the conduct of its business. Policies and procedures shall include but not be limited to:

(1) Provision for securing recommendations from members of the medical staff in the medical specialty, or clinical field of practice under review, and from persons in the appropriate nonmedical category who practice in the clinical field or specialty under review.

(2) Method for the approval of standardized procedures in accordance with Sections 2725 of

the Business and Professions Code in which affirmative approval of the administrator of designee and a majority of the physician members and a majority of the registered nurse members would be required and that prior to such approval, consultation shall be obtained from facility staff in the medical and nursing specialties under review.

(3) Providing for maintaining clear lines of responsibility of the nursing service for nursing care of patients and of the medical staff for medical services in the facility.

(4) Intended line of approval for each recommendation of the Committee.

22 CCR §70706.2. Standardized Procedures

(a) The Committee on Interdisciplinary Practice shall be responsible for:

(1) Identifying functions and/or procedures which require the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the facility, and initiating the preparation of such standardized procedures in accordance with this section.

(2) The review and approval of all such standardized procedures covering practice by registered nurses in the facility.

(3) Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee on Interdisciplinary Practice or by delegation to the director of nursing.

(b) Each standardized procedure shall:

(1) Be in writing and show date or dates of approval including approval by the Committee on Interdisciplinary Practice.

(2) Specify the standardized procedure functions which registered nurses are authorized to perform and under what circumstances.

(3) State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure.

~~(4) Specify any experience, training or special education requirements for performance of the functions.~~

(5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the functions.

(6) Provide for a method of maintaining a written record of those persons authorized to perform the functions.

(7) Specify the nature and scope of review and/or supervision required for the performance of the standardized procedure functions; for example, if the function is to be performed only

under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated.

(8) Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician or psychologist concerning the patient's condition.

(9) State any limitations on settings or departments within the facility where the standardized procedure functions may be performed.

(10) Specify any special requirements for procedures relating to patient recordkeeping.

(11) Provide for periodic review of the standardized procedure.

(c) If nurses have been approved to perform procedures pursuant to a standardized procedure, the names of the nurses so approved shall be on file in the office of the director of nursing.

22 CCR §70707. Patients' Rights

(a) Hospitals and medical staffs shall adopt a written policy on patients' rights.

(b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights may be read by patients. This list shall include but not be limited to the patients' rights to:

(1) Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, or the source of payment for care.

(2) Considerate and respectful care.

(3) Knowledge of the name of the physician or psychologist who has primary responsibility for coordinating the care and the names and professional relationships of other physicians or psychologist and nonphysicians who will see the patient.

(4) Receive information about the illness, the course of treatment and prospects for recovery in terms that the patient can understand.

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

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

(7) Full consideration of privacy concerning the medical care program. Case discussion,

consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.

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

(9) Reasonable responses to any reasonable requests made for service.

(10) Leave the hospital even against the advice of physicians or psychologists.

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

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

(13) Be informed of continuing health care requirements following discharge from the hospital.

(14) Examine and receive an explanation of the bill regardless of source of payment.

(15) Know which hospital rules and policies apply to the patient's conduct while a patient.

(16) Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

(17) Designate visitors of his/her choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, unless:

(A) No visitors are allowed.

(B) The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.

(C) The patient has indicated to the health facility staff that the patient no longer wants this person to visit.

(18) Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any person living in the household.

(19) This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

(c) A procedure shall be established whereby patient complaints are forwarded to the hospital administration for appropriate response.

(d) All hospital personnel shall observe these patients' rights.

22 CCR §70749. Patient Health Record Content

(a) Each inpatient medical record shall consist of at least the following items:

~~(1) Identification sheets which include but are not limited to the following:~~

(A) Name.

(B) Address on admission.

(C) Identification number (if applicable).

1. Social Security.

2. Medicare

3. Medi-Cal

(D) Age.

(E) Sex.

(F) Marital status.

(G) Religion.

(H) Date of admission.

(I) Date of discharge.

(J) Name, address and telephone number of person or agency responsible for patient.

(K) Name of patient's admitting physician or psychologist.

(L) Initial diagnostic impression.

(M) Discharge or final diagnosis.

(2) History and physical examination.

(3) Consultation reports.

(4) Order sheet including medication, treatment and diet orders.

~~(5) Progress notes including current or working diagnosis.~~

(6) Nurses' notes which shall include but not be limited to the following:

(A) Concise and accurate record of nursing care administered.

(B) Record of pertinent observations including psychosocial and physical manifestations as well as incidents and unusual occurrences, and relevant nursing interpretation of such observations.

(C) Name, dosage and time of administration of medications and treatment. Route of

administration and site of injection shall be recorded if other than by oral administration.

(D) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for soft tie restraints used for support and protection of the patient.

(7) Vital sign sheet.

(8) Reports of all laboratory tests performed.

(9) Reports of all X-ray examinations performed.

(10) Consent forms, when applicable.

(11) Anesthesia record including preoperative diagnosis, if anesthesia has been administered.

(12) Operative report including preoperative and postoperative diagnosis, description of findings, technique used, tissue removed or altered, if surgery was performed.

(13) Pathological report, if tissue or body fluid was removed.

(14) Labor record, if applicable.

(15) Delivery record, if applicable.

(16) A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, his condition on discharge and the recommendations and arrangements for future care.

22 CCR §70751. Medical Record Availability

(a) Records shall be kept on all patients admitted or accepted for treatment. All required patient health records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of:

(1) The admitting physician or psychologist.

(2) The nonphysician granted privileges pursuant to Section 70706.1.

(3) The hospital or its medical staff or any authorized officer, agent or employee of either.

(4) Authorized representatives of the Department.

(5) Any other person authorized by law to make such a request.

(b) The medical record, including X-ray films, is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. The hospital shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

(c) Patient records including X-ray films or reproduction thereof shall be preserved safely for

a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.

(d) If a hospital ceases operation, the Department shall be informed within 48 hours of the arrangements made for safe preservation of patient records as above required.

(e) If ownership of a licensed hospital changes, both the previous licensee and the new licensee shall, prior to the change of ownership, provide the Department with written documentation that:

(1) The new licensee will have custody of the patients' records upon transfer of the hospital and that the records are available to both the new and former licensee and other authorized persons; or

(2) Arrangements have been made for the safe preservation of patient records, as above required, and that the records are available to both the new and former licensees and other authorized persons.

(f) Medical records shall be filed in an easily accessible manner in the hospital or in an approved medical record storage facility off the hospital premises.

(g) Medical records shall be completed promptly and authenticated or signed by a physician, psychologist, dentist or podiatrist within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a ~~physician's~~ physician, psychologist, dentist, or podiatrist's signature, only when that physician, psychologist, dentist, or podiatrist has placed a signed statement in the hospital administrative offices to the effect that he is the only person who:

(1) Has possession of the stamp or key;

(2) Will use the stamp or key.

(h) Medical records shall be indexed according to patient, disease, operation and physician.

(i) By July 1, 1976 a unit medical record system shall be established and implemented with inpatient, outpatient and emergency room records combined.

(j) The medical record shall be closed and a new record initiated when a patient is transferred to a different level of care within a hospital which has a distinct part skilled nursing or intermediate care service.

22 CCR §70753. Transfer Summary

A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part skilled nursing or intermediate care service unit of the hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, medications, treatments, dietary requirement, rehabilitation potential,

known allergies and treatment plan and shall be signed by the physician or psychologist.

ACUTE PSYCHIATRIC FACILITIES (CHAPTER 3; §§71001 to 71667)

22 CCR §71005. Acute Psychiatric Hospital

(a) Acute psychiatric hospital means a hospital having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care for mentally disordered, incompetent or other patients referred to in Division 5 (commencing with section 5000) or Division 6 (commencing with section 6000) of the Welfare and Institutions Code, including the following basic services: medical, psychological, nursing, rehabilitative, pharmacy and dietary services.

(b) An acute psychiatric hospital shall not include separate buildings which are used exclusively to house personnel or provide activities not related to hospital patients.

22 CCR §71011. Basic Services

Basic services means those essential services required by law for licensure as a hospital including medical, psychological, nursing, rehabilitative, pharmacy and dietary services.

22 CCR §71101. Inspection of Hospitals

(a) The Department shall inspect and license hospitals.

(b) Any officer, employee or agent of the Department may, upon presentation of proper identification, enter and inspect any building or premise at any reasonable time to secure compliance with, or to prevent a violation of, any provision of these regulations.

(c) All hospitals for which a license has been issued shall be inspected periodically by a representative or representatives appointed by the Department. Inspections shall be conducted as frequently as necessary, but not less than once every two years, to assure that quality care is being provided. During the inspection, the representative or representatives of the Department shall offer such advice and assistance to the hospital as is appropriate. For hospitals of 100 licensed bed capacity or more, the inspection team shall include at least a physician, psychologist, registered nurse and persons experienced in hospital administration and sanitary inspections.

(d) The Department may provide consulting services upon request to any hospital to assist in the identification or correction of deficiencies or the upgrading of the quality of care provided by the hospital.

(e) The Department shall notify the hospital of all deficiencies of compliance with these regulations and the hospital shall agree with the Department upon a plan of corrections which shall give the hospital a reasonable time to correct such deficiencies. If at the end of the allotted time, as revealed by repeat inspection, the hospital has failed to correct the deficiencies, the Director may take action to revoke or suspend the license.

(f) Reports on the results of each inspection of a hospital shall be prepared by the inspector or inspection team and shall be kept on file in the Department along with the plan of correction and hospital comments. The inspection report may include a recommendation for reinspection. All inspection reports, lists of deficiencies and plans of correction shall be open to public inspection without regard to which body performs the inspection.

(g) The Department shall have the authority to contract for outside personnel to perform inspections of hospitals as the need arises. The Department, when feasible, shall contract with nonprofit, professional organizations which have demonstrated the ability to carry out the provisions of this section. Such organizations shall include, but not be limited to, the California Medical Association Committee on Medical Staff Surveys and participants in the Consolidated Hospital Survey Program.

22 CCR §71203. Medical Service General Requirements

(a) The medical service shall consist of the following organized and staffed elements:

(1) Psychiatric component.

(A) Psychiatrists or clinical psychologists within the scope of their licensure and subject to the rules of the facility, shall be responsible for the diagnostic formulation for their patients and the development and implementation of each patient's treatment plan.

(B) A psychiatrist or psychologist shall be available at all times for psychiatric emergencies.

(2) General medicine component.

(A) All incidental medical services necessary for the care and support of patients shall be provided by in-house staff or through the use of outside resources in accordance with Section 71513 of these regulations.

(B) Incidental medical services include but are not limited to:

1. General medicine and surgery.
2. Dental.
3. Radiological.
4. Laboratory.
5. Anesthesia.

- 6. Podiatry.
- 7. Physical therapy.
- 8. Speech pathology.
- 9. Audiology.

(3) Psychological component.

(A) Psychological services shall be provided by clinical psychologists within the scope of his/her licensure and subject to the provisions of Section 1316.5 of the Health and Safety Code.

(B) Facilities which permit clinical psychologists to admit patients shall do so only if there are arranged to have staff physicians who will provide the necessary medical care for the patients.

(C) ~~Only staff physicians on the medical staff~~ shall assume responsibility for those aspects of patient care which may be provided only by physicians.

(4) Social service component.

(A) Social service shall be provided by social workers under the direction of the medical staff.

(b) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. Policies and procedures shall be consistent with Sections 1316 and 1316.5 of the Health and Safety Code.

(c) The responsibility and the accountability of the medical service to the medical staff and administration shall be defined.

(d) An appropriate committee of the medical service shall:

(1) Identify and recommend to administration the equipment and supplies necessary for coping with emergency medical problems.

(2) Develop a plan for handling and/or referral of patients with emergency medical problems.

(3) Determine the circumstances under which electroconvulsive therapy may be administered.

(4) Develop guidelines for the administration of drugs when given in unusually high dosages or when given for purposes other than those for which the drug is customarily used.

(e) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.

22 CCR §71205. Medical Service Staff

(a) A physician shall have overall responsibility for the medical service.

(b) Psychiatric component.

(1) A psychiatrist or psychologist shall coordinate the psychiatric services provided.

(2) There shall be sufficient psychiatrists or psychologists on the staff to meet the needs of the patients.

(c) General medical component.

(1) A physician shall coordinate the general medical component relevant to the patient's physical status and that is outside the scope of practice of a psychologist.

(2) This physician shall have training and/or experience sufficient to coordinate the incidental medical services.

(d) Psychological component.

(1) One or more psychologists shall be employed available on a full-time, regular part-time or consulting basis.

(e) Social service component.

(1) One or more social workers shall be employed on a full-time, regular part-time or consulting basis.

22 CCR §71507. Patients' Rights

(a) All patients shall have rights which include, but are not limited to the following:

(1) To wear his own clothes, to keep and use his own personal possessions including his toilet articles; and to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases.

(2) To have access to individual storage space for his private use.

(3) To see visitors each day.

(4) To have reasonable access to telephones, both to make and receive confidential calls.

(5) To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.

(6) To refuse shock treatment.

(7) To refuse psychosurgery as defined in Section 5325, Welfare and Institutions Code.

(8) To be informed of the provisions of law regarding complaints and of procedures for registering complaints confidentially, including but not limited to, the address and telephone number of the complaint receiving unit of the Department.

(9) All other rights as provided by law or regulation.

(b) The physician or psychologist who has overall responsibility for the service or his designee, may for good cause, deny a person any of the rights specified in (a) above, except those rights specified in subsection (7) and (9) above and the rights under subsection (6) may be denied only under the conditions specified in Section 5326.7, Welfare and Institutions Code. The denial, and the reasons therefore, shall be entered in the patient's medical record.

(c) These rights, written in English and Spanish, shall be prominently posted.

(d) There shall be a procedure established whereby patient complaints are forwarded to hospital administration. Knowledge of this procedure shall be readily available to patients. The hospital administration shall, in all cases, acknowledge to the patient their receipt of his complaint. Additional follow-up of the complaint and response to the patient shall be handled as is appropriate.

22 CCR §71517. Admission, Transfer and Discharge Policies

(a) Each hospital shall have written admission, transfer and discharge policies which encompass the types of diagnoses for which patients may be admitted, limitations and non-discriminatory practices imposed by law or licensure, staffing limitations, rules governing emergency admissions, policies concerning advance deposits, rates of charge for care, charges for extra services, terminations of services, refund policies, insurance agreements and other financial considerations, discharge of patients and other related functions.

(b) Patients shall be admitted only upon the order and under the care of a member of the medical staff of the hospital who is lawfully authorized to diagnose, prescribe and establish a treatment plan, and treat patients. The patient's condition and provisional diagnosis shall be established at time of admission by the member of the medical staff who admits the patient subject to the rules and regulations of the hospital, and the provisions of Section 71505(a).

(c) Within 24 hours after admission or immediately before, every patient shall have a complete history and physical examination and psychiatric evaluation performed by persons lawfully authorized by their respective practice acts to perform such examinations providing the condition of the patient permits. Each patient shall have a complete psychological evaluation performed by a physician and surgeon or clinical psychologist consistent with the medical staff bylaws, and providing the condition of the patient permits.

(d) No mentally competent adult shall be detained in a hospital against his will. An emancipated minor shall not be detained in a hospital against his will. An unemancipated minor shall not be detained against the will of his parent or legal guardian. In those cases where law permits an unemancipated minor to contract for medical care without the consent of his parent or guardian, he shall not be detained in the hospital against his will. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the hospital in his own interest, nor

the temporary detention of a mentally disturbed patient for the protection of himself or others under the provisions of the Lanterman-Petris-Short Act (Welfare and Institutions Code, Section 5000 et seq.) if the hospital has been designated by the county as a treatment facility pursuant to said act, nor to prohibit a minor legally capable of contracting for medical care from assuming responsibility for his discharge. However, in no event shall a patient be detained solely for nonpayment of his hospital bill.

(e) No inpatient shall be transferred or discharged for purposes of effecting a transfer, from a hospital to another health facility, unless arrangements have been made in advance for admission to such health facility and the person legally responsible for the patient has been notified or attempts over a 24-hour period have been made and a responsible person cannot be reached. A transfer or discharge shall not be carried out if in the opinion of approved by the patient's physician, or psychologist who has consulted, as appropriate, with other members of the treatment team to determine whether such transfer or discharge would create an unnecessary medical or mental health hazard.

(f) A minor shall be discharged only to the custody of his or her parent or to his the minor's legal guardian or custodian, unless such parent or guardian shall otherwise direct in writing. This provision shall not be construed to preclude a minor legally capable of contracting for medical care from assuming responsibility for himself oneself upon discharge.

(g) Each patient upon admission shall be provided with a wristband identification tag or other means of identification unless the patient's condition will not permit such identification. Minimum information shall include the name of the patient, hospital admission number and the name of the hospital.

(h) Involuntary admission to the hospital shall be in conformity with the provisions of the Lanterman-Petris-Short Act (Welfare and Institutions Code, Section 5000 et seq.).

22 CCR §71545. Restraint of Patients

—(a) Restraint shall be used only when alternative methods are not sufficient to protect the patient or others from injury.

(b) Patients shall be placed in restraint only on the written order of the a physician or psychologist. This order shall include the reason for restraint and the type of restraint to be used. In a clear case of emergency, a patient may be placed in restraint at the discretion of a registered nurse and a verbal or written order obtained thereafter. If a verbal order is obtained it shall be recorded in the patient's medical record and be signed by the physician or psychologist on his the next visit.

(c) Patients in restraint by seclusion or mechanical means shall be observed at intervals not greater than 15 minutes.

(d) Restraints shall be easily removable in the event of fire or other emergency.

22 CCR §71551. Medical Record Availability

(a) Records shall be kept on all patients admitted or accepted for treatment. All required records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of: the attending physician or psychologist; the hospital or its medical staff or any authorized officer, agent or employee of either; authorized representatives of the Department; or any other person authorized by law to make such a request.

(b) The medical record, including X-ray film, is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. The hospital shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

(c) Patient records including X-ray film or reproductions thereof shall be preserved safely for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.

(d) If a hospital ceases operation, the Department shall be informed within 48 hours of the arrangements made for safe preservation of patient records as above required.

(e) If ownership of a licensed hospital changes, both the previous licensee and the new licensee shall, prior to the change of ownership, provide the Department with written documentation that:

(1) The new licensee will have custody of the patients' records upon transfer of the hospital, and that the records are available to both the new and former licensee and other authorized persons; or

(2) Arrangements have been made for the safe preservation of patient records, as required above, and that the records are available to both the new and former licensees and other authorized persons.

(f) Medical records shall be filed in an easily accessible manner in the hospital or in an approved medical record storage facility off the hospital premises.

(g) Medical records shall be completed promptly and authenticated or signed by a physician, dentist, podiatrist or clinical psychologist member of the staff within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician's medical staff member's signature, only when that physician medical staff has placed a signed statement in the hospital administrative office to the effect that he/she is the only person who

(1) Has possession of the stamp or key.

(2) Will use the stamp or key.

(h) Medical records shall be indexed according to patient, diagnoses and physician attending member of the medical staff.

(i) By July 1, 1976 a unit medical record system shall be established and implemented with inpatient, outpatient and emergency room records combined.

(j) The medical record shall be closed and a new record initiated when a patient is transferred to a different level of care within a hospital which has a distinct part skilled nursing or intermediate care service.

SKILLED NURSING FACILITIES (CHAPTER 3; §§72001 to 72713)

22 CCR §72109. Standing Orders

Standing orders means those written orders which are used or intended to be used in the absence of a prescriber's member of the medical staff's specific order for a specific patient.

22 CCR §72303. Physician Services—General Requirements

(a) Physician services shall mean those services provided by physicians responsible for the medical care of individual patients in the facility. All persons admitted or accepted for care by the skilled nursing facility shall be under the care of a physician or psychologist selected by the patient or patient's authorized representative.

(b) Physician services shall include but are not limited to:

(1) Patient physical evaluation including a written report of a physical examination within 5 days prior to admission or within 72 hours following admission.

(2) An evaluation of the patient's physical condition and review of orders for medical care and treatment on change of attending physicians.

(3) Patient the physician responsible for the patient's physical medical care.

(3) Patient medical diagnoses.

(4) Advice, treatment and determination of appropriate level of physical medical care needed for each patient.

(5) Written and signed orders for diet, physical medical care, diagnostic tests and physical medical treatment of patients by others. Orders for restraints shall meet the requirements of Section 72319(b).

(6) Health record progress notes relevant to medical diagnoses and other appropriate entries in the patient's health records.

(7) Provision for alternate physician coverage in the event the attending physician responsible for the patient's physical condition is not available.

(c) Nonphysician practitioners may be permitted to render those medical services which they are legally authorized to perform. Nonphysician practitioners means any of the following:

(1) Physicians' assistants working under the responsibility and supervision of a physician approved as a supervisor by the Board of Medical Quality Assurance and performing only those selected diagnostic and therapeutic tasks identified in Title 16, California Administrative Code, Chapter 13, Subchapter 3, Article 5.

(2) Registered nurses may perform patient care services utilizing "Standardized Procedures"

which have been approved by the medical staff, or by the medical director if there is no organized medical staff, the registered nurse and the administrator as authorized in the Business and Professions Code, Chapter 5, Article 2, Section 2725.

22 CCR §72305. Physician Services—Medical Director and Clinical Director

(a) The facility shall have a medical director who shall be responsible for standards, coordination, surveillance and planning for improvement of physical medical care in the facility. In facilities for mentally or developmentally disordered patients, the facility shall have a psychologist or psychiatrist as clinical director who shall be responsible for standards, coordination, surveillance and planning for improvement of mental health care in the facility. In all skilled nursing facilities, a physician shall be responsible for physical medical services that can only be provided by physicians.

(b) The medical or clinical director shall:

(1) Act as a liaison between administration, and the staff's attending physicians and psychologists.

(2) Be responsible for reviewing and evaluating administrative and patient care policies and procedures.

(3) Act as a consultant to the director of nursing service in matters relating to patient care services.

(4) Be responsible for reviewing employees' preemployment and annual health examination reports.

22 CCR §72307. Physician Services—Supervision of Care

(a) Each patient admitted to the skilled nursing facility shall be under the continuing supervision of a physician or psychologist who evaluates the patient as needed and at least every 30 days unless there is an alternate schedule, and who documents the visits in the patient health record.

~~(b) Alternate schedules of visits shall be documented in the patient health record with a medical/clinical justification by the attending physician or psychologist. The alternate schedule shall conform with facility policy.~~

22 CCR §72319. Nursing Service—Restraints and Postural Supports

(a) Written policies and procedures concerning the use of restraints and postural supports shall be followed.

(b) Restraints shall only be used with a written order of a physician, psychologist, or other person lawfully authorized to prescribe care. The order must specify the duration and circumstances under which the restraints are to be used. Orders must be specific to individual patients. In accordance with Section 72317, there shall be no standing orders and in accordance with Section 72319(i)(2)(A), there shall be no P.R.N. orders for physical restraints.

(c) The only acceptable forms of physical restraints shall be cloth vests, soft ties, soft cloth mittens, seat belts and trays with spring release devices. Soft ties means soft cloth which does not cause abrasion and which does not restrict blood circulation.

(d) Restraints of any type shall not be used as punishment, as a substitute for more effective medical and nursing care, or for the convenience of staff.

(e) No restraints with locking devices shall be used or available for use in a skilled nursing facility.

(f) Seclusion, which is defined as the placement of a patient alone in a room, shall not be employed.

(g) Restraints shall be used in such a way as not to cause physical injury to the patient and to insure the least possible discomfort to the patient.

(h) Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency.

(i) The requirements for the use of physical restraints are:

(1) Treatment restraints may be used for the protection of the patient during treatment and diagnostic procedures such as, but not limited to, intravenous therapy or catheterization procedures. Treatment restraints shall be applied for no longer than the time required to complete the treatment.

(2) Physical restraints for behavior control shall only be used on the signed order of a physician, psychologist or other person lawfully authorized to prescribe care, except in an emergency which threatens to bring immediate injury to the patient or others. In such an emergency an order may be received by telephone, and shall be signed within 5 days. Full documentation of the episode leading to the use of the physical restraint, the type of the physical restraint used, the length of effectiveness of the restraint time and the name of the individual applying such measures shall be entered in the patient's health record.

(A) Physical restraints for behavioral control shall only be used with a written order designed to lead to a less restrictive way of managing, and ultimately to the elimination of, the behavior for which the restraint is applied. There shall be no PRN orders for behavioral restraints.

(B) Each patient care plan which includes the use of physical restraint for behavior control shall specify the behavior to be eliminated, the method to be used and the time limit for the use of the method.

(C) Patients shall be restrained only in an area that is under supervision of staff and shall be afforded protection from other patients who may be in the area.

(j) When drugs are used to restrain or control behavior or to treat a disordered thought process, the following shall apply:

(1) The specific behavior or manifestation of disordered thought process to be treated with the drug is identified in the patient's health record.

(2) The plan of care for each patient specifies data to be collected for use in evaluating the effectiveness of the drugs and the occurrence of adverse reactions.

(3) The data collected shall be made available to the prescriber in a consolidated manner at least monthly.

(4) PRN orders for such drugs shall be subject to the requirements of this section.

(k) "Postural support" means a method other than orthopedic braces used to assist patients to achieve proper body position and balance. Postural supports may only include soft ties, seat belts, spring release trays or cloth vests and shall only be used to improve a patient's mobility and independent functioning, to prevent the patient from falling out of a bed or chair, or for positioning, rather than to restrict movement. These methods shall not be considered restraints.

(1) The use of postural support and the method of application shall be specified in the patient's care plan and approved in writing by the physician, psychologist, or other person lawfully authorized to provide care.

(2) Postural supports shall be applied:

(A) Under the supervision of a licensed nurse.

(B) In accordance with principles of good body alignment and with concern for circulation and allowance for change of position.

22 CCR §72413. Occupational Therapy Service Unit—Services

(a) "Occupational therapy service" means those medically lawfully prescribed services in which selected purposeful activity is used as treatment in the rehabilitation of persons with a physical or mental disability.

(b) Occupational therapy services shall include but not be limited to:

(1) Assisting the physician or psychologist in an evaluation of a patient's level of function by applying diagnostic and prognostic tests.

(2) Conducting and preparing written initial and continuing assessment of the patient's condition and modifying treatment goals under the order of a physician or psychologist, consistent with identified needs of the patient.

(3) Decreasing or eliminating disability during patient's initial phase of recovery following injury or illness.

- (4) Increasing or maintaining a patient's capability for independence.
 - (5) Enhancing a patient's physical, emotional and social well-being.
 - (6) Developing function to a maximum level.
 - (7) Guiding patients in their use of therapeutic, creative and self-care activities.
- (c) An occupational therapy service unit shall meet the following requirements:

- (1) Patient health records shall contain pertinent information and signed orders for treatment.
- (2) Notes shall be written and entered in the patient's health record after completion of each procedure. The note shall indicate the procedure(s) performed, the reaction of the patient to the procedure(s) and shall be signed by the occupational therapist.
- (3) Initial and continuing assessment, development of a treatment plan and discharge summary shall be written and entered in each patient's health record.
- (4) Individual progress notes shall be written and signed at least weekly by the occupational therapist.

22 CCR §72423. Speech Pathology and/or Audiology Service Unit--Services

(a) "Speech pathology and/or audiology services" means those services referred or ordered by a physician or psychologist which provide diagnostic screening and preventive and corrective therapy for persons with speech, hearing and/or language disorders.

(b) Speech pathology and/or audiology service shall include but not be limited to the following:

- (1) Conducting and preparing written initial and continuing assessment of a patient.
- (2) Notes written and entered in the patient's health record after each treatment. The notes shall indicate the treatment performed, the reaction of the patient to the treatment, and be signed by the speech pathologist or audiologist.
- (3) Instruction of other health team personnel and family members in methods of assisting the patient to improve or correct a speech or hearing disorder.

~~(c) A speech pathology and/or audiology service unit shall meet the following requirements:~~

- (1) Patient health records shall contain a patient's history and signed orders for treatment.
- (2) Progress notes shall be written at least weekly and entered in the patient health record and shall be signed by the speech pathologist and/or audiologist.

22 CCR §72433. Social Work Service Unit--Services

(a) "Social work services" means those services which assist staff, a patient and a patient's family to understand and cope with a patient's personal, emotional and related health and environmental problems.

(b) Social work services unit shall include but not be limited to the following:

(1) Interview and written assessment of each patient within five days after admission to the service.

(2) Development of a plan, including goals and treatment, for social work services for each patient who needs such services, with participation of the patient, the family, the patient's physician or psychologist, the director of nursing services and other appropriate staff.

(3) Weekly progress reports in the patient's health record written and signed by the social worker, social work assistant or social work aide.

(4) Participation in regular staff conferences with the attending physician or psychologist, the director of nursing service and other appropriate personnel.

(5) Discharge planning for each patient and implementation of the plan.

(6) Orientation and in-service education of other staff members on all shifts shall be conducted at least monthly by the social worker in charge of the social work service.

22 CCR §72453. Special Treatment Program Service Unit—Rights of Patients

(a) Each patient admitted to a special treatment program in a skilled nursing facility shall have the following rights, a list of which shall be prominently posted in English and Spanish in all facilities providing such services. The rights shall also be brought to the patient's attention by additional, appropriate means:

(1) To wear their own clothes; to keep and use personal possessions including toilet articles; and to keep and be allowed to spend a reasonable sum of their own money for small purchases.

(2) To have access to individual storage space for private use.

(3) To see visitors each day.

(4) To have reasonable access to telephones, both to make and receive confidential calls.

(5) To have ready access to letter writing materials, including stamps and to mail and receive unopened correspondence.

(6) To refuse shock treatment.

(7) To refuse lobotomy services.

(8) Other rights as provided by law.

(b) The attending physician or psychologist may, for good cause, deny or limit a patient his or her rights, except the right to refuse lobotomy or shock treatment. Any denial or limitation of a

patient's rights shall be entered in the patient's health record.

(c) Information pertaining to denial of rights contained in the patient's health record shall be made available on request to the Department and to the individuals authorized by law.

22 CCR §72461. Special Treatment Program Service Unit--Orders for Restraint and Seclusion

(a) Restraint and seclusion shall only be used on the signed order of a physician or psychologist which shall be renewed every 24 hours. In a documented case of emergency, which threatens to bring immediate injury to the patient or others, a restraint may be applied, and a physician or psychologist shall give an order for application of the restraint within one hour. A physician or psychologist may give the order by telephone. In such an event, the physician or psychologist shall sign the order within 5 days.

(b) A daily log shall be maintained in each facility exercising behavior restraint and seclusion indicating the name of the patient for whom behavior restraint or seclusion is ordered.

(c) Full documentation of the episode leading to the behavior restraint or seclusion, the type of behavior restraint or seclusion used, the length of time that the restraint or seclusion was applied or utilized, and the name of the individual applying such measures shall be entered in the patient's health record.

22 CCR §72471. Special Treatment Program Service Unit--Patient Health Records and Plans for Care

(a) The facility shall maintain an individual health record for each patient which shall include but not be limited to the following:

(1) A list of the patient's care needs, based upon an initial and continuing individual assessment with input as appropriate from the health professionals involved in the care of the patient. Initial assessments by a licensed nurse shall commence at the time of admission of the patient and shall be completed within seven days after admission.

(2) The plan for meeting behavioral objectives. The plan shall include but not be limited to the following:

(A) Resources to be used.

(B) Frequency of plan review and updating.

(C) Persons responsible for carrying out plans.

(3) Development and implementation of an individual, written care plan based on identified patient care needs. The plan shall indicate the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. The objectives shall be measurable, with time frames, and shall be reviewed and updated at least every 90 days.

(b) There shall be a review and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.

(c) The patient care plan shall be approved, signed and dated by the attending physician psychologist.

(d) There shall be at least monthly progress notes in the record for each patient which shall include notes written by all members of the staff providing program services to the patient. The notes shall be specific to the needs of the patients and the program objectives and plans.

(e) At the time of reassessment there shall be a summary of the progress of the patient in the program, the appropriateness of program objectives and the success of the plan.

22 CCR §72515. Admission of Patients

The licensee shall:

- (a) Admit a patient only on physician's physician or psychologist's orders.
- (b) Accept and retain only those patients for whom it can provide adequate care.

22 CCR §72520. Bed Hold

(a) If a patient of a skilled nursing facility is transferred to a general acute care hospital as defined in Section 1250(a) of the Health and Safety Code, the skilled nursing facility shall afford the patient a bed hold of seven (7) days, which may be exercised by the patient or the patient's representative.

(1) Upon transfer to a general acute care hospital, the patient or the patient's representative shall notify the skilled nursing facility within twenty-four (24) hours after being informed of the right to have the bed held, if the patient desires the bed hold.

(2) Except as provided in Section 51555.1, Title 22, California Administrative Code, any patient who exercises the bedhold option shall be liable to pay reasonable charges, not to exceed the patient's daily rate for care in the facility, for bed hold days.

(3) If the patient's attending physician or psychologist notifies the skilled nursing facility in writing that the patient's stay in the general acute care hospital is expected to exceed seven (7) days, the skilled nursing facility shall not be required to maintain the bed hold.

(b) Upon admission of the patient to the skilled nursing facility and upon transfer of the patient

of a skilled nursing facility to a general acute care hospital, the skilled nursing facility shall inform the patient, or the patient's representative, in writing of the right to exercise this bed hold provision. No later than June 1, 1985, every skilled nursing facility shall inform each current patient or patient's representative in writing of the right to exercise the bed hold provision. Each notice shall include information that a non-Medi-Cal eligible patient will be liable for the cost of the bed hold days, and that insurance may or may not cover such costs.

(c) A licensee who fails to meet these requirements shall offer to the patient the next available bed appropriate for the patient's needs. This requirement shall be in addition to any other remedies provided by law.

The provisions of this section do not apply to patients covered only by Medicare, Title XVIII benefits pursuant to Code of Federal Regulations, Title 42, Subsection 489.22(d)(1).

22 CCR §72525. Required Committees

(a) Each facility shall have at least the following committees: patient care policy, infection control and pharmaceutical service.

(b) Minutes of every committee meeting shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed and action taken.

(c) Committee composition and function shall be as follows:

(1) Patient care policy committee.

(A) A patient care policy committee shall establish policies governing the following services: Physician, psychologist, dental, nursing, dietetic, pharmaceutical, health records, housekeeping, activity programs and such additional services as are provided by the facility.

(B) The committee shall be composed of: at least one physician, at least one psychologist, the administrator, the director of nursing service, a pharmacist, the activity leader and representatives of each required service as appropriate.

(C) The committee shall meet at least annually.

(D) The patient care policy committee shall have the responsibility for reviewing and approving all policies relating to patient care. Based on reports received from the facility administrator, the committee shall review the effectiveness of policy implementation and shall make recommendations for the improvement of patient care.

(E) The committee shall review patient care policies annually and revise as necessary. Minutes shall list policies reviewed.

(F) The Patient Care Policy Committee shall implement the provisions of the Health and Safety Code, Sections 1315 and 1316.5, by means of written policies and procedures.

1. ~~Facilities which choose to allow clinical psychologists to refer patients for admission shall do so only if there are physicians who will provide for patients to be admitted or managed by~~

psychologists shall arrange to have physicians to provide the necessary medical care for the referred patients.

2. Only physicians shall assume ~~overall~~ responsibility for the physical medical care of patients, including performing admitting medical history and physical examinations and issuing orders for physical medical care.

(G) The Patient Care Policy Committee shall implement the provisions of the Health and Safety Code, Sections 1316 and 1316.5, by means of written policies and procedures.

1. Facilities which ~~choose to allow podiatrists to refer patients for admission shall do so only if there are~~ provide for patients to be admitted or managed by podiatrists or psychologists shall have physicians who will provide the necessary medical care for the referred patients that cannot be lawfully provided by podiatrists or psychologists.

~~2.~~ Only physicians shall assume ~~overall~~ responsibility for the medical care of patients, including performing admitting history and physical examinations.

(2) Infection control committee.

(A) An infection control committee shall be responsible for infection control in the facility.

(B) The committee shall be composed of representatives from the following services; physician, psychology, nursing, administration, dietetic, pharmaceutical, activities, housekeeping, laundry and maintenance.

(C) The committee shall meet at least quarterly.

(D) The functions of the infection control committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for investigating, controlling and preventing infections in the facility.

2. Maintaining, reviewing and reporting statistics of the number, types, sources and locations of infections within the facility.

(3) Pharmaceutical service committee.

(A) A pharmaceutical service committee shall direct the pharmaceutical services in the facility.

(B) The committee shall be composed of the following: a pharmacist, the director of nursing service, the administrator and at least one physician and at least one psychologist.

(C) The committee shall meet at least quarterly.

(D) The functions of the pharmaceutical service committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for safe procurement, storage, distribution and use of drugs and biologicals.

2. Reviewing and taking appropriate action on the pharmacist's quarterly report.

3. Recommending measures for improvement of services and the selection of pharmaceutical

reference materials.

22 CCR §72528. Informed Consent Requirements

(a) It is the responsibility of the attending physician or psychologist to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. Information that is commonly appreciated need not be disclosed. The disclosure of the material information and obtaining informed consent shall be the responsibility of the physician or psychologist.

(b) The information material to a decision concerning the administration of a psychotherapeutic drug or physical restraint, or the prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function shall include at least the following:

(1) The reason for the treatment and the nature and seriousness of the patient's illness.

(2) The nature of the procedures to be used in the proposed treatment including their probable frequency and duration.

(3) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.

(4) The nature, degree, duration and probability of the side effects and significant risks, commonly known by the health professions.

(5) The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment.

(6) That the patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time.

(c) Before initiating the administration of psychotherapeutic drugs, or physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function, facility staff shall verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure. The facility shall also ensure that all decisions concerning the withdrawal or withholding of life sustaining treatment are documented in the patient's health record.

(d) This section shall not be construed to require obtaining informed consent each time a treatment or procedure is administered unless material circumstances or risks change.

(e) There shall be no violation for initiating treatment without informed consent if there is documentation within the patient's health record that an emergency exists where there is an unanticipated condition in which immediate action is necessary for preservation of life or the prevention of serious bodily harm to the patient or others or to alleviate severe physical pain, and it is impracticable to obtain the required consent, and provided that the action taken is within the customary practice of physicians or psychologists of good standing in similar circumstances.

(f) Notwithstanding Sections 72527(a)(5) and 72528(b)(4), disclosure of the risks of a proposed treatment or procedure may be withheld if there is documentation of one of the following in the patient's health record:

(1) That the patient or patient's representative specifically requested that he or she not be informed of the risk of the recommended treatment or procedure. This request does not waive the requirement for providing the other material information concerning the treatment or procedure.

(2) That the physician or psychologist relied upon objective facts, as documented in the health record, that would demonstrate to a reasonable person that the disclosure would have so seriously upset the patient that the patient would not have been able to rationally weigh the risks of refusing to undergo the recommended treatment and that, unless inappropriate, a patient's representative gave informed consent as set forth herein.

(g) A general consent provision in a contract for admission shall only encompass consent for routine nursing care or emergency care. Routine nursing care, as used in this section, means a treatment or procedure that does not require informed consent as specified in Section 72528(b)(1) through (6) or that is determined by the physician or psychologist not to require the disclosure of information material to the individual patient. Routine nursing care includes, but is not limited to, care that does not require the order of a physician or psychologist. This section does not preclude the use of informed consent forms for any specific treatment or procedure at the time of admission or at any other time. All consent provisions or forms shall indicate that the patient or incapacitated patient's representative may revoke his or her consent at any time.

(h) If a patient or his or her representative cannot communicate with the physician or psychologist because of language or communication barriers, the facility shall arrange for an interpreter.

(1) An interpreter shall be someone who is fluent in both English and the language used by the patient and his or her legal representative, or who can communicate with a deaf person, if deafness is the communication barrier.

(2) When interpreters are used, documentation shall be placed in the patient's health record indicating the name of the person who acted as the interpreter and his or her relationship to the patient and to the facility.

22 CCR §72543. Patients' Health Records

(a) Records shall be permanent, either typewritten or legibly written in ink, be capable of being photocopied and shall be kept on all patients admitted or accepted for care. All health records of discharged patients shall be completed and filed within 30 days after discharge date and such records shall be kept for a minimum of 7 years, except for minors whose records shall be kept at least until 1 year after the minor has reached the age of 18 years, but in no case less than 7 years. All exposed X-ray film shall be retained for seven years. All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon

the request of the attending physician or psychologist, the facility staff or any authorized officer, agent, or employee of either, or any other person authorized by law to make such request.

(b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws.

(c) If a facility ceases operation, the Department shall be informed within three business days by the licensee of the arrangements made for the safe preservation of the patients' health records.

(d) The Department shall be informed within three business days, in writing, whenever patient health records are defaced or destroyed before termination of the required retention period.

(e) If the ownership of the facility changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation stating:

(1) That the new licensee shall have custody of the patients' health records and that these records or copies shall be available to the former licensee, the new licensee and other authorized persons; or

(2) That other arrangements have been made by the licensee for the safe preservation and the location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons; or

(3) The reason for the unavailability of such records.

(f) Patients' health records shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each patient. Such records shall be filed and maintained in accordance with these requirements and shall be available for review by the Department. All entries in the health record shall be authenticated with the date, name, and title of the persons making the entry.

(g) All current clinical information pertaining to a patient's stay shall be centralized in the patient's health record.

(h) Patient health records shall be filed in an accessible manner in the facility or in health record storage. Storage of records shall provide for prompt retrieval when needed for continuity of care. Health records can be stored off the facility premises only with the prior approval of the Department.

(i) The patient health record shall not be removed from the facility, except for storage after the patient is discharged, unless expressly and specifically authorized by the Department.

22 CCR §72547. Content of Health Records

(a) A facility shall maintain for each patient a health record which shall include:

(1) Admission record.

(2) Current report of physical examination, and evidence of tuberculosis screening.

(3) Current diagnoses.

(4) Physician or psychologist orders, including drugs, treatment and diet orders, progress notes, signed and dated on each visit. ~~Physician's~~ Physician or psychologist's orders shall be correctly recapitulated.

(5) Nurses' notes which shall be signed and dated. Nurses' notes shall include:

(A) Records made by nurse assistants, after proper instruction, which shall include:

1. Care and treatment of the patient.

2. Narrative notes of observation of how the patient looks, feels, eats, drinks, reacts, interacts and the degree of dependency and motivation toward improved health.

3. Notification to the licensed nurse of changes in the patient's condition.

(B) Meaningful and informative nurses' progress notes written by licensed nurses as often as the patient's condition warrants. However, weekly nurses' progress notes shall be written by licensed nurses on each patient and shall be specific to the patient's needs, the patient care plan and the patient's response to care and treatments.

(C) Name, dosage and time of administration of drugs, the route of administration or site of injection, if other than oral. If the scheduled time is indicated on the record, the initial of the person administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both initials and the time of administration. Medication and treatment records shall contain the name and professional title of staff signing by initials.

(D) Justification for the results of the administration of all PRN medications and the withholding of scheduled medications.

(E) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for postural supports used for the support and protection of the patient.

(F) Medications and treatments administered and recorded as prescribed.

(G) Documentation of oxygen administration.

(6) Temperature, pulse, respiration and blood pressure notations when indicated.

(7) Laboratory reports of all tests prescribed and completed.

(8) Reports of all X-rays prescribed and completed.

(9) Progress notes written and dated by the activity leader at least quarterly.

(10) Discharge planning notes when applicable.

(11) Observation and information pertinent to the patient's diet recorded in the patient's health record by the dietitian, nurse or food service supervisor.

(12) Records of each treatment given by the therapist, weekly progress notes and a record of

reports to the physician or psychologists after the first 2 weeks of therapy and at least every 30 days thereafter. Progress notes written by the social service worker if the patient is receiving social services.

(13) Consent forms for prescribed treatment and medication not included in the admission consent for care.

(14) Condition and diagnoses of the patient at time of discharge or final disposition.

(15) A copy of the transfer form when the patient is transferred to another health facility.

(16) An inventory of all patients' personal effects and valuables as defined in Section 72545 (a) made upon admission and discharge. The inventory list shall be signed by a representative of the facility and the patient or his authorized representative with one copy to be retained by each.

(17) The name, complete address and telephone number where the patient was transferred upon discharge from the facility.

INTERMEDIATE CARE FACILITIES (CHAPTER 4; §§73001 to 73727)

22 CCR §73077. Patient

(a) "Patient" means a person accommodated in an intermediate care facility who because of a physical or mental condition, or both, requires supervision and nursing care, but does not in the opinion of the attending physician or psychologist have an illness, injury or disability for which continuous skilled nursing care is required.

(b) Ambulatory Patient. "Ambulatory Patient" means a patient who is capable of demonstrating the mental competence and physical ability to leave a building without assistance or supervision of any person under emergency conditions.

(c) Nonambulatory Patient. "Nonambulatory patient" means a patient who is unable to leave a building unassisted under emergency conditions. It includes, but is not limited to, those persons who depend upon mechanical aids such as crutches, walkers, or wheelchairs, profoundly or severely mentally retarded persons and shall include totally deaf persons.

22 CCR §73085. Physician and Attending Clinician

(a) "Physician" means a person licensed as a physician and surgeon by the California Board of Medical Examiners or by the California Board of Osteopathic Examiners.

(b) Attending Physician Clinician. "Attending physician clinician" means the physician or psychologist responsible for the medical treatment of the patient in the facility.

(c) Advisory Physician. "Advisory physician" means the physician who assumes responsibility for the medical guidance of the licensed facility.

(d) Psychiatrist. "Psychiatrist" means a physician who has specialized training and/or experience in psychiatry.

22 CCR §73089. Psychologist

"Psychologist" means a person licensed as a psychologist by the California Board of Medical Examiners:

Psychology and who meets the criteria set forth in California Health & Safety Code § 1316.5 (d).

22 CCR §73301. Required Services

(a) Intermediate care facilities shall provide as a minimum, but shall not be limited to, the following required services: Physician, psychologist, intermittent nursing, dietary, pharmaceutical

and an activity program.

(b) Intermediate care facilities caring for patients who are mentally disordered, developmentally disabled or substance abusers and who have identified program needs as described in Section 73391 shall meet also the requirements for a special disability service.

(c) Intermediate care facilities caring for day care patients shall meet all the requirements for inpatients and shall not exceed their licensed bed capacity.

(d) Written arrangements shall be made for obtaining all necessary diagnostic and therapeutic services prescribed by the attending physician, podiatrist, dentist or clinical psychologist subject to the scope of licensure and the policies of the facility. If the service cannot be brought into the facility, the facility shall assist the patient, if necessary, in arranging for transportation to and from the service location.

(e) Provision shall be made for dental examinations and dental treatments by a dentist as indicated by the needs of the patient.

(f) Arrangements shall be made for one or more physicians to be called in an emergency.

22 CCR §73303. Physician Attending Clinician Services--General

(a) Physician Attending Clinician services are services provided by physicians or psychologists responsible for the care of individual patients in the facility. All persons admitted or accepted for care by the intermediate care facility shall be under the care of a physician or psychologist. Physician Attending Clinician services shall include but are not limited to:

(1) Patient examinations.

(2) Patient diagnosis.

(3) Advice, treatment and treatment plan, and determination of appropriate level of patient care needed for each patient.

(4) Written and signed orders for care, diagnostic tests and treatment of patients by others. Orders for restraints must specify the duration and circumstances under which the restraints are to be used and must comply with the following:

(A) Orders must be specific to individual patients.

(B) In accordance with Section 73355 there shall be no standing orders.

(C) There shall be no P.R.N. orders for physical restraints.

(5) Health record progress notes and other appropriate entries in the patient's health records.

(6) Periodic reevaluation of the patient's condition and the review and updating of treatment orders and care program at least every 60 days unless otherwise approved by the Department.

(7) Provision of emergency medical services in the facility when indicated.

22 CCR §73305. Physician Attending Services--Policies and Procedures

There shall be available to attending physicians/clinicians a list of the services provided in or available through the facility and a listing of the types of patients who may be admitted for care. Information pertinent to the orientation of new physicians or psychologist to the facility or changes in services or policy shall be made available by the facility. Patient care policies, manuals or other patient care instruction or reference materials shall be available for review or reference by individual physicians or psychologist when requested or indicated.

22 CCR §73311. Nursing Service--General

Nursing service shall include, but not be limited to, the following:

(a) Identification of problems and development of an individual plan of care for each patient based upon initial and continuing assessment of the patient's needs by the nursing staff and other health care professionals. The plan shall be reviewed and revised as needed but not less often than quarterly.

(b) Notification of the attending physician/clinician immediately of any patient exhibiting unusual signs or behavior.

(c) Ensuring that patients are served the diets as prescribed by attending physicians/clinicians, and that patients are provided with the necessary and acceptable equipment for eating and that prompt assistance in eating is given when needed.

(d) Any marked or sudden change in weight shall be reported promptly to the attending physician.

22 CCR §73313. Nursing Service--Drug Administration

Nursing service shall include but not be limited to the following, with respect to the administration of drugs:

(a) Medications and treatments shall be administered as prescribed and shall be recorded in patient's health records.

(b) Preparation of doses for more than one scheduled administration time shall not be permitted.

(c) Medications shall only be administered by personnel who have completed a state-approved training program in medication administration.

(d) Medications shall be administered as soon as possible after doses are prepared and shall be administered by the same person who prepared the doses for administration. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.

(e) Patients shall be identified prior to administration of a drug.

(f) The time and dose of drug administered to the patient shall be properly recorded in each patient's medication record by the person who administered the drug.

(g) No medication or treatment shall be given except on the order of a person lawfully authorized to give such order.

(h) Telephone orders shall be received only by a licensed nurse or pharmacist and shall be recorded immediately in the patient's health record and shall be signed by the prescriber within 48 hours.

(i) Medications brought by or with the patient to the facility shall not be used unless all of the conditions specified in Section 73363 are met.

(j) A registered nurse or a pharmacist shall review each patient's medications monthly and if appropriate, request a review from the patient's attending physician/clinician.

22 CCR §73315. Nursing Service--Patient Care

(a) No patient shall be admitted or accepted for care by an intermediate care facility except upon the order of a physician or psychologist.

(b) Each patient shall be treated as an individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind.

(c) Each patient, upon admission, shall be given proper orientation to the intermediate care facility and the facility's services and staff.

(d) Each patient shall show evidence of good personal hygiene, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming, cleaning and cutting of fingernails and toenails and shall be free of offensive odors.

(e) Each patient shall be encouraged and/or assisted to achieve and maintain his highest level of self-care and independence. Every effort shall be made to keep patients active except when contraindicated by physician's lawful orders.

(f) Such supportive and restorative nursing and personal care needed to maintain maximum functioning of the patient shall be provided.

(g) Treatment for minor illness or routine treatments for minor disorders when ordered by the physician or psychologist shall be administered by nursing personnel.

(h) Bedside nursing care may be provided on a temporary basis when the attending physician/clinician determines the illness to be temporary and minor.

(i) When a patient requires services which are not considered to be intermediate care services, the physician or psychologist shall be notified and arrangements made to transfer the

patient from the intermediate care facility.

22 CCR §73325. Dietetic Service—Food Service

(a) The dietetic service shall provide food of the quality and quantity to meet the patient's needs in accordance with physicians' dietary orders and, to the extent medically possible, to meet "the Recommended Daily Dietary Allowance," 1974 Edition, adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, 2107 Constitution Avenue, Washington, D.C., 20418; and the following:

- (1) Not less than three meals shall be served daily.
- (2) Not more than 14 hours shall elapse between the evening meal and breakfast of the following day.
- (3) Nourishment or between meal feedings shall be provided as required by the diet prescription. Bedtime nourishments shall be offered to all patients unless contraindicated.
- (4) Patient food preferences shall be adhered to as much as possible and substitutes for all food refused shall be from appropriate food groups.
- (5) Table service shall be provided for all who can and wish to eat at a table. Tables of appropriate height shall be provided for wheelchairs.
- (6) When food is provided by an outside commercial food service, all applicable requirements shall be met. The facility shall maintain adequate space, equipment and food supplies to provide patients' food service in emergencies.
- (7) Food shall be prepared by methods that conserve nutritive value, flavor and appearance. Food shall be served attractively at appropriate temperatures and in a form to meet individual needs.

22 CCR §73329. Dietetic Service—Diet Manual

A current therapeutic diet manual, if appropriate, is approved by the dietitian and readily available to attending physicians/clinicians and nursing and dietetic service personnel.

22 CCR §73331. Dietetic Service—Therapeutic Diets

Therapeutic diets shall be provided as prescribed by the attending physician/clinician and shall be planned, prepared and served with supervision and/or consultation from the dietitian. Persons responsible for therapeutic diets shall have sufficient knowledge of food values to make appropriate substitutions when necessary.

22 CCR §73409. Special Disability Services--Orders for Restraint and Seclusion

(a) Restraint and seclusion shall only be used on the signed order of a physician or psychologist which shall be renewed every 24 hours. In a clear case of medical emergency, a physician or psychologist may give the order by telephone. In such an event, the physician or psychologist shall sign the order within 48 hours.

(b) A daily log shall be maintained in each facility exercising behavior restraint and seclusion indicating the name of the patient for whom behavior restraint or seclusion is ordered, full documentation of the episode leading to the behavior restraint or seclusion, the type of the behavior restraint or seclusion used, the length of time and the name of the individual applying such measures.

22 CCR §73449. Social Work Service Unit

(a) Social work services are those services which assist staff, patients and patients' families to understand and cope with patient's personal, emotional and related health and environmental problems.

(b) A social work service unit shall meet the following requirements:

(1) The social worker, social work assistant or social work aide shall develop a plan, including goals and treatment, for social work services for each patient who needs them, with participation of the patient, the family, the patient's physician or psychologist, the supervisor of health services and other appropriate staff.

(2) Each patient within five days after admission shall be interviewed and a social work assessment completed. When indicated, a social work treatment plan reviewed and approved by the social worker shall be carried out, as appropriate, by the social worker, social work assistant or social work aide.

(3) Signed and dated progress reports shall be written at least monthly in the health record of each patient receiving social services, by the social worker, social work assistant or social work aide.

(4) The social worker, social work assistant or social work aide shall participate in regular staff conferences with the attending physician/clinician, the director of nursing service and other appropriate personnel.

(5) There shall be discharge planning and implementation through liaison with local health and welfare agencies, other community personnel and the patient's family or authorized representative.

(6) Orientation and in-service training of other staff members on all shifts shall be conducted at least monthly by the social worker in charge of the social work service, to assist in the

recognition and understanding of the emotional problems and social needs of patients and families and to learn how to implement appropriate action to meet such identified needs. Orientation and training shall include informing the staff about available community resources and services.

22 CCR §73469. Occupational Therapy Service Unit

(a) Occupational therapy is a medically prescribed service in which selected purposeful activity is used as treatment in the rehabilitation of persons with a physical or emotional disability.

(b) Occupational therapy service includes:

(1) Assisting the physician or psychologist in his evaluation of a patient's level of function by applying diagnostic and prognostic tests.

(2) Reevaluating the patient as his condition changes and modifying treatment goals consistent with these changes.

(3) Decreasing or eliminating disability during patient's initial phase of recovery following injury or illness.

(4) Increasing or maintaining a patient's capability for independence.

(5) Enhancing a patient's physical, emotional and social well-being.

(6) Developing function to a maximum level so that early testing can be applied for future job training and employment.

(7) Guiding patients in their use of therapeutic, creative and self-care activities for improving function.

(c) An occupational therapy service unit shall meet the following requirements:

(1) Health records shall contain pertinent information on the patient and procedures for obtaining signed medical orders.

(2) Notes shall indicate procedures performed and be signed by the occupational therapist.

(3) Initial evaluation, treatment plan and discharge summary shall be written and posted in each patient's health record.

(4) Progress notes shall be written and signed on each visit by the occupational therapist.

(5) Personnel policies shall define the occupational therapy director's responsibilities and the duties assigned to the occupational therapy assistant.

22 CCR §73479. Speech Pathology and/or Audiology Service Unit

(a) Speech pathology and/or audiology services are physician or psychologist referred services which provide diagnostic screening, preventive and corrective therapy for individuals with speech, hearing and/or language disorders.

(b) Speech pathology and/or audiology services include:

(1) Evaluation of patients to determine the type of speech, language and/or hearing disorder.

(2) Determination and recommendation of the appropriate speech, language and hearing therapy.

(3) Instruction of other health team personnel and family members in methods of assisting the patient to improve and/or correct speech or hearing disorders.

(c) A speech pathology and/or audiology service unit shall meet the following requirements:

(1) Health records shall include all pertinent information of patient history and background and a signed medical order for the service.

(2) Progress notes, including the patient's reaction to treatment and any change in condition, shall be written at least monthly and be signed by the speech pathologist and/or audiologist.

(3) Personnel policies shall define the duties of the speech pathology and audiology director and allied personnel in the speech and audiology service unit.

22 CCR §73489. Rehabilitation Service Unit

(a) Rehabilitation service is a service prescribed by a physician or psychologist for the purpose of maximum reduction of physical disability and restoration of the patient to the highest possible functional level.

(b) A rehabilitation service unit shall include all of the following services:

(1) Physical Therapy.

(2) Occupational Therapy.

(3) Speech Pathology and/or Audiology.

(4) Social Work Services.

(5) Rehabilitation Nursing Services.

(c) A rehabilitation service unit shall meet the following requirements:

(1) Health records shall contain pertinent information of the patient's history and background

and shall contain signed medical orders for the prescribed services needed.

(2) Daily notes shall indicate procedures performed and be signed by the appropriate discipline member.

(3) Initial evaluation, treatment plan and discharge summary shall be written and posted on each record.

(4) Progress notes shall be written and signed on each visit by the appropriate discipline member.

(5) Personnel policies shall define the duties of the director of rehabilitation service and auxiliary personnel.

22 CCR §73517. Admission of Patients

(a) The licensee shall:

(1) Admit a patient only on physician's physician or psychologist's orders.

(2) Accept and retain only those patients for whom it can provide adequate care.

(3) Admit each patient only after a preadmission personal interview according to the written policies of the facility, with the patient's physician, psychologist, referring health practitioner, the patient, the patient's next of kin and/or sponsor, as appropriate. A telephone interview may be substituted when a personal interview is not feasible.

22 CCR §73519. Administrative Policies and Procedures

(a) Written administrative policies shall be reviewed and revised at least annually and shall include the following:

(1) Written management and personnel policies to govern the administration of the intermediate care facility shall be established and implemented. Job descriptions detailing the functions of each classification of employee shall be written and available to all personnel. Facility policies shall adhere to the requirements of Sections 1316 and 1316.5 of the Health and Safety Code.

(2) All intermediate care facilities shall have written admission and discharge policies which shall include rate of charge for care, charges for extra services, limitation of services, cause for termination of services and refund policies applying to termination of services. These policies shall be made available to patients or their agents upon admission and upon request and shall be made available to the public upon request.

(b) The following types of patients shall not be admitted, nor cared for, in an intermediate care facility:

(1) Persons with a communicable disease.

(2) Mentally disturbed persons who require special services not available in the intermediate care facility.

(3) Mentally retarded persons requiring special services not available in the intermediate care facility.

(4) Persons requiring skilled nursing care and observation on a 24-hour basis.

(5) Those requiring daily care by a physician or psychologist.

(c) All patients shall have a tuberculosis screening procedure done upon admission. These procedures shall be determined by the patient care policy committee. Subsequent tuberculosis screening procedures shall be determined by attending physicians. A tuberculosis screening procedure may not be required if there is satisfactory written evidence available that a tuberculosis screening procedure has been completed within 90 days of the date of admission to the intermediate care facility.

(d) Nondiscrimination Policies. No intermediate care facility shall deny admission to a patient on account of race, color, religion, ancestry or national origin except as provided in this section. Admission policies shall state that, except as provided herein, patients will be accepted for care and cared for without discrimination on the basis of race, color, religion, ancestry or national origin.

Any bona fide nonprofit religious, fraternal or charitable organization which can demonstrate to the satisfaction of the Department that its primary or substantial purpose is not to evade this section may establish admission policies limiting or giving preference to its own members or adherents and such policies shall not be construed as a violation of the first paragraph of this subdivision. Any admission of nonmembers or nonadherents shall be subject to the first paragraph of this subdivision.

(e) Written policies and procedures governing patient health records shall be developed with the assistance of a person skilled in record maintenance and preservation. Health records shall be stored and systematically organized to facilitate retrieving of information.

(f) The Patient Care Policy Committee shall implement the provisions of the Health and Safety Code, Sections 1315 and 1316.5, by means of written policies and procedures.

(1) ~~Facilities which choose to allow clinical~~ provide for psychologists to refer patients for admissions ~~shall do so only if there are physicians who will provide the or to manage patients shall arrange to have physicians available to provide any necessary medical care for the referred patients.~~

(2) ~~Only physicians shall assume overall care of patients including performing the admitting history and physical examinations.~~

(3) ~~Facilities which choose to allow dentists to refer patients for admission shall do so only if there are physicians who will provide the necessary medical care for the referred patients.~~

Dentists shall perform only those duties lawfully authorized by their practice act.

(g) The Patient Care Policy Committee shall implement the provisions of Health and Safety Code, Section 1316, by means of written policies.

(1) Facilities which choose to allow podiatrists to refer patients for admission shall do so only if a physician provides necessary medical care for the referred patient.

(2) Only physicians shall assume overall care of patients referred by podiatrists, including performing admitting history and physical examinations.

22 CCR §73521. Patient Care Policy Committee

Written patient care policies shall be established and followed in the care of patients governing the following services: physician, psychologist, dental, nursing, dietetic, pharmaceutical and an activity program and such diagnostic, social, psychological and therapy services as may be provided. Such policies shall be developed by a committee whose membership shall consist of at least one physician, at least one psychologist, the administrator, the supervisor of health services and such other professional personnel as may be appropriate. These policies shall be reviewed and revised by the committee at least annually and minutes of the committee meetings shall be maintained on file indicating the names of members present, the subject matter discussed and action taken.

22 CCR §73523. Patients' Rights

(a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right:

(1) To be fully informed, as evidenced by the patient's written acknowledgment prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facilities' basic per diem rate or not covered under Title XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician or psychologist of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical health, nursing, and psychosocial needs and the

planning of related services.

(4) To consent to or to refuse any treatment or procedure or participation in experimental research.

(5) To receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure. The disclosure of material information for administration of psychotherapeutic drugs or physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function shall include the disclosure of information listed in Section 73524(c).

(6) To be transferred or discharged only for medical or mental health reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(7) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(8) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept his written delegation of this responsibility subject to the provisions of Section 73557.

(9) To be free from mental and physical abuse.

(10) To be assured confidential treatment of the patient's financial and health records and to approve or refuse their release, by law.

(11) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.

(12) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(13) To associate and communicate privately with persons of the patient's choice, and to send and receive his personal mail unopened.

(14) To meet with and participate in activities of social, religious and community groups at the patient's discretion.

(15) To retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients.

(16) If married, to be assured privacy for visits by the patient's his/her spouse and if both are patients in the facility, to be permitted to share a room.

(17) To have daily visiting hours established.

(18) To have visits from members of the clergy at the request of the patient or the patient's

representative.

(19) To have visits from persons of the patient's choosing at any time if the patient is critically ill, unless medically contraindicated as determined by the attending clinician.

(20) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(21) To have reasonable access to telephones both to make and receive confidential calls.

(22) To be free from any requirement to purchase drugs or rent or purchase medical supplies or equipment from any particular source in accordance with the provisions of Section 1320 of the Health and Safety Code.

(23) To be free from psychotherapeutic psychotropic and/or physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic psychotropic drugs used as a chemical restraint as defined in Section 73012, except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint 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 and used only for a specified and limited period of time.

(24) Other rights as specified in Health and Safety Code Section 1599.1.

(25) Other rights as specified in Welfare and Institutions Code Sections 5325 and 5325.1 for persons admitted for psychiatric evaluations or treatment.

(26) Other rights as specified in Welfare and Institutions Code, Sections 4502, 4503 and 4505 for patients who are developmentally disabled as defined in Section 4512 of the Welfare and Institutions Code.

(b) A patient's rights as set forth above may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented in the patient's health record.

(c) If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. The patient's incapacity shall be determined by a court in accordance with state law or by the patient's physician or psychologist unless the physician's physician or psychologist's determination is disputed by the patient or patient's representative.

(d) Persons who may act as the patient's representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person designated as attorney in fact in the patient's valid durable power of attorney for health care, patient's next of kin, other appropriate surrogate decisionmaker, designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7

(commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient is a minor, informed consent must be obtained from a person lawfully authorized to represent the minor.

(e) Patients' rights policies and procedures established under this section concerning consent, informed consent and refusal of treatments or procedures shall include, but not be limited to the following:

(1) How the facility will verify that informed consent was obtained pertaining to the administration of ~~psychotherapeutic~~ psychotropic drugs or physical restraints or the prolonged use of a device that may lead to the inability of the patient to regain the use of a normal bodily function.

(2) How the facility, in consultation with the patient's physician, will identify, consistent with current statutory and case law, who may serve as a patient's representative when an incapacitated patient has no conservator or attorney-in fact under a valid Durable Power of Attorney for Health Care.

22 CCR §73524. Informed Consent Requirements

(a) It is the responsibility of the attending ~~physician~~ clinician to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. Information that is commonly appreciated need not be disclosed. The disclosure of the material information and obtaining informed consent shall be the responsibility of the ~~physician~~ attending clinician.

(b) The information material to a decision concerning the administration of a ~~psychotherapeutic~~ psychotropic drug or physical restraint, or the prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function shall include at least the following:

- (1) The reason for the treatment and the nature and seriousness of the patient's illness.
- (2) The nature of the procedures to be used in the proposed treatment including their probable frequency and duration.
- (3) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.
- (4) The nature, degree, duration and the probability of the side effects and significant risks, commonly known by the health professions.
- (5) The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment.
- (6) That the patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time.

(c) Before initiating the administration of ~~psychotherapeutic~~ psychotropic drugs, or physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal

bodily function, facility staff shall verify that the patient has given informed consent to the proposed treatment or procedure. The facility shall also ensure that all decisions concerning the withdrawal or withholding of life sustaining treatment are documented in the patient's health record.

(d) This section shall not be construed to require obtaining informed consent each time a treatment or procedure is administered unless material circumstances or risks change.

(e) There shall be no violation for initiating treatment without informed consent if there is documentation within the patient's health record that an emergency exists where there is an unanticipated condition in which immediate action is necessary for preservation of life or the prevention of serious bodily harm to the patient or others or to alleviate severe physical pain, and it is impracticable to obtain the required consent, and provided that the action taken is within the customary practice of physicians or psychologists of good standing in similar circumstances.

(f) Notwithstanding Sections 73523(a)(5) and 73524(c)(4), disclosure of the risks of a proposed treatment or procedure may be withheld if there is documentation of one of the following in the patient's health record:

(1) That the patient or patient's representative specifically requested that he or she not be informed of the risk of the recommended treatment or procedure. This request does not waive the requirement for providing the other material information concerning the treatment or procedure.

(2) That the physician or psychologist relied upon objective facts, as documented in the health record, that would demonstrate to a reasonable person that the disclosure would have so seriously upset the patient that the patient would not have been able to rationally weigh the risks of refusing to undergo the recommended treatment and that unless inappropriate a patient's representative gave informed consent as set forth herein.

(g) A general consent provision in a contract for admission shall only encompass consent for routine nursing care or emergency care. Routine nursing care, as used in this section, means a treatment or procedure that does not require informed consent as specified in Section 73524(c)(1) through (6) or that is determined by the physician or psychologist not to require the disclosure of information material to the individual patient. Routine nursing care includes, but is not limited to, care that does not require the order of a physician or psychologist. This section does not preclude the use of informed consent forms for any specific treatment or procedure at the time of admission or at any other time. All consent provisions or forms shall indicate that the patient or incapacitated patient's representative may revoke his or her consent at any time.

(h) If a patient or his or her representative cannot communicate with the physical because of language or communication barriers, the facility shall arrange for an interpreter.

(1) An interpreter shall be someone who is fluent in both English and the language used by the patient and his or her legal representative, or who can communicate with a deaf person, if deafness is the communication barrier.

(2) When interpreters are used, documentation shall be placed in the patient's health record

indicating the name of the person who acted as the interpreter and his or her relationship to the patient and to the facility.

22 CCR §73543. Patients' Health Records

(a) Records shall be permanent, either typewritten or legibly written with pen and ink and shall be kept on all patients admitted or accepted for treatment. All health and social records of discharged patients shall be completed and filed within 30 days and such records shall be kept for a minimum of seven years, except for minors whose records shall be kept at least until one year after the minor has reached the age of 18 but in no case less than seven years. If a facility operates an X-ray unit, all exposed X-ray film shall be retained for seven years. All required records, either originals or faithful and accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon request of the attending physician/clinician, ~~in~~ the facility or any authorized officer, agent or employee of either or any other person authorized by law to make such request.

(b) Information contained in the records shall be treated as confidential and disclosed only to authorized persons.

(c) If a facility ceases operation, the Department shall be informed immediately of the arrangements made for the safe preservation of the patients' records.

(d) The Department shall be informed in writing immediately whenever patients' health records are defaced or destroyed before termination of the required retention period.

(e) If the ownership of the facility changes, both the licensee and the new applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation, stating:

(1) That the new licensee will have custody of the patients' records and these records will be available to the former licensee, the new licensee and other authorized persons; or

(2) That other arrangements have been made by the current licensee for the safe preservation and location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons; or

(3) The reasons for the unavailability of such patients' health records.

(f) Patients' health records shall be current and kept in detail consistent with acceptable professional practice based on the service provided to each patient. Such records shall be filed and maintained in accordance with these requirements and shall be available for review by the Department.

(g) Patients' health records shall be filed and stored so as to be protected against loss, destruction or unauthorized use.

22 CCR §73547. Content of Health Records

(a) A facility shall maintain for each patient a health record which shall include the following:

(1) Diagnoses (current).

(2) Drug and treatment orders.

(3) Diet orders.

(4) Progress notes written at the time of visit by professional personnel in attendance to the patient.

(5) Nurses' notes which shall include:

(A) Narrative notes made by nurses' aides when appropriate, and after such aides have been properly instructed. They shall include:

1. Care and treatment done with and for the patient.

2. Patients' reactions to care and treatment.

3. Daily observation of how patient looks, feels, reacts, interacts, degree of dependency and motivation towards improved health.

(B) Meaningful and informative nurses' progress notes written by licensed nurses as often as the patient's condition warrants. However, weekly nurses' progress notes shall be written by licensed personnel on each patient and shall be specific to the psychological, emotional, social, spiritual, recreational needs and related to the patient care plans.

Progress notes reflecting observations of the patient's response to his environment, physical limitations, independent activities, dependency status, behavioral changes, skin problems, dietary problems and restorative measures to characterize the functional status of progression and/or regression.

(C) Name, dosage and time of administration of drugs, the route of administration if other than oral and site of injection. If the scheduled time is indicated on the record the initial of the person administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both his initials and the time of administration.

(D) Justification for and the results of the administration of all P.R.N. medications and the withholding of scheduled medications.

(E) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for soft tie restraints prescribed by the physician or psychologist for the support and protection of the patient.

(F) Medications and treatments administered and recorded as prescribed.

- (6) Current history and physical examination or appropriate health evaluation.
- (7) Temperature, pulse and respiration where indicated.
- (8) Laboratory reports of all tests prescribed and completed.
- (9) Reports of all X-rays prescribed and taken.
- (10) Condition and diagnosis of patient at time of discharge and final disposition.
- (11) Physician or psychologist orders, including drug, treatment and diet orders signed on each visit. Physician and psychologist orders recapitulated as appropriate.
- (12) Observation and information pertinent to the dietetic treatment recorded in the patient's health record by the dietitian or nurse. Pertinent dietary records shall be included in patient's transfer records to ensure continuity of nutritional care.
- (13) Consent forms for prescribed treatment and medication.
- (14) An inventory of all patients' personal effects and valuables made upon admission and discharge. The inventory list shall be signed by a representative of the facility and the patient or his authorized representative with one copy to be retained by each.

CORRECTIONAL TREATMENT CENTERS (CHAPTER 12; §§ 79501 to 79861)

22 CCR §79561. Attending Clinician; Physician; Psychologist

(a) Physician means a person licensed as a physician and surgeon by the Medical Board of California or by the Osteopathic Medical Board.

(b) Psychologist means a person licensed as a psychologist by the California Board of Psychology and who meets the criteria set forth in California Health & Safety Code § 1316.5 (d).

(c) Attending physician/clinician means the physician or psychologist responsible for the medical treatment of the patient in the correctional treatment center.

22 CCR §79599. Physician/Attending Clinician Services

Physician/Attending Clinician services are services provided by licensed physicians or psychologists responsible for the care of individual inmate-patients in the correctional treatment center. All inmates admitted to or accepted for medical/health or mental health care by the correctional treatment center shall be under the care of a physician/attending clinician.

22 CCR §79601. Physician/Attending Clinician Services—General Requirements

(a) Physician/Attending Clinician services shall include, but not be limited to:

(1) Inmate-patient evaluation, including an admission physical history and physical performed by a physician within 24 hours for immediate care planning. A complete written history and physical examination shall be in the record within 72 hours unless done within 5 days prior to admission.

(2) Reevaluation of the inmate-patient's condition, including the review and updating of orders for care at least every thirty (30) days, upon change of attending physician/clinician and upon transfer.

(3) Inmate-patient diagnosis.

(4) Advice, treatment and the determination of appropriate level of care needed for each inmate-patient.

(5) Written and signed orders for diet, care, diagnostic tests and treatment of inmate-patients by others.

(6) Health record progress notes at least every three days or more often as the inmate-patient's condition requires. A progress note will be documented on each visit by the attending physician/clinician.

(7) Provision for alternative physician/clinician coverage in the event the attending

physicianclinician is not available.

(8) Provision for nonphysician practitioners to be permitted to render those medical services that they are legally authorized to perform. There shall be written policies addressing the granting of clinical privileges and the role of nonphysician providers. Nonphysician practitioner includes, but is not limited to the following:

(A) Physician's assistants who work under the responsibility and supervision of a physician approved as a supervisor by the Medical Board of California and perform only those selected diagnostic and therapeutic tasks identified in the California Code of Regulations, Title 16, Division 13.8, Section 1399.541.

(B) Nurse practitioners who have been certified as a nurse practitioner by the Board of Registered Nursing.

(C) Other registered nurses may perform medical services utilizing "Standardized Procedures" developed pursuant to Section 2725(d), Business and Professions Code, and approved by the medical director of the correctional treatment center.

(D) Certified nurse anesthetists who have completed an accredited program for the education of nurse anesthetists and have received certification as a nurse anesthetist from the Board of Registered Nursing.

(E) Certified nurse midwives who have been certified by the Board of Registered Nursing.

22 CCR §79603. PhysicianAttending Clinician Services--Policies and Procedures

(a) Written policies and procedures shall be maintained and implemented by the correctional treatment center and shall include, but not be limited to:

(1) A description of the types and scope of physicianattending clinician services that the correctional treatment center will provide.

(2) Policies relating to inmate-patient care and the types of inmate-patients who may be admitted for care.

(3) Policies for the follow-up care of inmate-patients treated in the correctional treatment center.

(4) Referral of inmate-patients to other agencies or health care facilities.

(5) Provision for handling emergencies and unusual occurrences.

(6) Medical record requirements, including the frequency of documentation and time periods for completion.

(7) Information pertinent to the orientation of new physiciansattending clinicians.

(b) Inmate-patient care policy and procedure manuals and other necessary reference materials shall be readily available for review by individual physiciansclinicians.

22 CCR §79637. Nursing Service--Patient Care

(a) No patient shall be admitted or accepted for care by a correctional treatment center except on the order of a physician or psychologist.

(b) Each patient shall be treated as an individual with dignity and respect, and shall not be subjected to verbal or physical abuse of any kind from employees or independent contractors of the licensee.

(c) Each patient, upon admission, shall be given orientation to the unit, emergency call system, patients' rights and rules of behavior.

(d) Each patient shall be provided care which shows evidence of good personal hygiene, except where staff safety may be compromised, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming (except where contraindicated due to criminal identification purposes), cleaning and cutting of fingernails and toenails. The patient shall be kept free of offensive odors.

(e) Patients, when indicated, shall be given care to prevent formation and progression of decubiti, contractures, and deformities. Such care shall include:

(1) Changing position of bedfast and chairfast patients with preventive skin care in accordance with the needs of the patient.

(2) Encouraging, assisting and training in self-care and activities of daily living.

(3) Maintaining proper body alignment and joint movement to prevent contractures and deformities.

(4) Using pressure-reducing devices where indicated.

(5) Providing care to maintain clean, dry skin free from feces and urine.

(6) Changing of linens and other items in contact with the patient, as necessary, to maintain a clean, dry skin free from feces and urine.

(7) Carrying out of physician's orders for treatment of decubitus ulcers. The facility shall notify the physician when a decubitus ulcer first occurs, as well as when treatment is not effective, and shall document such notification.

(f) Each inmate-patient who requires help in eating shall be provided with assistance when served, and shall be provided with training or adaptive equipment in accordance with identified needs, based upon patient assessment, to encourage independence in eating.

(g) Each inmate-patient shall be provided with good nutrition and with necessary fluids for hydration.

(h) Fluid intake and output shall be recorded for each inmate-patient as follows:

- (1) If ordered by the physician or other responsible clinician.
- (2) For each inmate-physician with an indwelling catheter or receiving intravenous or tube feedings.
 - (i) The weight and length of each inmate-patient shall be taken and recorded in the inmate-patient's health record upon admission. The weight shall be taken and recorded once a month thereafter.
 - (j) Each inmate-patient shall be provided visual privacy during medical treatments and personal care, unless contraindicated due to security considerations.
 - (k) Inmate-patient call signals shall be answered promptly.
- (l) The following shall be easily accessible at each nurse's station:
 - (1) The correctional treatment center's infection control policies and procedures.
 - (2) Names, addresses and telephone numbers of local health officers.
 - (3) The correctional treatment center's current diet manual.
 - (4) The correctional treatment center's current drug formulary.
 - (5) The correctional treatment center's current nursing policy and procedure manual.

22 CCR §79689. Dietary Service Therapeutic Diets

- (a) Therapeutic diets shall be provided as prescribed by ~~the attending physician~~ and shall be planned by a registered dietitian. Therapeutic diets shall be prepared and served with supervision or consultation from a registered dietitian.
- (b) Dietary service staff who prepare and serve therapeutic diets shall have received in-service training on the dietary standards and food groups and therapeutic diets and shall have sufficient knowledge of food values to make appropriate substitutions.

22 CCR §79781. Required Committees

- (a) Each correctional treatment center shall have at least the following committees: patient care policy, infection control and pharmaceutical service.
- (b) Minutes of every committee meeting shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed and action taken.
- (c) In those correctional treatment centers where appropriate, these functions may be performed by a committee of the whole.
- (d) Committee composition and function shall be as follows:

(1) Patient Care Policy Committee.

(A) A patient care policy committee shall establish policies governing the following services: Physician, psychiatrist, psychologist, dental, nursing, dietetic, pharmaceutical, health records, housekeeping and such additional services as are provided by the facility.

(B) The committee shall be composed of at least the medical director, the administrator (if appointed), the director of nursing service, a pharmacist and a representative of each required service as appropriate.

(C) The committee shall meet at least annually.

(D) The patient care policy committee shall have the responsibility for reviewing and approving all policies relating to patient care. Based on reports received from the facility administrator, the committee shall review the effectiveness of policy implementation and shall make recommendations for the improvement of patient care.

(E) The committee shall review patient care policies annually and revise as necessary. Minutes shall list policies reviewed.

(F) The patient care policy committee shall implement the provisions of Health and Safety Code Sections 1315, 1316, and 1316.5, by means of written policies and procedures.

(G) Only physicians shall assume responsibility for the overall physical medical care of patients that can only be lawfully assumed by physicians, including performing the admitting physical history, and the physical examinations and the issuance of orders for physical medical care.

(2) Infection Control Committee.

(A) An infection control committee shall be responsible for infection control in the facility.

(B) The committee shall be composed of representatives from at least the following services; physician, psychologist, nursing, administration, dietary, pharmaceutical, housekeeping, and laundry.

(C) The committee shall meet at least quarterly.

(D) The functions of the infection control committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for investigating, controlling and preventing infections, including tuberculosis, in the correctional treatment center. These shall be based on the 1990 recommendations of the Centers for Disease Control.

2. Maintaining, reviewing and reporting statistics of the number, types, sources and locations of infections within the facility. This shall include maintaining a confidentiality log which contains the dates and results of Mantoux tuberculin skin tests recorded in millimeters of induration and chest X-ray results of all correctional treatment center employees and inmate-patients.

(E) A registered nurse shall be assigned on a full-time or part-time basis to infection control surveillance.

(3) Pharmaceutical Service Committee.

(A) A pharmaceutical service committee shall direct the pharmaceutical services in the facility.

(B) The committee shall be composed of the following; a pharmacist, the director of nursing service, the administrator (if appointed), and the medical director or at least one physician and at least one psychologist.

(C) The committee shall meet at least quarterly.

(D) The functions of the pharmaceutical service committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for the safe procurement, storage, distribution and use of drugs, biologicals, and chemicals.

2. Reviewing and taking appropriate action on the pharmacist's quarterly report.

3. Recommending measures for improvement of services and the selection of pharmaceutical reference materials.

22 CCR §79801. Clinical Restraint, Treatment Restraint, and Clinical Seclusion

(a) Written policies and procedures concerning the use of clinical restraint, treatment restraint, and clinical seclusion shall be developed and approved by the correctional treatment center's health administration.

(b) Clinical restraint and clinical seclusion shall only be used on a written or verbal order of a psychiatrist or clinical psychologist. Clinical restraint shall additionally require a physician's or physician's assistant's or a nurse practitioner's (operating under the supervision of a physician) written or verbal approval to assure there is not medical contraindication for the procedure. The order shall include the reason for restraint or seclusion and the types of restraints. Under emergency circumstances clinical restraint or clinical seclusion may be applied and then an approval and/or an order must be obtained as soon as possible, but at least within one hour of application. Emergency circumstances exist when there is a sudden marked change in the inmate-patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate-patient or others, and it is impractical to first obtain an order and approval. Telephone orders and approvals for clinical restraint and clinical seclusion shall be received only by licensed medical and mental health care staff, shall be recorded immediately in the inmate-patient's health record, and shall be signed within twenty-four (24) hours.

(c) A physician or nurse practitioner shall complete a medical assessment of an inmate-patient at the earliest opportunity but not later than within twenty-four (24) hours after the inmate-patient has been placed in clinical restraint or clinical seclusion.

(d) Clinical restraint, treatment restraint, and clinical seclusion shall only be used as a measure to prevent injury to self or others. Clinical restraint, treatment restraint, and clinical seclusion shall only be used when less restrictive alternative methods are not sufficient to protect the inmate-patient

or others from injury, and shall not be used as punishment or as a substitute for more effective programming or for the convenience of the staff. Removing an inmate-patient from an activity or area to another unlocked area for a period of time as a way to use separation as a behavioral modification technique shall not be considered clinical seclusion.

(e) Each order for clinical restraint and clinical seclusion shall be in force no longer than twenty-four (24) hours.

(f) There shall be no PRN orders (as needed orders) for clinical restraint and clinical seclusion.

(g) An inmate-patient placed in clinical restraint shall be physically checked at least every fifteen (15) minutes by nursing staff to assure that the restraints remain properly applied, that circulation is not impaired, that the inmate-patient is not in danger of harming himself or herself, and that other medical problems are not present. Routine range of motion exercises shall be done with clinically restrained inmate-patients. Fluids and nourishment shall be provided every two (2) hours, except during sleep. An inmate-patient placed in clinical seclusion shall be observed by nursing staff at least every fifteen (15) minutes. A written record shall be kept of these checks and range of motion exercises and maintained in the individual inmate-patient's health record.

(h) The inmate-patient's health record shall include written justification for the application of clinical restraints, note the times of application and removal of restraints and document the inmate-patient's status and the judgment of the physician or clinical psychologist on the necessity for continuation of clinical restraints at a minimum of once every twenty-four (24) hours.

(i) Clinical and treatment restraints shall be used in such a way as to minimize the risk of physical injury to the inmate-patient and to ensure the least possible discomfort. Minimum force shall be used. Belts and cuffs shall be well padded.

(j) Clinical restraints shall be placed on inmate-patients only in an area that is under direct observation of staff. Such inmate-patients shall be afforded protection from other inmate-patients who may also be in the area.

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ATTACHMENT 1-B

State of California—Health and Human Services Agency
Department of Health Services



California
Department of
Health Services

SANDRA SHEWRY
Director



ARNOLD SCHWARZENEGGER
Governor

November 22, 2004

Mr. Carl London
Rose and Kindel
915 L Street, Suite 1210
Sacramento, CA 95814

Dr. Bill Safarjan, Ph.D.
Psychology Shield
Attention: Michele Licht, Esq.
5440 Roundmeadow Road
Hidden Hills, CA 91302

PETITION FOR AMENDMENT OF REGULATIONS

Dear Mr. London and Dr. Safarjan:

This will acknowledge receipt on November 9, 2004, of your letter requesting that the Department of Health Services amend several health facility licensing regulations in order to clarify the authorized scope of practice of psychologists. The content of your letter qualifies it as a petition for the amendment of regulations under Government Code section 11340.7, so the Department will process the letter as a petition.

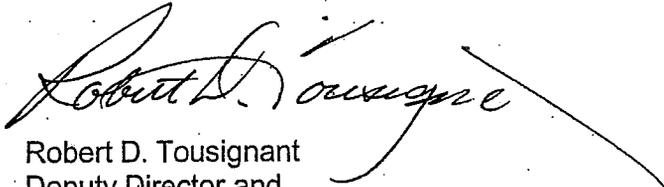
The Department is considering and evaluating the requested amendments, and will respond to your petition as soon as possible. Although Government Code section 11340.7 requires the Department to act on the petition within 30 days of receipt, given the volume of the requested changes and the approaching holidays, we would appreciate your agreement to an extension of time to act until December 31, 2004, so that we may more thoroughly consider your recommendations.

We have noted your concerns with the Section 100 Changes without Regulatory Effect that the Department recently submitted to the Office of Administrative Law. Please be assured that those changes do not preclude or limit the Department's authority to make any further regulatory changes that are necessary and appropriate.

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Thank you for your continuing interest in this matter, and for your work in drafting recommended changes to the regulations. Please let me or Jennifer Kent know if you are willing to extend the time for us to act on your petition.

Sincerely,

A handwritten signature in cursive script, reading "Robert D. Tousignant". The signature is written in black ink and is positioned above the typed name. A long horizontal line extends from the end of the signature to the right.

Robert D. Tousignant
Deputy Director and
Chief Counsel



1. The first part of the document
 discusses the general principles
 of the system and its objectives.
 It outlines the scope of the
 project and the roles of the
 various stakeholders involved.
 The second part of the document
 provides a detailed description
 of the system architecture and
 the components that make up
 the system. This includes a
 discussion of the hardware and
 software requirements, as well
 as the data flow and the
 control logic of the system.
 The third part of the document
 describes the implementation
 process and the results of the
 system. It includes a discussion
 of the challenges that were
 encountered during the
 implementation and the solutions
 that were used to overcome
 these challenges. Finally, the
 document concludes with a
 summary of the key findings
 and a list of references.

2. The second part of the document
 discusses the system architecture
 and the components that make up
 the system. This includes a
 discussion of the hardware and
 software requirements, as well
 as the data flow and the
 control logic of the system.
 The third part of the document
 describes the implementation
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3. The third part of the document
 describes the implementation
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 of the challenges that were
 encountered during the
 implementation and the solutions
 that were used to overcome
 these challenges. Finally, the
 document concludes with a
 summary of the key findings
 and a list of references.

ATTACHMENT 1-C

State of California—Health and Human Services Agency
Department of Health Services



ARNOLD SCHWARZENEGGER
Governor

California
Department of
Health Services

SANDRA SHEWRY
Director

April 26, 2005

Mr. Carl London
- Rose and Kindel
915 L Street, Suite 1210
Sacramento, CA 95814

Dr. Bill Safarjan, Ph.D.
Psychology Shield
Attn: Michele Licht, Esq.
5440 Roundmeadow Road
Hidden Hills, CA 91302

PETITION FOR AMENDMENT OF REGULATIONS

Dear Mr. London and Dr. Safarjan:

This letter is the response by the Department of Health Services (Department) to your petition for regulation changes which originated with your letter of November 8, 2004. The Department appreciates your patience while your proposed changes have been under review.

After review of your requested changes, the Department has been able to group the regulations into roughly four groups. These groups are (1) the regulations which the Department proposes to change just as you have requested; (2) the regulations which the Department believes no longer need to be changed due to the previous Section 100 regulation changes; (3) the regulations which the Department agrees need to be changed, but for which the Department proposes to use broader language than what you have recommended; and (4) the remaining regulations, for which the requested changes are denied for various specific reasons as listed in this letter.

Because the Department has treated your request as a petition for a regulation change, it is required to either grant or deny each of your requests in the form and exact wording in which you made it. Therefore, the Department is granting the petition for the first regulation group, but denying the others. However, the Department remains open to further input as the proposed regulations package is being developed, and we will

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consider additional information that you may wish to submit regarding the necessity for and appropriateness of the changes being denied in this letter.

The Department is authorized to adopt, amend or repeal regulations in these categories, pursuant to Health and Safety Code sections 1275 and 100275.

The changes that you have proposed to the following regulations are granted; the Department will propose the regulatory changes as requested in your petition:

70577(d)(2), 70577(f), 70703(f), 71203(b), 71205(d)(1), 71551(a), 71551(h), 72319(l)(2), 72319(k)(1), 72453(b), 72543(a), 72547(a)(4) and (a)(12) [with style or grammar corrections], 73089, 73315(l), 73449(b)(1), and 73519(a)(1).

The proposed regulation changes in the second group relate to an issue already addressed in the earlier Section 100 regulation package and are, therefore, denied.

70577(e)(1), 70577(j)(2), 71203(a)(3)(B) and (C), 71517(b), 71517(e), and 71545(b).

For this third group of proposed regulation changes, the Department agrees that changes are needed. However, the Department has decided to take this opportunity to use more all-inclusive language to avoid intruding into the area of scope of practice regulation, which is beyond the authority of this Department. Therefore, the specific changes that you have requested for the following regulations are denied.

70577(k)(2), 70706(b), 70707(b)(3), 70707(b)(10), 70707(b)(12), 70749(a)(1)(K), 70751(a)(1), 70751(g), 70753, 71507(b), 72109, 72319(b), 72413(a), 72413(b)(1) and (2), 72423(a), 72433(b)(2) and (4), 72461(a), 72471(c), 72515(a), 72525(c)(1)(F)(1) and (2), 72525(c)(1)(G)(1) and (2), 72528, 73077(a), 73303(a), 73305, 73311(b) and (c), 73313(f), 73315(a), 73329, 73409(a), 73449(b)(4), 73469(b)(1), 73479(a), 73489(a), 73517(a)(1) and (3), 73519(b)(5), 73519(f)(1) and (2), 73519(g)(2), 73523(a)(19), 73523(c), 73524(a), 73524(e), 73524(f)(2), 73524(g), 73543(a)73547(a)(5)(E), 73547(a)(11), 79637(a) 79637(h)(1), and 79689(a).

The fourth group of proposed regulation changes cannot be granted for a variety of reasons, specific to the individual regulations. The Department may continue to work on these regulations; but the specific changes that you have proposed in the following regulations are denied.

70101(c), 70101(g), 70577(d)(3), 70579(a), 70703(a)(1), 70703(a)(2), 70706.2(b)(8), 71005, 71011, 71101, 71203(a)(1)(A), 71203(a)(1)(B), 71205(b)(1), 71205(b)(2), 71205(c)(1), 71517(a), 71517(f), 71551(g), 72303, 72303(a), 72303(b)(1)-(7), 72305(a), 72305(b), 72305(b)(1), 72307(a) and (b), 72520(a)(3), 72525(c)(1)(A) and (B),

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72525(c)(2)(B), 72525(c)(3)(B), 73085 (Title) and (b), 73301, 73301(d), 73315(g) and (h), 73325(a), 73331, 73521, 73523(a)(3), 73523(a)(6), 73523(a)(23), 73523(e)(1), 73524(b) and (c), 79561(b) and (c), 79599, 79601(a)(1), (2), (6) and (7), 79603(a)(1) and (7), 79603(b), 79781(d)(1)(G), 79781(d)(2)(B), 79781(d)(3)(B), 79801(a), 79801(b), 79801(c), and 79801(h).

Section 70101(c) restates Health & Safety Code section 1279. "Psychologist" does not appear in section 1279, and, therefore, is not authorized to be added to section 70101(c). Generally, regulations which simply restate statutes are unnecessary and should be repealed.

Section 70101(g) restates Health & Safety Code section 1282. "[T]he California Psychological Association" does not appear in section 1282, and, therefore, is not authorized to be added to section 70101(g). Generally, regulations which simply restate statutes are unnecessary and should be repealed.

Section 70577(d)(3). The scope of practice of a psychologist is not wide enough to enable him or her to handle the full range of psychiatric emergencies.

Section 70579(a). The reason for this proposed change is unclear, and the Department is not persuaded that the requested change is necessary or appropriate.

Section 70703(a)(1)-(2). These proposed changes exceed the authority of Health & Safety Code 1316.5. The law does not require hospitals that are not owned and operated by the state to include psychologists as part of the medical staff.

Section 70706.2(b)(8). The specialized circumstances resulting in notification need to be specified. Further, more all-inclusive language must be used to avoid intruding into the area of scope of practice regulation, which is beyond the authority of this Department.

Section 71005 restates Health & Safety Code section 1250(b). "Psychological" does not appear in section 1250(b), and, therefore, is not authorized to be added to section 71005. Generally, regulations which simply restate statutes are unnecessary and should be repealed.

Section 71011 would require a new basic service and add significant new licensing requirements beyond the authority of section Health & Safety Code 1250(b).

Section 71101 restates Health & Safety Code section 1279. "Psychologist" does not appear in section 1279, and, therefore, is not authorized to be added to section 71101.

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Generally, regulations that simply restate statutes are unnecessary and should be repealed.

Section 71203(a)(1)(A), 73301(d). Since clinical psychologist is defined in Health & Safety Code 1316.5, allowing "clinical" to remain clarifies that psychologists without required clinical experience are not eligible to treat patients.

~~Section 71203(a)(1)(B). The scope of practice of a psychologist is not wide enough to enable him or her to handle the full range of psychiatric emergencies.~~

Section 71205(b)(1). Some elements within the full scope of the psychiatric component are outside the scope of practice of psychologists.

Section 71205(b)(2). This regulation uses the term "sufficient," and while that term was obviously accepted by the Office of Administrative Law in the past, the Department believes the regulation would need to be rewritten to define what "sufficient" means for the regulation to be approved under today's standards.

Section 71205(c)(1). The Department will use language consistent with section 70577(e).

Section 71517(a). The Department agrees that non-discrimination should be part of a hospital's policies and procedures, but the Department would prefer different language.

Section 71517(f). Proposed change is improper use of "oneseff."

Section 71551(g). All clinicians should complete the record within two weeks, whether they are on staff or not.

Sections 72303, 72305, and 72307. Psychologist services are not appropriate under the heading of Physician Services. Separate regulations or reorganized regulations are more appropriate.

Section 72520(a)(3). Additional research must be done to determine the impact, if any, on Medi-Cal bed-hold payments. Further, more all-inclusive language must be used to avoid intruding into the area of scope of practice regulation, which is beyond the authority of this Department.

Section 72525(c). Since skilled nursing facilities are not required to provide psychological services, they should not be forced to establish policies and have psychologists on committees if they do not provide psychological services.

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Section 73085. Clinician definition should be in its own separate section and should not be commingled with the definition of "physician."

Section 73301. This proposed change exceeds the authority of Health & Safety Code 1316.5. The Department cannot require non-state-owned and -operated health facilities to include psychologist services as part of the required services.

~~Section 73331. Ordering of special therapeutic diets may need to be limited. Further,~~ more all-inclusive language must be used to avoid intruding into the area of scope of practice regulation, which is beyond the authority of this Department.

Section 73521. This proposed change exceeds the authority of Health & Safety Code 1316.5. The law does not require health facilities not owned and operated by the state to include psychologist services in patient care policies or psychologists on the Patient Care Policy Committee.

Section 73523(a)(3). This proposed change may change and limit a patient's right to his or her total information. Further, if a change were to be made, more all-inclusive language would need to be used to avoid intruding into the area of scope of practice regulation, which is beyond the authority of this Department.

Section 73523(a)(6). "Mental health reasons" appear to be already included in "patient's welfare", so that the change is unnecessary.

Section 73523(a)(23) and (e)(1), 73524(b) and (c). The differences in meaning among "psychotropic", "psychotherapeutic" and "psychoactive" are not clear, and the Department is not persuaded that "psychotropic" should be the chosen term.

Section 79561(b) & (c), 79599, 79601, 79603. Regulations should not be commingled with those applicable to physicians. These changes are more appropriate to sections 79509 and 79611. Otherwise, this causes duplication and clarity issues.

Sections 79781(d)(2)(B) and 79781(d)(3)(B). These changes would exceed the requirements of Health and Safety Code section 1316.5. Not all correctional treatment centers are owned and operated by the state, and the law does not require health facilities not owned and operated by the state to appoint clinical psychologists to their medical staffs.

Section 79781(d)(1)(G). The Department is not persuaded that the requested change is necessary or appropriate, since the regulation addresses medical care.

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Section 79801(a). It is unclear to the Department how "health administration" is different from "administration."

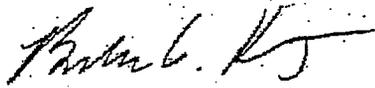
Section 79801(b). Since clinical psychologist is defined in Health & Safety Code 1316.5, allowing "clinical" to remain clarifies that psychologists without required clinical experience are not eligible to treat patients. The second proposed change may be unnecessary.

Section 79801(c). The Department believes this change would be an unnecessary dilution of access to physician's care.

Section 79801(h). Since clinical psychologist is defined in Health & Safety Code 1316.5, allowing "clinical" to remain clarifies that psychologists without required clinical experience are not eligible to treat patients. The second proposed change may be unnecessary.

After you have had an opportunity to review this response, you may contact Gina Henning, R.N. of my staff, at 916 552 9370, with any questions or comments you may have. Thank you again for your patient assistance in this process.

Sincerely,



Brenda G. Klutz
Deputy Director
Licensing and Certification Program

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bcc: Jennifer Kent
Deputy Director
LGA

Robert D. Tousignant
Deputy Director and Chief Counsel
Office of Legal Services

Joyce C. Johnston
Assistant Chief Counsel
Office of Legal Services

Barbara Gallaway, R.N.
Office of Regulations