Obsolete by 4/84 Reg. File of Behavioral Health Centers

WEST VIRGINIA LEGISLATIVE RULES
BOARD OF HEALTH

Regulations for Licensing Psychiatric and Other Related Facilities and Programs

Chapter 27-9
Series I
(1983)

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 12-30-82
Administrative Law Division

FOREWORD

The West Virginia licensing law was developed by the Department of Mental Health as a source of information for each service program to provide the best psychiatric service possible. These regulations are presented as an educational standard.

In order to become licensed under these regulations, the principles herein set forth shall be complied with, and noncompliance which constitutes sufficient cause for revocation of license shall be related to patient safety, general welfare, or lack of program effectiveness. Because of the wide range of program types, each program shall be surveyed and licensed in terms of its individual program goals.

The primary purpose of this document is to assist all mental health hospitals and mental health centers and programs to conjoin their efforts to perform an effective comprehensive mental health program in the State of West Virginia.

M. Mitchell-Bateman, M.D.
Director
West Virginia Department
of Mental Health

WEST VIRGINIA LEGISLATIVE RULES
BOARD OF HEALTH

Regulations for Licensing Psychiatric and Other Related Facilities and Programs

Chapter 27-9
Series I
(1983)

INDEX

WEST VIRGINIA LEGISLATIVE RULE
BOARD OF HEALTH

Chapter 27-9
Series I
(1983)

Subject: Regulations for Licensing Psychiatric and Other Related Facilities and Programs

---

Section 1. General

1.1. These legislative regulations establish the rules and standards for license to operate a hospital, center or institution or part thereof, to provide inpatient, outpatient, or other services to contribute to the care and treatment of the mentally ill or mentally retarded, or prevention of such disorders.

Mental health services in West Virginia are rapidly expanding, with increasing legislative and local government support. With expanded services, efforts are under way to establish objective, attainable requirements for all levels of mental health program operation including establishment, community involvement, organization and administration, minimum staff qualifications, services according to the needs of the community, clinical records, administrative statistics, evaluation and environmental support.

While it is felt desirable to establish uniform, minimum standards for operation and maintenance of mental health programs, it is also highly

---

Editor's note: This regulation (now legislative rule) was promulgated and filed by the West Virginia department of mental health which was merged with the state health department in 1977. The authority for mental health licensure was transferred to the health department. The authority for promulgation of licensure regulations was transferred to the state board of health. The regulation was last revised in 1975. References within this regulation to the department of mental health should be interpreted in accordance with these and additional changes in the law. A detailed analysis has not been attempted for this refiling.

desirable to allow maximum flexibility so that each program can develop according to the unique needs of the community and the capabilities of its staff so long as it remains consistent with the comprehensive mental health plan for West Virginia, September, 1966, as amended.

The delivery of mental health services to a population encompasses nearly as many variations as there are staff and recipients of service. These regulations, therefore, are designed to enhance, rather than to restrict the delivery of services to a population served by a mental health program; to provide source information to assist providers to reach and maintain the defined minimum standards for safe care required by local, state, and federal statutes for the welfare of the general public.

The regulations herein are based on the belief that every individual has the inalienable right to receive treatment appropriate to his problems or illness, under conditions that protect his privacy and dignity, and with essential humanity. Hence, each mental health or mental retardation program and/or facility applying for a license to operate in West Virginia must be measured against the following basic principles:

(a) The acknowledgment of responsibility for the dignity and protection of the rights of all its clients;

(b) The ultimate goals are to provide:

(1) Preventive programs through consultation and education, and

(2) Needed diagnostic, treatment, and rehabilitation services to restore individuals to an optimal level or functioning at home and in the community, as well as preventive measures in all treatment and services;

(c) The provision for a competent staff functioning according to the ethical standards of their various professions;

(d) The integration of services with other community resources and a continuing responsiveness to community needs;

(e) The compliance with standards and reimbursement requirements of various third-party payors in order to provide for its clients the economic protection of health insurance;

(f) Accurate, current, and complete clinical, financial, personnel, and administrative records are kept;

(g) The policies, procedures, and plans are developed, written, and periodically reviewed for needed revision;

(h) The physical plant provides a safe, wholesome environment that enhances the program;

(i) The programs are available, accessible, and appropriate for the care of all potential clients;

(j) The programs promote a climate that makes possible the establishment of significant relationships between staff, clients or students, and their families.

1.2. Authority - These revised legislative regulations are issued under Chapter 27, Article 9, Section 1, Code of West Virginia, 1931, as amended.

1.3. Filing Date - This revision of West Virginia Administrative Regulations of the department of mental health, Chapter 27-9, Series I, 1971, entitled Regulations for Licensing Psychiatric and Other Related Facilities and Programs, filed August 11, 1971, and revisions filed Novem-

ber 30, 1971, and February 23, 1973, supercede and replace all the regulations filed August 11, 1971 and revisions filed November 30, 1971, and February 23, 1973, was filed on the 6th day of December, 1974.

1.4. Effective Date - These regulations, with revisions which supercede and replace all the regulations filed on the 11th day of August, 1971, the 30th day of November, 1971, and the 23rd day of February, 1973, by the department of mental health, were promulgated on the 6th day of December, 1974, and became effective on the 6th day of January, 1975.

1.5. Refiling Date - These legislative regulations were refiled pursuant to Chapter 29A, Article 2, Section 5 of the West Virginia Code of 1931, as amended on the 30th day of December, 1982.

1.6. Procedures Governing Adoption, Amendment and Recision of These Regulations - The West Virginia department of mental health shall have the power to make, enforce, modify, amend, or rescind rules and regulations governing the operation and conduct of psychiatric hospitals, centers, institutions, and other related facilities and/or services or parts thereof, specified in Chapter 27, Article 9, Section 1, Code of West Virginia, 1931, as amended.

1.7. Regulations by Cross-Reference - The requirements within these regulations for specific facilities and programs to comply with other specific federal, state, and local regulations and laws, including cross-reference requirements within these regulations, do not exempt a facility or program from compliance with other federal, state and local regulations, as revised, if the type and scope of the facility, or program, to be licensed, extends beyond specific references.

1.8. Information and Referral Service Required - No facility or program providing any of the elements of care and treatment of the mentally ill/mentally retarded, or prevention of such disorders, shall operate without properly implementing such services by providing, or establishing on a contractual basis, an effective information and referral service.

1.9. Administrative Regulations Custody - These administrative regulations remain the property of the State of West Virginia. They shall be kept in the chief executive's office and made available for reference to staff and personnel at all times. Pages shall not be removed, or sections eredicated or added to, except by legal procedure. They should be placed in permanent three-ring binders for convenience in receiving and inserting additions, revisions, and deletions. This Section 1.9 shall be applicable to bulletins excerpted and published by the department of mental health.

Section 2. Application and Enforcement

2.1. Application - These legislative regulations shall apply to any hospital, center or institution or part thereof providing inpatient, outpatient or other services designed to contribute to the care and treatment of mentally ill or mentally retarded persons or to the prevention of such disorders, which is established, maintained or operated by any political subdivision or any person, persons, association or corporation.

2.2. Enforcement - The enforcement of these regulations shall be vested with the West Virginia department of health.

Section 3. Definitions

3.1. Act - The Mental Health Act, Chapter 27, Code of West Virginia, 1931, as amended.

3.2. Acute Psychiatric Patient - An individual with some degree of psychiatric illness, deemed to be reversible as opposed to the chronic psychiatric patient, whose condition is irreversible.

3.3. Addiction - "Addiction" means the frequent or constant use of alcohol, narcotic or other intoxicating or stupefying substance which renders the person using such substance incapable of exercising reasonable judgment in the conduct of his affairs or which causes such person to be dangerous to himself or others.

3.4. Administrator - A person who may act as the hospital administrator, business manager, and/or comptroller of a facility dependent upon his training, experience and demonstrated ability. He may be responsible to the executive director for the management of the facility's long-range fiscal program as well as the day-to-day fiscal operations of the facility.

3.5. Aftercare Service - An organized program of follow-up care designed to assist the patient in his re-entry into the community and his adjustment thereafter, including backup services, if needed.

3.6. Applicant - The person who submits an application for a license, or a renewal of a license, to operate a hospital, center, or institution or part thereof, to provide inpatient, outpatient, or other services to contribute to the care and treatment of the mentally ill, mentally retarded or addicted individuals or prevention of such disorders.

3.7. Audit - An accurate accounting of all receipts and disbursements in the construction, administration, or operation of a mental health facility or service and/or part thereof, in a form consistent with acceptable accounting practices, performed by an independent accounting firm or a

certified or public accountant.

3.8. Autopsy, Psychological - Explores in detail the motivation and behavioral clues that might have led to different management of the patient to prevent suicide.

3.9. Bed Capacity - The greatest number of beds the facility is licensed to offer for patient or residential care.

3.10. Business Manager - A person responsible to the executive officer for the execution of the day-to-day fiscal management of a facility and/or comptroller, dependent upon his qualifications, experience and demonstrated ability.

3.11. Catchment Area - A geographic medical service area with population of not less than 75,000 and not greater than 200,000 established in accordance with recommendation of, and subject to the approval of, the West Virginia department of mental health, to provide mental health services to the population of the geographic area. Catchment areas are annually reviewed and delineated in detail in the West Virginia state plan for construction of community health facilities to determine priority for funding of center applications (subject to annual approval by the United States department of health, education and welfare).

3.12. Chief Medical Officer - (27-1-13) -- "Chief medical officer" means the physician responsible for medical programs within a mental health facility and shall include the clinical director of a state hospital.

3.13. Chronic Psychiatric Patient - An individual with a diagnosis of mental illness which is deemed to be irreversible as opposed to the acute psychiatric patient whose condition is reversible.

3.14. Clinical Director - A physician responsible to the executive officer or superintendent of a given facility for management of the facility's clinical services. He is responsible for the management of patients by his staff and the coordination of their efforts. He may also be responsible for detailing and executing the facility's clinical programs as defined by the governing body and organized by the executive officer. In an inpatient facility, the clinical director may be called the "chief of service." The clinical director may be the superintendent or executive officer, responsible directly to the governing body, dependent upon his training, experience and/or ability.

3.15. Comptroller - The chief accounting officer of a facility responsible directly to the executive officer for the fiscal management of the facility's long-range fiscal program as well as being responsible for the day-to-day fiscal management by his staff. He is responsible for maintaining a current interpretation of the fiscal status and reporting immediately any variation which would affect the adherence to any budget limitation.

3.16. Continuity of Care - Intelligently programmed care and treatment which ensures that persons being treated in mental health/mental retardation facilities at any given time are receiving the most appropriate and suitable form of care as their needs dictate.

3.17. Department - The West Virginia department of mental health.

3.18. Director - The director of the West Virginia department of mental health.

3.19. Drug Abuse Patient - The term "drug abuse patient" means any person who is or has been interviewed, examined, diagnosed, treated, or rehabilitated in connection with any drug abuse prevention function.

3.20. Drug Abuse Prevention Function - The term "drug abuse prevention function" means any program or activity relating to drug abuse education, training, treatment, rehabilitation, or research, and includes any such function even when performed by an organization whose primary mission is in the field of drug traffic prevention functions as defined in 21 U.S.C. 1103 (c), or is unrelated to drugs.

The term "drug abuse prevention function" authorized or assisted under any provision of the drug abuse office and treatment act of 1972 (Public Law 92-255), or any act amended by the drug abuse office and treatment act of 1972, means any drug abuse prevention function:

(1) Which is conducted in whole or in part by any department, agency, or instrumentality of the United States; or

(2) For the lawful conduct of which in whole or part any license, permit, or other authorization is required to be granted by any department or agency of the United States.

3.21. Drug Dependent - An individual is "drug dependent" when his addiction reaches a stage where a daily administration of heroin or other morphine-like drug is required to avoid the onset of signs of withdrawal.

3.22. Executive Director - The individual responsible for the coordination of all program activities and in whom is vested the prime authority for the operation and maintenance of the mental health program.

3.23. Facility Types

3.23.1. Center - A mental health facility, public or private, established to provide one or more elements of mental health services, including facilities and clinics providing services to contribute to the care and treatment of mentally ill or mentally retarded or prevention of such disorders. Synonym: mental health agency, community mental health center, comprehensive mental health center.

3.23.2. Community Mental Health Center - A mental health facility which forms a service network providing services and continuity of care for individuals with mental illness, mental retardation, or addiction providing emergency, outpatient, partial hospitalization, inpatient, and consultation and education services.

3.23.3. Comprehensive Community Mental Health Center - A mental health facility which forms a service network providing comprehensive services and continuity of care for individuals with mental illness, mental retardation or addiction providing emergency, outpatient, partial hospitalization, inpatient, consultation and education, in-service training and education, research and evaluation, administrative and rehabilitative services.

3.24. Day Training Center - A mental health facility which provides training in self-help, activities of daily living and social development preliminary to special education or other placement providing rehabilitation and habilitation in a nonresident setting. Synonym: day care for the mentally retarded: Any child care facility including facilities commonly called "child care center," "day nurseries," "nursery schools," "kindergartens," "play groups" (excepting bonafide kindergartens or nursery schools operated by public or private elementary or secondary level school systems, or those

facilities operated in connection with a shopping center or service where transient children are received while parents are on the premises), which has for its primary purpose the care and protection of children with, or without, stated educational purposes during part of all of the day, between 6 a.m. and 9 p.m., accepting for care educable, trainable, including severely and profoundly mentally retarded children.

3.25. Detoxification Facility - A mental health facility either a free-standing unit, or beds specifically designed for detoxification in a hospital or other facility, providing treatment, medically supervised, by use of medication, rest, fluids and nursing care to restore physiological function after it is upset by toxic agents such as alcohol, barbiturates, or other drugs.

3.26. Drug Abuse Center - A mental health facility providing a network of services by psychiatrists, physicians, psychologists, social service professionals, trained counselors and mental health workers to provide planned programs of therapy for the care and treatment of drug abusers and planned programs of preventive care of individuals with drug-related problems.

3.27. Halfway House - A mental health facility providing transitional care which bridges the gap betwen the hospital and community living. Its purpose is to provide preventive and aftercare services for persons who do not need to be hospitalized but who benefit from a supportive living arrangement. The halfway house may be oriented either toward mentally ill, alcohol abusers, drug abusers, or the mentally retarded.

3.28. Hospital - Any public or private structure, agency, institution, or other facility with an organized medical staff with permanent facilities which include inpatient beds, and with medical services including physician services and continuous nursing services to provide diagnosis and treatment for patients.

3.29. Hospital, General with Separate Psychiatric Unit - A separate psychiatric unit is an organizational unit within a general hospital which provides one or more treatment or other clinical services for patients with a known or suspected psychiatric disorder and is specifically established and staffed for use by patients served in this unit.

3.30. Hospital, General with General Psychiatric Inpatient Services but no Separate Unit - A hospital which knowingly and routinely admits patients with a known or suspected psychiatric disorder, but for whom services are not provided in a separate psychiatric unit.

3.31. Hospital, Psychiatric - A mental health facility, public or private, that knowingly and routinely admits patients for the expressed purpose of diagnosing and treating mental disorders providing inpatient twenty-four (24) hour treatment, may also provide services in other modes such as outpatient and day/night services.

3.32. Hospital, State - "State hospital" means any hospital center or institution, or part thereof, established, maintained, and operated by the department of mental health or by the department of mental health in conjunction with a political subdivision of the state to provide inpatient or outpatient care and treatment for the mentally ill, mentally retarded or addicted.

3.32.1. Information and Referral Center - A mental health facility whose primary purpose is to direct people with alcohol or drug problems to available helping resources, and/or other individuals seeking assistance in securing care and treatment or preventive care for problems related to mental illness or mental retardation. The information and referral center provides the most basic of outpatient services in assisting individuals in the community in taking advantage of existing resources and conducting public information sessions and similar functions for the community.

3.32.2. Institution - Any establishment including centers and hospitals providing services to contribute to the care and treatment of mentally ill, mentally retarded, or addicted individuals.

3.32.3. Mental Health Agency - A mental health facility providing less than the five (5) essential elements of mental health care.

3.32.4. Mental Health Facility - "Mental health facility" means any inpatient, residential or outpatient facility for the care and treatment of the mentally ill, mentally retarded, or addicted which is operated, or licensed to operate, by the department of mental health and shall include state hospitals as defined in Section Six, Article 1, Chapter 27, Code of West Virginia, 1931, as amended. The term shall also include a veterans administration hospital. (27-1-9)

3.33. Mental Retardation Facilities

3.33.1. Day Care Center for Mentally Retarded Children - A mental health facility which provides developmental programs for mentally retarded children which will assist them in reaching maximum capabilities, including special training for self-care, socialization, maturation, and self-expression;

and parent education as to nature, causes and consequences of mental retardation, and supportive participation.

3.33.2. Residential Facilities for the Mentally Retarded - A mental health facility that provides twenty-four (24) hour residential and domiciliary directed to enhancing the health, welfare, and development of individuals classified as mentally retarded emphasizing social skills, behavioral shaping activities, recreation, and physical fitness programs.

3.33.3. Outpatient Psychiatric Clinic - A mental health facility whose primary purpose is to provide nonresidential mental health services and in which a psychiatrist assumes medical responsibility for all patients and/or directs the mental health program.

3.33.4. Rehabilitation Center - A public or private facility providing habilitation or rehabilitation services for handicapped individuals by professional staff of physicians, psychologists, social workers, registered nurses and vocational rehabilitation counselors in which disabled, mentally ill, mentally retarded, or addicted individuals are viewed as a whole. Other qualified professional personnel representing the multi-disciplines utilized in the habilitation/rehabilitation process may be required as dictated by patient needs.

3.34. Fiscal Record - All documents related to the receipts, disbursements, accounts receivable, accounts payable, or any other specific record maintained in the financial management of any mental health/mental retardation facility or service, subject to these regulations.

3.35. Foster Grandparent - A person age sixty (60) or over with low income, physically able to serve and willing to accept supervision. A high

school education is not required but the foster grandparent must be able to read, write and communicate with children. The foster grandparent must care about children and want to help them.

3.36. Foster Grandparent Program - Provides training and employment for low income elderly persons to serve in a one to one relationship with mentally retarded, and/or emotionally disturbed children in facilities approved by the West Virginia department of mental health for license.

3.37. Governmental Personnel - The term "governmental personnel" means those persons who are employed by the U.S. government, by any state government, or by any agency or political subdivision of either.

3.38. Governing Body - The legal entity having authority and total responsibility for the operation of a mental health facility and/or service.

3.39. He, Him, His - The male pronoun is used throughout to refer to individuals of either sex.

3.40. Inpatient Service - Twenty-four (24) hour care provided by any hospital or residential facility to those who are mentally ill or mentally retarded.

3.41. License - The legal document issued by the director of West Virginia department of mental health granting authority to operate a psychiatric hospital, mental health center, or institutions or part thereof to provide inpatient, outpatient, or other services to contribute to the care and treatment of mentally ill or mentally retarded persons, or prevention of such disorders.

3.42. Likely to Cause Serious Harm - "Likely to cause serious harm" refers to a person who has:

(1) A substantial tendency to physically harm himself manifested by threats of or attempts at suicide or serious bodily harm or other conduct, either active or passive, demonstrating that he is dangerous to himself; or

(2) A substantial tendency to physically harm other persons manifested by homicidal or other violent behavior which places others in reasonable fear of serious physical harm. (27-1-12)

3.43. Medical Personnel - The term "medical personnel" includes physicians, nurses, psychologists, counselors, and supporting clerical and technical personnel.

3.44. Mental Illness - "Mental illness" means a manifestation in a person of significantly impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotional and physical well-being. (27-1-2)

3.45. Mental Retardation - "Mental retardation" means significantly subaverage intellectual functioning which manifests itself in a person during his developmental period and which is characterized by his inadequacy in adaptive behavior. (27-1-3)

3.46. Methadone Detoxification Treatment - Detoxification treatment using methadone is the administering or dispensing of methadone as a substitute narcotic drug in decreasing doses to reach a drug-free state in a period not to exceed twenty-one (21) days in order to withdraw an individual who is dependent on heroin or other morphine-like drugs from the use of these drugs.

3.47. Methadone Dispenser - A methadone dispenser is a practitioner licensed under state or federal law to order narcotic drugs or an agent of

such practitioner. The agent of the practitioner may only be a licensed pharmacist, registered nurse, or licensed practical nurse.

3.48. Methadone Maintenance Treatment - "Maintenance treatment" using methadone is the continued administering or dispensing of methadone, in conjunction with provisions of appropriate social and medical services, at relatively stable dosage levels for a period in excess of twenty-one (21) days as an oral substitute for heroin or other morphine-like drugs, for an individual dependent on heroin. An eventual drug-free state is the treatment goal for patients but it is recognized that for some patients the drug may be needed for long periods of time.

3.49. Methadone Program Sponsor - Methadone program sponsor is an individual responsible for a particular methadone program.

3.50. Methadone Treatment Medication Unit - A "methadone treatment medication unit" is a facility, established by a program sponsor as part of his program, from which licensed private practitioners and community pharmacists are permitted to administer and dispense methadone. These medication units may also collect urine for testing for narcotic drugs. Any such facility shall be geographically dispersed from the primary facility and other medication units that have been established. The enrollment in a medication unit shall be of reasonable size in relation to the space available for treatment and the size of the staff at the facility, and may not exceed thirty (30) patients.

3.51. Methadone Treatment Program - A methadone treatment program is defined as a person or organization furnishing a comprehensive range of services using methadone for the detoxification and/or maintenance

treatment of narcotic addicts, conducting initial evaluation of patients and providing ongoing treatment at a specified location or locations. If there is a centralized organizational structure, consisting of a primary facility and other outpatient facilities, all of which conduct initial evaluation of patients and administer or dispense medication, both the primary facility and each outpatient facility shall be considered a separate program even though some services may be shared (e.g. the same hospital or rehabilitative services).

3.52. Minimal Psychiatric Services - A basic holding operation providing immediate availability of a physician capable of an initial evaluation and of the ordering of psychotropic drugs when needed; a psychiatrist available for consultation, at least by telephone; availability of a nurse or attendant who has been trained to special a disturbed patient; a place where the disturbed patient can be housed; and a mechanism for getting the patient to a suitable treatment center.

3.53. Normalization - The use of means that are as culturally normative as possible to elicit and maintain behavior that is as culturally normative as possible, taking into account local and subcultural differences.

3.54. Patient/Client/Student/Recipient - Any individual receiving diagnostic, intake, or treatment services from any of the types of facilities included under these regulations, or formally enrolled in a training program or a student in a mental health facility, or receiving training in a program providing services for the mentally ill/mentally retarded. For statistical purposes patient/client/student/recipient is considered synonymous if the individual is the recipient of the service of a facility subject under these regulations.

3.55. Persons - Any individual, partnership, association, corporation, or any local governmental unit, or any division, department, board or agency thereof.

3.56. Psychiatric Emergency - Refers to suicidal, agitated, inebriated/intoxicated (including alcoholic or drug detoxification withdrawal phase), or agressive persons, and family tolerance situation needing immediate treatment.

3.57. Psychologist - "Psychologist" means any person licensed under the laws of this state to engage in the practice of psychology. (27-1-10)

3.58. Public Information Service - A service established to better acquaint the general public with the goals of the mental health/mental retardation programs and the progress toward the attainment of these goals which should be under the supervision of a fully qualified public information specialist.

3.59. Special Care Room - A patient room from which immediate exit is impeded by lock, latch, bar, hook, or other device which cannot be operated by the patient, the keys, or means of ingress for which are immediately available to personnel in the area in case of an emergency.

3.60. State Authority - "State authority" means the state authority designated pursuant to Section 409 of Public Law 92-255, the drug abuse office and treatment act of 1972. The director of the department of mental health is the West Virginia state authority under Section 409 of Public Law 92-255.

3.61. Trained Personnel - Trained personnel may be any staff member who is licensed or otherwise qualified to provide individual-oriented

services to patients. Some of these workers may be professional level persons while others may be psychiatric aides, psychiatric technicians, or attendants, providing ward-level psychiatric care and treatment under the supervision of a licensed physician, registered nurse, or other mental health professional.

3.62. Treatment - The processes provided by a psychiatric or related facility designed to reduce or eliminate the symptoms or severity of a mental illness or disorder.

3.63. Verbs

Is to be) Terms used to indicate a mandatory statement, the only
Must be) acceptable methods under the present standards.
Shall.)

Should be) Terms used in the interpretation of a standard to reflect the commonly accepted method yet allowing for the use of effective alternates.

May be) Terms in the interpretation of a standard to reflect an acceptable method that is recognized but not necessarily preferred.

Section 4. License

4.1. Programs to be Licensed - No hospital, center, or institution or part thereof, to provide inpatient, outpatient, or other services designed to contribute to the care and treatment of mentally ill or mentally retarded, or prevention of such disorders, shall be established, maintained or operated by any political subdivision or any person, persons, association or corporation unless a license therefor shall be first obtained from the direc-

tor of mental health in accordance with Chapter 27, Article 9, Section 1, Code of West Virginia, 1931, as amended.

4.2. Institutions and Services Exempted from these Regulations

(a) Hospitals operated by the federal government;

(b) Institutions licensed by the West Virginia department of welfare such as day nurseries, child care institutions and child care centers, except where primary care is for the mentally retarded or emotionally disturbed;

(c) Nursing and convalescent homes, personal care homes, or institutions regularly licensed by the West Virginia nursing home licensing board, except those institutions having dual functions one of which is clearly subject to licensure under these regulations;

(d) Special education classes for exceptional children under the jurisdiction of county boards of education;

(e) Services provided by licensed practitioners within the scope of proffessional license.

4.3. Application for License

(a) Applicants for license shall file applications with the West Virginia department of mental health upon Form DMH-1 (as revised) prescribed by the department in addition to such other data requested by the director;

(b) Applicants operating satellite programs at locations other than shown on DMH-1 shall apply for license for each separate location on DMH-1 supplement (as revised).

4.3.2. Architectural Drawings Required

(a) An accepted architectural standard drawing of plan of the facility, or the psychiatric unit of a facility, shall be attached to the license application and made a part of the permanent licensing record;

(b) All major subsequent changes, additions, or new construction affecting programs shall be subject to the approval of the director of the department of mental health.

4.3.3. Authority to Sign - Copy of resolution of the governing body granting authority to sign authenticating the signature of the person signing application on behalf of applicant shall accompany each applicant, where applicable.

4.3.4. Articles of Incorporation - The article of incorporation of a corporation operating any mental health facility subject to these regulations shall be consistent and in compliance with these regulations.

4.3.5. Bed Capacity - Each application for license shall specify the maximum number of beds, if any, and shall indicate the planned utilization of beds to inpatient, hospitalization, partial hospitalization, residential care, or a combination thereof.

4.3.6. Name of Facility, or Program - Each applicant for psychiatric hospital, center, related institution, or related facility and/or service or part thereof, or program shall be specifically identified as such by an appropriate name which shall be used in applying for a license.

4.3.7. Changes of Name

(a) The name of a mental health facility, or program, shall not be changed without the approval of the department of mental health; except however, general hospitals providing psychiatric services shall notify the

department of mental health as soon as approval for change of name has been granted by the department of health.

(b) Grantees of federal staffing funds shall apply to the regional health education and welfare office through the department of mental health for authority to change name. The application for change shall include the following:

(1) Current name of community mental health center;

(2) Proposed name of community mental health center;

(3) Reasons for change; and

(4) A description of extent to which the community and the state and local mental health agencies have been involved in the proposal.

4.3.8. Change of Address - Immediate notice shall be given to the concerned state and local health agencies of any change of address, and such notice shall be made known throughout the catchment area it serves, including the effecting of changes in telephone and other directories.

4.3.9. Full Disclosure - There shall be full disclosure of the names and addresses of all owners, governing body members, or if a corporation, the names and addresses of all officers, directors, and persons who are principal stockholders, whether beneficial or of record.

4.4. Issuance of License Certificate

4.4.1. The license will be issued on a certificate prescribed by the director of the West Virginia department of mental health and shall set forth the name, location, services to be rendered, and number of beds, if any, for which the psychiatric hospital, center, related institution or other related facility and/or service, or part thereof, is licensed.

4.4.2. Two classes of licenses will be issued as follows:

Class I: Full approval of all services for which license is applied, shall be issued for a twelve-month period.

Class II: Provisional approval contingent upon removal of deficiencies within one or more services for which license is applied. Deficiencies shall be noted on the face of the license certificate for disclosure to patients, clients and/or students and their families.

4.4.3. License to be Posted - The Class I and Class II license certificates shall be posted in a conspicious place at each location where mental health/mental retardation services are provided.

4.4.4. License Non-Transferable - The license shall be nontransferable and nonassignable. The department of mental health shall be immediately notified of any change relative to the ownership, name, location or operation of the institution, and an application form for a new license shall be requested for filing with the department.

4.5. Surveys for License or Renewal of License

4.5.1. Authorized Surveyors - Only duly authorized representatives of the department of mental health shall have the right to enter upon or into the premises of any hospital, center, institution, or other related facility and/or part thereof in order to survey all elements of operations in accordance with the licensing authority vested in the department.

4.5.2. Survey Team Credentials

(a) Each surveyor of the survey team appointed by the director of mental health shall carry official identifying credentials indicating his authority to make a qualitative survey of the facility. Surveyors who review

psychiatric medical records, alcohol and drug abuse medical records, or methadone treatment records shall carry credentials which specifically state the authority of the director to review such records.

(b) Positive identification of the licensing surveyors shall be the responsibility of the medical records administrator. In the absence of a certified medical record administrator, the administrator, superintendent, or clinical director of the facility shall be responsible for positive identification.

4.5.3. Survey Team - A survey team for each region as defined in the West Virginia state plan for construction of community mental health centers and mental retardation facilities shall be annually appointed by the director of the department of mental health and shall include:

1 Administrator, community mental health center, or hospital;

1, or more if needed, fire inspector, state fire marshal designee(s);

1 director, or designee, mental health licensing program;

1 mental health/mental retardation professional, as needed;

1 sanitarian, local department of health, designee;

1 psychiatrist, as needed;

1 architect, as needed;

1 attorney, as needed;

1 auditor, as needed;

1 director, or designee, community services division, as needed;

1 engineer, as needed;

Provided however, that no surveyor shall participate in the survey of his own facility.

4.5.4. Report of Survey - The survey team, prior to leaving the premises after a survey, shall submit either an oral, or written, report of its findings with the superintendent or executive officer, or his duly authorized representative.

4.5.5. Survey Required Before License Issued - Surveys shall be made prior to the initial issuance of a license, renewal of a license, or at any time during the licensing period in order to assure continuing conformity with the standards contained in these rules and regulations.

4.5.6. Noncompliance with Regulations - Noncompliance with a regulation, or regulations, noted by the surveyors may constitute sufficient cause for refusal or revocation of license, at the discretion of the director of the West Virginia department of mental health.

4.5.7. Certification by State Fire Marshal to be Posted - All mental health facilities required to be licensed under the provisions of these regulations shall comply with and conform to all rules and regulations which provide minimum standards for the prevention of fire and for the protection of life and property against loss or damage by fire or panic. A certificate of approval shall be obtained from the state fire marshal by any institution required to be licensed. Written approval of the institution shall be filed with the state department of mental health and a copy of such certificate shall be posted in a conspicuous place on the premises of the licensee.

4.6. Expiration and Renewal of License

4.6.1. Expiration of License - All licenses issued by the department of mental health shall expire on the thirty-first (31st) day of December following issuance, provided that any such license in effect on the thirty-

first (31st) day of December of any year, for which application for renewal has been made to the department of mental health in conformance with these regulations and prior to the expiration date of such license, shall continue in effect until:

(a) The thirty-first (31st) day of December next following the expiration date of such license;

(b) The date of revocation or suspension of such license; or

(c) The date of issuance of a new license whichever date first occurs.

4.6.2. Renewal of License

(a) Applications for the renewal of license will be mailed to each hospital, center, institution, related facility and/or service or part thereof before September 30th, which shall be completed and returned to the department of mental health before issuance or renewal of license;

(b) The renewal of a license shall be contingent upon evidence of compliance with the licensing law and minimum standards and regulations herein set forth.

4.6.3. Notification of Noncompliance - Each applicant will be duly notified, in writing, of any noncompliance and shall comply with the provision of the law, rules and regulations herein set forth before the issuance or reissuance of a Class I license to operate.

4.7. Revocation and Reissuance of License

4.7.1. Right to Hearing Before Revocation - After an opportunity for a hearing before a review committee, the department of mental health may revoke the license of any institution or agency found in noncompliance with

the licensing law or the rules and regulations issued pursuant thereto.

4.7.2. Multidisciplinary Review Committee

(a) The director of the department of mental health shall appoint a multidisciplinary review committee. Members shall be given initial appointments of one, two, or three years and thereafter terms of three years to provide for a rotation of membership on the committee;

(b) The review committee shall be representative of the West Virginia health, education, and welfare state agencies and such other professional associations representative of facilities and programs and consumer groups concerned about the mentally ill and/or mentally retarded to ensure a fair and unbiased review of the deficiencies cited as reason for the revocation of license to operate. The director of the mental health licensing program shall be an ex officio member of the review committee;

(c) The review committee shall meet on call, as needed. Thirty (30) day notice shall be given of meetings.

4.7.3. Revocation of License - After consideration of the recommendations of the review committee, the decision to revoke, or not to revoke, the license shall be made by the director of the department of mental health and shall be final.

4.7.4. License to be Returned to Department of Mental Health - The license shall be returned by the applicant to the department of mental health immediately upon its revocation, or when an institution, or agency, voluntarily ceases operation, or if license is technically voided because of transfer or change of ownership, name, location, or operation.

Section 5. Community Mental Health Centers

5.1. General

5.1.1. Community Mental Health Center - A community mental health center is a mental health facility which provides within the center or on a written contractual basis, the following essential elements of care:

(a) Emergency;

(b) Outpatient;

(c) Partial hospitalization;

(d) Inpatient; and

(e) Consultation and Education; unless, however, temporary waiver not to exceed eighteen (18) months has been granted to community mental health centers operating with federal grant funds and serving areas designated as urban or rural poverty areas by the secretary of health, education, and welfare, in which case the community mental health center shall:

(a) Be able to provide at least three of the five essential services;

(b) Be able to initiate the waived services within eighteen (18) months from the date that the application was signed by the authorized representative;

(c) Make satisfactory arrangements for residents of the catchment area to obtain the essential elements of service not provided during the waiver period.

5.1.2. Comprehensive Community Mental Health Center - The comprehensive community mental health center is a mental health facility which provides within the center or on written contractual basis, in addition to the five (5) essential elements of care set forth in Section 5.1.1. of these

regulations, the following supportive services;

(a) In-service training and education;

(b) Research and evaluation;

(c) Administrative services;

(d) Rehabilitation services.

5.1.3. Mental Health Agencies Providing Less Than the Five Essential Elements of Care - The mental health agency is a mental health facility providing less than the five (5) essential elements of mental health care. The mental health agency shall:

(a) Post in a prominent place a list of the service(s) provided;

(b) The names, licenses, registration, and/or professional degree certificates of professional staff;

(c) The elements of services provided shall meet the standards herein set forth for each service.

5.1.4. Habilitation and/or Rehabilitation - A community mental health center should recognize the importance of providing habilitation and/or rehabilitation services within the essential elements of care set forth in Section 5.1.1.

5.1.5. Population-At-Risk Should be Identified - The community mental health center should utilize indices and reliable statistical data to identify the populations-at-risk for drug dependence, alcoholism, aging, delinquency, behavioral problem children, mental retardation, and any other special mental health problems within its catchment area.

5.1.6. Programs Focused Toward Social Systems - The community mental health center should provide programs to help various social systems

of the community to function in ways that develop and sustain effectiveness of individuals within these systems.

5.1.7. Extension of Services to Families - The service treatment records of a community mental health center client shall show, in addition to treatment of clients, evidence of making available services to the family, when indicated.

5.1.8. Accessibility of Services - Community mental health centers, facilities, and programs shall ensure services be accessible and responsive to the needs of the mentally ill/mentally retarded individuals in the catchment area they serve by:

(a) Locating conveniently to transportation and providing adequate parking;

(b) Clearly visible signs, telephone listings, newspaper articles, and effective information and referral service, and other media to reach total catchment area it serves;

(c) Developing administrative procedures which will enable individuals needing help to receive services without unnecessary admitting delays, waiting time, or time consuming referral procedures between elements of service;

(d) Making the services equally available to all residents in the catchment area regardless of age, sex, race, creed, color, national origin, diagnostic category, duration of residency, voluntary or involuntary status, or ability to pay;

(e) Providing inviting architecture and decor which is generally comforting and acceptable, and a name acceptable to the population of the

catchment area, in order to ensure the center be psychologically accessible to entire population of area served;

(f) Developing programs which will reflect the different structures of the population served to ensure the cultural accessibility of the center.

5.1.9. Provision of Services to All Persons in Catchment Areas, When Needed - If a community mental health center does not provide direct treatment at the center for every person in need of services within the catchment area, the center must arrange for the provision of services, either directly or indirectly through systematic referral to other resources, both private and public, to residents of the catchment area.

5.1.10. Provision of Services Outside Catchment Area

(a) Community mental health centers may provide services outside the catchment area it serves only if such service does not adversely affect the center's ability to serve the population for which it is responsible;

(b) If a community mental health center serves clients outside its catchment area, priority shall be given to catchment area residents.

5.1.11. Continuity of Care - All community mental health centers shall establish mechanisms designed to assure continuity of care by providing for:

(a) Ready accessibility of all services of the center including smooth transfer of clients between elements of service;

(b) Availability at all times of the full range of community mental health services, direct and indirect, when needed by clients being treated in any one service;

(c) Prompt delivery of pertinent records and information required for transfer;

(d) Coordination of all services, direct or indirect, provided by the center;

(e) Procedures for the coordination and integration of mental health service programs with other pertinent state and local service agency programs;

(f) Smooth referral and follow-up systems between center and private physicians and noncenter agencies and organizations within and outside the catchment area frequently used by the center.

5.1.12. Patients'/Clients' Rights - Every mental health facility providing one, or more, mental health service(s) shall be in full compliance with Administrative Regulations 27-9, Series I, 1971, as revised, pertaining to patients'/clients' rights, set forth in said Administrative Regulations 27-9, Section 10, entitled "Humanities."

5.1.13. Organization and Management

(a) There shall be an organized governing body which has full authority and legal responsibility for the conduct of the center, for establishing policies to ensure a high quality of professional services rendered, and for maintaining a safe functional physical facility. The governing body may be a governmental unit or a board of trustees;

(b) Board membership shall have appropriate representation.

(1) The governing body shall include a broad representation of the catchment area served and be representative of persons of all walks of life. Its members should be selected for their ability to participate effectively in

fulfilling the governing body's responsibilities and to satisfy legal requirements; provided however, that specific board membership shall be representative of the area it serves regardless of affluence and higher education. If the catchment area served includes more than one county, each county shall be equitably represented on the governing board. It should be representative of minority groups within the area served;

(2) In the absence of adequate representation of consumers on the governing board, or if current programs do not meet community needs, a consumers advisory board shall be formed, and meet regularly;

(3) No person shall be appointed or elected to serve as a member of the governing body who is an employee of the center; however, the chief executive officer should be an ex officio member of the governing body;

(4) There shall be a rotation of membership in the governing body structure. The governing body shall establish initial terms of membership for one, two, three but not more than four years to create a membership rotation in the governing body structure. No member shall serve more than one term without absence of one (1) year.

(c) The governing body shall adopt bylaws in accordance with legal requirements. They shall include, but not be limited to:

(1) Election of officers;

(2) Definitions of powers and duties of the governing body officers and commitee. Committees of the governing body should include, but not be limited to, executive, finance, recruitment and personnel, planning, professional staff liaison and accountability, and community involvement. A small governing board may perform the duties of these committees working as a committee of the whole;

(3) Annual audit by an accredited auditor in accordance with generally accepted accounting procedures;

(4) Duties and responsibilities of executive officer defined;

(5) Periodic review of bylaws and revisions as necessary;

(6) Insurance protection of property, personnel and patients/clients;

(7) Approval of bylaws that delineate the purposes and functions of auxiliary organizations;

(8) Orientation and education of governing body members.

(d) The governing body shall establish policies in accordance with legal requirements and community responsibility, identifying the purposes of the community mental health center and the means of fulfilling them. They shall include, but not be limited to, policies which will support provision for:

(1) Continuity of care;

(2) Flexibility of the organization to meet changing and current needs of the community;

(3) Development of community support in center financing;

(4) Regularly updating information of sources of financial support including, but not limited to, grant monies, tax funds, fees, and private endowments;

(5) Recruitment methods to provide adequate qualified professional and nonprofessional personnel to carry out community mental health services, avoiding under and over staffing;

(6) Provision for supporting staff qualified in medicine, psychology, social work, nursing as well as other allied disciplines, as needed, including administrative and clerical staff to provide case record recording;

(7) Continuing programs of orientation and education, staff training, and development to ensure effective center programming.

(e) The community mental health center governing body shall provide for regular meetings, preferably monthly, but at least bimonthly;

(f) Special governing body meetings devoted to long-range planning shall be held periodically to integrate the community mental health services provided with other state and local mental health services; to develop new services as needed; eliminate services in keeping with the changing needs of the community; and integrate fiscal structures with other mental health affiliates, state and local, to strengthen total community mental health/ mental retardation fiscal structures and avoid duplication of services and personnel costs;

(g) Minutes of all meetings of the governing body and of all committees shall be kept; including roster of attendance; and shall be signed promptly upon adoption;

(h) An agenda, in writing, shall be prepared for all governing body meetings, including at least the following:

Regular meetings:

Call to order;

Minutes of previous meetings, regular or special;

Financial report;

Unfinished business;

Communications;

New business;

Reports of executive officer and committee chairpersons;

Discussion of items relating to orientation of new members, education, improvement of mental health facility or services;

Adjournment.

Special Meetings:

Reading of the notice calling the meeting;

Transaction of the business stated in the notice;

Adjournment.

(i) Each community mental health center shall have an administrative structure which is an identifiable, unified entity, even though the center may be a part of a larger organization providing other types of human services, or made up of two or more affiliating agencies.

(j) The executive officer of the community mental health center shall be a qualified psychiatrist, psychologist, social worker, mental health nurse, professional administrator with experience and demonstrated ability in the field of mental health, or other mental health professional with demonstrated ability, who shall be appointed by the governing body of the center to carry out its policies.

His duties and responsibilities shall be defined in the governing body policies, which should include, but not be limited to, the following:

(1) Delegation of authority and responsibility in the carrying out of the policies of the governing body in the administration of the center;

(2) Preparation and submission to the governing body for approval

an organizational plan of personnel and staff to provide a functional operation of the community mental health center at as high a standard as possible, but at least the minimum standards of these regulations. Consideration should be given to adequate clerical, medical records, business office, dietary, housekeeping, infection control, safety, and maintenance staff to permit the treatment team to carry on its primary responsibility, and ensure all individuals a smooth continuity of care and treatment;

(3) Provision of a manual of policies and procedures, in writing, for the operation of the community mental health center relating to all elements of the mental health programs and administrative responsibilities, including provisions for:

a. Maintaining and sharing clinical records setting forth legal and administrative policies for confidentiality;

b. Maintaining and sharing financial records;

c. Development and maintenance of programs to foster satisfactory relationships between the community mental health center and the community;

d. Clinical and program coordination responsibilities with affiliates and other community agencies;

e. Fulfillment of all other obligations and assurances required by the community mental health center act of 1963 (PL 83-164) as amended, and Chapter 27, Code of West Virginia, 1931, as amended;

f. Coordination of the center's services with other community resources including follow-up of persons referred to such resources;

g. Active community involvement in center programs and services.

(4) Establishing and maintaining an accrual system of accounting, providing for a monthly closing of accounts and reporting fiscal data to the governing body.

(5) Preparation of an annual budget forecasting funding and other receipts, and expenditures, with projection and control statistics pertinent to the current operation and long-range planning.

(6) Provision of essential elements of care within the catchment area served, not provided within the community mental health center, by agreements which are fully executed by both parties, setting forth the scope of the services provided and the specific procedures which will ensure smooth continuity of care as clients move between elements of service as their needs dictate.

(7) Developing cost accounting procedures for all elements of the center.

(8) Establishing fee schedules based upon ability to pay and actual cost of services.

(9) Providing written personnel policies and practices that adequately support sound client services.

(10) Selecting, employing, controlling, and discharging personnel, subject to the budget allocations and the limitations approved by the governing body.

(11) Maintaining an environment reflecting an atmosphere of mutual understanding, respect, and cooperative relationships between members of the staff, the administration, and the governing body.

(12) Providing for compliance with all laws and regulations pertinent

to the admissions and release of clients/patients.

(13) Attending all governing body meetings, committee and staff meetings as an ex officio member in order to coordinate the combined efforts in the program.

(14) Participating in community organizations and activities to further community education in the care, treatment, and prevention of mental disorders.

(15) Providing for compliance with administrative regulation 27-9, Series I, 1971, as revised, Section 12, entitled "transportation," if the center provides transportation for any of its services or programs.

(16) Making annual reports on forms provided by the department of mental health, and providing such other information as requested.

(17) Completing and submitting promptly department of mental health data collection forms.

(18) Establishment of treatment data controls so that reliable data on what takes place in the treatment programs can be readily available for constant scrutiny for evaluation, research, and program development.

(19) Establishment of a system of constant evaluation of the efficiency and effectiveness of the center programs to determine:

a. What kinds of clients are being served;

b. Any deficiencies in the client's total care program; and

c. Use of the community's total resources to serve clients.

(20) Providing for compliance with administrative regulations 27-9, Series I, 1971, as revised, Section 13, entitled "research and evaluation" by:

a. Providing evidence of developing a professional utilization review and evaluation project to establish techniques for utilization review and client/patient care evaluation; and

b. Giving consideration in the said utilization review and evaluation projects to:

1. Review of structure;

2. Review of outcome;

3. Review of process.

5.2. Professional Staff

5.2.1. Professional Staff Services - The professional staff of a community mental health center, or agency, shall include the services, either full-time, or as a consultant, of either a qualified psychiatrist and/or a physician, psychologist, a master's level social worker, registered mental health nurse, or registered nurse, and other consultants representing other allied disciplines determined by needs of clients served and programs conducted.

5.2.2. Staff Participation - Provision shall be made for clinical and administrative staff to participate actively in the formulation of treatment programs, administrative, and personnel policies.

5.2.3. Professional Responsibility for Care Within All Elements of Service - Professional staff responsible for client services within one element, when not clinically contraindicated, should be permitted to continue to care for that client within any other element, if practicable.

5.2.4. Professional Staff Informed as to All Services Available Through the Center - Each individual on the mental health center team shall be fa-

miliar with all elements of services in the center or on a contractual or affiliate basis, to ensure continuity of care.

5.2.5. Medical Responsibility - The medical responsibility for each client shall be vested in a physician. If the physician is not a psychiatrist, psychiatric consultation must be available to the center staff on a continuing and regularly scheduled basis not less than once weekly. In cooperatively defining the areas of activity in patient care, a physician or his designee, must be recognized as having ultimate responsibility for patient care.

5.2.6. Neurological Services - If a neurologist is not on the staff of the community mental health center or agency, arrangements should be made for services as needed.

5.2.7. Medications Administered - All medications administered to clients shall be given only on written, dated, and signed order of a physician.

5.2.8. Medications Dispensed - Medications dispensed by a community mental health center, or agency, shall be in compliance with procedures established under Section 5.13.6 of these regulations, whether the center, or agency, maintains a pharmacy or drug supply area.

5.2.9. Medications in Isolated Areas - In isolated areas, including camps, which are part of a mental health facility program licensed in the State of West Virginia, medications may be administered under the supervision of a registered nurse currently licensed in the State of West Virginia, by prescription ordered by the patient's physician; provided however, that the medication shall be packaged, sealed, and delivered to

the registered nurse direct, and the label on the prescription container shows name of drug, strength, and dose, and is in compliance with West Virginia board of pharmacy regulations, as amended, and the uniform controlled substances act, Chapter 60A, Code of West Virginia, 1971.

5.2.10. Clinical Records - The staff shall observe professional standards of recording, care, and treatment of clients. The records should be problem oriented and goal structured.

5.2.11. Quality Assurance Report - The professional staff should provide the governing body with a monthly report reflecting the quality of care.

5.3. Admissions Policies and Procedures

5.3.1. Admission Policies and Procedures in Writing - Each community mental health center shall establish, in writing, its admission policies and procedures and the manner in which these are routinely accomplished, including, but not limited to, the following:

(a) Role of the family, its rights and responsibilities;

(b) Provision for any individual eligible for treatment within one service to be eligible for treatment within any other element of service;

(c) Provision for transfer of clients from one element of service to another promptly without unnecessary evaluations when such transfer is indicated by clients' needs;

(d) Services of center not to be denied to any person residing in the area served by the center on the ground that such person does not meet a requirement for a minimum period of residence in such area;

(e) Provide method for channeling information relative to gaps or

inadequacies in service to the attention of the body having responsibility for overall planning, supervision, protection, recreation, and employment of patient and counseling of the family;

(f) Transportation data when such service is affiliated with, or provided by, the center; and

(g) Legal requirements for initiating and terminating services.

5.3.2. Review And Evaluation To Determine Need For Hospitalization

Community mental health centers and agencies shall offer whatever evaluation, consultation, treatment, or referral services regularly provided, or contracted for, by the center or agency which are needed and feasible for voluntary admission of persons under eighteen (18) years of age, involuntary admission by medical certification, involuntary hospitalization admission by emergency procedure, and involuntary hospitalization admission of persons charged or convicted of a crime.

(a) Community mental health centers, and/or agencies designated by the director of the department of mental health shall establish and publicize procedures for securing evaluations and review for hospitalization of clients in each of the above categories of admission in full compliance with Chapter 27, Code of West Virginia, 1931, as amended, as follows (see exhibit A):

(1) Voluntary admission of persons in accordance with Section 15 of these regulations promulgated under Chapter 27, Article 4, Code of West Virginia, 1931, as amended.

(2) Involuntary admission by medical certification; involuntary admission by emergency procedure; and involuntary commitment of persons

in accordance with Section 16 of these regulations promulgated under Chapter 27, Article 5, Code of West Virginia, 1931, as amended.

(3) Involuntary admission of persons charged or convicted of a crime in accordance with Section 17 of these regulations promulgated under Chapter 27, Article 6A, Code of West Virginia, 1931, as amended.

(4) Involuntary admission of juveniles for examination or period of observation in accordance with Section 17.1.9. of these regulations promulgated under Chapter 27, Article 6A-1 (f), Code of West Virginia, 1931, as amended.

(b) Publication of procedures for securing review and evaluation for hospitalization shall be publicized generally in the catchment area, and specifically sent to the following agencies:

(1) County circuit courts, domestic relations courts, juvenile delinquency courts, and mental hygiene commissioners, police departments, doctors, health and mental health agencies (for civil admissions or commitments).

(2) Criminal courts of record requiring evaluations and review to determine:

a. An individual's competency to stand trial;

b. An individual's irresponsibility in committing a crime because of mental illness, mental retardation, or addiction; or

c. Other specific reviews and evaluations as ordered by the court of record.

(c) Community mental health centers, and/or agencies where applicable, shall prepare regular schedules, evening and weekend sched-

ules, and emergency care schedules of availability for determining need for hospitalization.

5.3.3. Community Mental Health Center Outpatient/Inpatient Admissions Under Chapter 27, Code of West Virginia, 1931, as amended - Community mental health centers and/or agencies admitting individuals for outpatient treatment or to inpatient center beds under Sections 15, 16, or 17 promulgated under Chapter 27, Article 4, 5, or 6A, Code of West Virginia, 1931, as amended, shall be in full compliance with these regulations where applicable.

5.3.4. Examinations for Court Commitments at State Hospitals - Examinations and evaluations for court commitments, if not available locally, may be conducted by professional staff of the state hospital designated for the area by the director.

5.3.5. Availability of Beds and Services - Community mental health centers and agencies shall establish immediate and continuing communication routes between all mental health facilities in the catchment area specifying number of beds and types of service available at all times.

5.3.6. Intake Worker - The intake worker in admissions shall be a psychiatrist, psychologist, nurse, social worker, or other supervised staff member or trained volunteer, dependent upon clients' needs.

5.4. Diagnosis and Treatment

5.4.1. Initial Evaluation - The initial evaluation shall be promptly recorded in client's record and should include, when indicated, the following:

(a) Presenting problems;

(b) Social history;

(c) Psychiatric/psychological evaluation;

(d) Physical examination;

(e) Description of current functioning;

(f) Neurological examination;

(g) Laboratory tests, dependent upon clients' needs in view of presenting problems;

(h) Interview data, and special needs for;

(i) Occupational therapy;

(j) Physical therapy;

(k) Recreational therapy, including physical fitness; and

(l) Rehabilitation.

and should adhere to the problem-oriented system of care, providing complete problem lists which are kept current.

5.4.2. Presenting Problems - A presenting problem or problems shall be recorded promptly upon admission and such additional informative observations as to client's condition shall be succinctly recorded in his case record promptly and kept current.

5.4.3. Treatment Summary - At termination a summary of care and treatment shall be set forth clearly in the case record.

5.4.4. Diagnosis

(a) Diagnoses shall be rendered in standard nomenclature as provided in the american psychiatric association's latest edition of the diagnostic and statistical manual of mental disorders and/or the latest edition of the international classification of diseases;

(b) All diagnoses shall be substantiated by valid and reliable data based upon accepted professional standards of examinations and tests indicated by factual description of clients' symptoms and/or problems.

5.4.5. Coordination of Treatment Planning Efforts - There shall be, in writing, a workable method of providing appropriate coordination of staff efforts in evaluation, and in the formulation of planning.

5.4.6. Plan of Treatment

(a) There shall be a written plan of treatment and/or training program for each client based on the initial medical and psychiatric evaluation of his condition, his treatment, or training needs, his potential for habilitation and/or rehabilitation and the resources of the center and the community to meet these needs. The treatment and/or training plan shall be developed within seven (7) days of admission;

(b) There shall be frequent reviews and revisions, when indicated, of the written plan of treatment to determine the client's need for continuing such service element, or for transfer to another service for referral elsewhere, or for termination.

5.4.7. Need for Drug or Other Somatic Treatment

(a) Drug therapy, electroconvulsive therapy and other somatic treatment modalities shall be given only upon the written order and under the direct supervision of a physician based upon positive criteria (see Section 10.7 and 10.8);

(b) An inventory of emergency drugs, equipment and supplies shall be maintained and reviewed periodically to ensure they are current and in keeping with accepted standards of practice.

5.4.8. Treatments Time Limited - All treatments should be goal directed and time limited.

5.5. Emergency Service

5.5.1. Organizational Plan in Writing - There shall be a written plan for emergency service specifying its relationship to other community emergency services, and providing for training of an adequate staff. The organizational plan should include provision for twenty-four (24) hour walk-in service, home visits, and a service for suicide prevention. The plan shall be reviewed and periodically.

5.5.2. Telephone Service - There shall be adequate telephone service to ensure immediate emergency response to mental health emergencies of all types including, but not limited to, need for medical management of withdrawal periods when necessary for alcoholics and drug addicts, and suicide intervention.

5.5.3. Emergency Service Policies in Writing - There shall be written policies specifying the extent of treatment to be carried out in the emergency service. Such policies shall be approved by the professional staff and reviewed periodically, and revised as necessary showing dates of reviews and revisions.

5.5.4. Emergency Service Procedures in Writing - There shall be written procedures including, but not limited to, the following:

(a) Specification of staff coverage, and consultants on call;

(b) Instructions relative to identification of patient's personal physician and the transmission of relevant reports;

(c) Provision for communication with the nearest poison control center, with police, and with other local resources:

(d) Clarification of the levels of professional responsibility;

(e) Circumstances under which definitive care should not be provided and procedures which should be followed in referring an individual to a more appropriate facility.

5.5.5. Emergency Service Affiliation with General Hospital - A community mental health center may develop emergency services in conjunction with a local general hospital provided such arrangement is on a written contractual basis and available round-the-clock.

5.5.6. Case Records for Emergency Service Clients - A case record shall be kept on every individual receiving emergency service and shall become an official mental health center record. The record may include, but not be limited to, the following:

(a) Emergency telephone contacts:

(1) Identification data relating to:

a. Individual making contact;

b. Client, if not the individual making contact;

c. Client family contact(s).

(2) Description of client's psychodynamic evaluation;

(3) Response of professional taking the emergency call;

(4) Record of recommendation made;

(5) Specific instructions given for client;

(6) Provisions for follow-up.

(b) Walk-in emergencies - emergency admissions:

(1) Identification data including the client's legal status;

(2) The time of arrival, and the time of discharge;

(3) Means of transportation to the emergency service;

(4) Pertinent history including emergency care given prior to the arrival at the mental health center;

(5) A description of significant clinical data;

(6) Description of treatment given;

(7) The condition of the individual on transfer or discharge;

(8) Disposition including instructions given to the individual relative to necessary follow-up care;

(9) The signature of the staff member responsible for its clinical accuracy:

(10) Instructions given to clients upon discharge from the emergency service shall be given in writing, dated and signed, and a copy of such instructions shall be made a part of the client's emergency medical record;

(11) The individual's emergency record shall be incorporated in his previous mental health record, if he has one, and a copy shall be sent to his personal physician promptly, unless client refuses written consent for release.

5.6. Outpatient Service

5.6.1. Type and Scope of Service Defined

(a) The type and scope of services and goals of the outpatient services shall be clearly defined in writing;

(b) Outpatient services should include, but not be limited to, individual, family, and group therapy, play therapy, behavior modifica-

tions, indicated somatic therapies such as chemotherapy, and appropriate occupational and recreational therapies.

5.6.2. Availability - The total services of the community mental health center shall be made available on a regularly scheduled basis to all individuals living within the catchment area served by the center. Provisions should be made for nonscheduled services in the outpatient services as needed by individuals during periods of increased stress or crisis.

5.6.3. Policies and Procedures

(a) There shall be written procedures for providing each major service modality including: inpatient, partial care, twenty-four (24) hour emergency treatment, and any service(s) provided, or contracted, by the center;

(b) There shall also be policies and procedures concerning waiting lists.

5.6.4. Pre-Care, Aftercare, and Back-Up Care - The outpatient service shall be designed to carry out an active treatment program with provisions for pre-care, aftercare, back-up and follow-up services, as needed, to ensure the continuity of care important to patient's effective treatment.

5.6.5. Evening Hours - The community mental health center should provide evening hours at least one day per week and, if clients cannot reach the center, it should be possible to arrange for a meeting at home or at some other accessible location.

5.6.6. Staffing - The staffing pattern of the mental health center outpatient service should be clearly defined, in writing, and adequate to provide the services defined.

5.6.7. Family Participation - In the treatment of clients, family participation should be stressed when indicated.

5.6.8. Geriatric Services - The outpatient service should include programs, or sponsoring of programs, for elderly, provide for visiting mental health workers and consultation services for staff of other agencies concerned with the elderly.

5.6.9. Children's Services - The outpatient services should include special preventive and corrective services geared to children's needs throughout the catchment area.

5.6.10. Outpatient Service Affiliated with a General Hospital - The outpatient service may be provided by an affiliate agency such as the outpatient clinic or psychiatric service of a general hospital; provided however, that its services are easily accessible and its hours are convenient for its clients and its services are available as an integral part of the community mental health center program.

5.7. Partial Hospitalization

5.7.1. Type and Scope of Service Defined - The type and scope of services and goals of the partial hospitalization service shall be clearly defined in writing to show the services to be an alternate to inpatient hospitalization.

5.7.2. Compliance with Sections 7 and/or 8 - Partial care facilities in a community mental health center shall meet all the requirements where applicable in Section 7 and/or 8 for psychiatric inpatient services in these regulations.

5.7.3. Coordinated with Other Services - Partial hospitalization ser-

vices should be well coordinated with other community mental health center services to ensure continuity of care and treatment to clients.

5.7.4. Client Records - A case record shall be kept for all clients during the partial care which will meet the licensing standards. It should show a planned treatment program for each client which is a broader program than that which is possible through outpatient visits, but less than full-time hospitalization.

5.7.5. Aftercare - The partial hospital program shall provide aftercare, back-up, and emergency services, as needed.

5.7.6. Programs Geared to Patient Needs and Interests - The partial hospital program should fit the interests of the clients it serves and provide recreational, social, special educational classes for disturbed and mentally retarded children, vocational activities, as well as milieu therapy and other treatment modalities.

5.7.7. Medical Responsibility - A psychiatrist shall be present on a regularly scheduled basis to assume medical responsibility for all clients, or act as a consultant to the staff on a regular basis provided at least one of the following assumes professional responsibility for the program -- a physician, a psychologist, a psychiatric nurse, or a phychiatric social worker (see Section 5.2.5.).

5.7.8. Day Care - The partial hospitalization program shall include as a minimum a day care service.

(a) The day care service should be designed as a therapeutic community, which fosters each client's responsibility for his own well being;

(b) The day care service should establish satellite programs

through training and supervision of volunteers to conduct activities in churches or other community facilities.

5.7.9. Evening and Night Care

(a) The evening program, enabling clients to work and live at home while receiving sustaining help, should be available as needed;

(b) The night program should be planned for clients who can handle jobs during the day, but are unable to deal with family or home situations at night.

5.7.10. Weekend Care

(a) The weekend care program should be provided for clients devoting weekdays to their accustomed pursuits, and obtain intensive treatment on Saturdays and Sundays;

(b) The weekend hospital care program should also be available for clients needing day care services, but who live too far away from the facility to receive day care.

5.7.11. Residential Care - Community placements through halfway houses, group homes, or personal care homes should be provided for clients requiring a transitional living arrangement with support services of an essentially nonmedical nature.

(a) The residential care program may be used as a temporary residence for the client with no family, as an aftercare temporary residence for the client not yet reestablished in an independent life, or as an overnight service for family situational disruptions;

(b) The residential care program should also serve as an overnight service for psychiatric emergency cases;

(c) Nursing and convalescent homes, personal care homes, or institutions providing care for mentally ill/mentally retarded, or addicted persons, shall be licensed by the West Virginia nursing home licensing board and shall be subject to these regulations where applicable.

5.7.12. Partial Hospitalization for Mentally Ill or Mentally Disturbed Children - Partial hospitalization services should provide pre-care and aftercare facilities for the emotionally disturbed children waiting for, or returning to the community from, a comprehensive center for the emotionally disturbed.

5.7.13. Inviting Atmosphere - The design, use of space, and decor of the facilities utilized for partial hospitalization should establish a warm, informal, inviting atmosphere in keeping with the services and treatment provided.

Note: Personal care home placement care does not currently meet the criteria established for partial hospitalization, and federally funded community mental health centers shall not at present report persons in personal care homes as partial care patients.

Decisions relating to compliance in providing partial hospitalization services in this section will be decided upon an individual basis taking into consideration the current changes in process.

5.8. Inpatient Services

5.8.1. Type and Scope of Service Defined - The type and scope of the service and goals of the inpatient service shall be clearly defined in writing.

5.8.2. Compliance with Sections 7 and/or 8 - Inpatient services within a community mental health center shall meet the requirements, where applicable, in Section 7 and/or 8 of these regulations, for psychiatric hospital inpatient services, including habilitation and/or rehabilitation services, as needed, keeping in mind the primary functions of the psychiatric inpatient hospital.

5.8.3 Inpatient Services Integral Part of Center Program - The inpatient services should be provided within the community mental health center program as an integral and important service to the patient whose care and treatment extends beyond the back-up services provided by an emergency service and/or a partial hospitalization service.

5.8.4. Inpatient Services may be Contracted - Inpatient services in a community mental health center may be established on a contractual basis with a licensed general hospital, nursing home, convalescent facility, or other related facility; provided such program is in compliance with Section 7 and/or 8 of these regulations, where applicable.

5.8.5. Prompt Continuing Care and Treatment - Intensive therapy for duration of treatment shall be provided promptly in the inpatient service, and twenty-four (24) hour therapeutic milieu should be available for patients as needed.

5.8.6. Professional Staff - There shall be professional staff coverage including psychiatric and/or other medical services provided, as needed, in inpatient service facilities.

5.8.7. Nursing Service - There shall be twenty-four (24) hour nursing service provided.

5.8.8. Inviting Atmosphere - The design, use of space and decor should establish a warm, informal, inviting atmosphere in keeping with the services and treatment provided in the facility.

5.9. Consultation and Education Services

5.9.1. Type and Scope of Services Defined - There shall be written policies specifying clearly the type and scope of the consultation and education services.

5.9.2. Consultation Services - Consultation should be a process of interaction between the staff of the center (consultant) and representative(s) of another organization (consultee) or an individual practitioner (consultee) to assist the consultee to impart mental health knowledge, skills or attitudes and to assist the consultee in carrying out his mission by problem-solving methods as opposed to formal education processes.

5.9.3. Case-Oriented Consultation Services - There should be case-oriented consultation services relating to identifiable individual clients, or family units, for the primary purpose of diagnosis, treatment, and/or disposition in which center staff personnel collaborates with a consultee in providing services in the position as joint therapist rather than consultant.

5.9.4. Program-Oriented Consultation Services - There should be program-oriented consultation services which are either agency centered or community centered:

(a) Agency-center program-oriented consultation services directed toward the administration of an agency to assist in planning and developing programs, solving program problems, and/or indirectly improving an administrator's insights and mental health skills. Such consultation services should relate to:

(1) Aspects of program administration;

(2) Planning;

(3) Policy determination;

(4) Recruiting;

(5) Training;

(6) Operating efficiency;

(7) Interagency group dynamics;

(8) Interpersonal relationships of the consultee and his staff.

(b) Community-centered program-oriented consultation services directed toward aiding agencies, community commissions and boards, community leaders, organizations, and citizen groups in originating planning and implementing programs within the community. Such consultation services should relate to:

(1) Schools;

a. Guidance programs;

b. Special education classes (for emotionally disturbed children, mentally retarded, etc.);

c. Educational drug program;

d. Parent education program.

(2) Community leaders;

(3) Citizens groups;

a. Planning for enhancement and enrichment of community;

b. Solutions for community mental problems.

5.9.5. Staff Development and/or Continued Education Consultation Services - There should be consultation directed toward staff development

focusing on skill building, and development of staff and/or didactic in-service training, to upgrade the understanding and performance of the consultee and/or his staff.

5.9.6. Public Education - There should be educational efforts aimed at identified priority needs within the catchment area, and provision of center education programs to:

(a) Increase the visibility, identifiability and accessibility of the community mental health center for all residents of its catchment area;

(b) Promote mental health and prevent emotional disturbance through dissemination of relevant mental health knowledge; and

(c) Better acquaint the general public with the goals of the consultation education program and the progress toward the attainment of these goals. It should be under the supervision of a mental health information specialist.

5.9.7. Professional Staff Participation in Consultation and Education Programs - A percentage of professional staff time shall be devoted to indirect services through the consultation education programs.

5.9.8. Consultation and Education Records - Measurement tools should be developed to evaluate the effectiveness of these indirect services in relation to direct services.

5.10. Public Information Programs

5.10.1. Supervision of Programs - Public information programs should be under the direction of a fully qualified public information specialist in the field of public health, social work, or related fields; however, qualified individuals having a degree in communications or journalism with experience

in public health, social work, or related fields, or a degree in public health, social work, or related fields with experience in communications with regular consultation services of a fully qualified information specialist may be eligible.

5.10.2. Development of Lists of Alternative Resources to Patient Hospitalization - The information and referral services shall develop lists of local and regional alternatives to hospitalization.

5.10.3. Continuing Communication with Other Agencies - Information and referral service should provide information to assist in the transfer of patients from one element of service to another efficiently and humanely.

5.10.4. Active Role in Locating Out-Reach Services - The information and referral service should participate actively in arranging services for patients who have been in a psychiatric treatment program and are in need of aftercare; provide extensions of the therapeutic community and social group activities; follow-up nursing home care; and consultation with public health nurses and other assisting former, or potential patients.

5.10.5. Continuing Patient Contact - The information and referral service shall be responsible for continuing contact and application of all existing resources to the needs of patients.

5.11. Laboratory

(a) Laboratory facilities provided in a community mental health service shall meet Joint Commission on Accreditation of Hospitals standards;

(b) If the laboratory services are not available in the community mental health center, contractual services may be arranged with a nearby laboratory which meets the minimum requirements of the Joint Commission on

Accreditation of Hospitals laboratories;

(c) Laboratories providing services for any drug abuse testing shall be in full compliance with Section 6 of these regulations entitled "Alcohol and Drug Abuse Facilities and Programs."

5.12. Radiology

(a) X-ray services provided in a community mental health center shall meet Joint Commission on Accreditation of Hospitals standards applicable;

(b) If the radiology services are not available in the community mental health center, contractual services may be arranged in a nearby radiology service which meets the minimum requirements of the Joint Commission on accreditation of hospitals.

5.13. Pharmacy

5.13.1. Scope of Service - The scope of the pharmaceutical service shall be consistent with the medication needs of the patients and shall include a program for the control and accountability of drug products throughout the center.

5.13.2. Legal Compliance - Community mental health centers maintaining pharmacy services of any type or scope shall meet the requirements applicable as set forth in Part VI, Section A, West Virginia regulations for licensing hospitals, promulgated by the West Virginia state department of health, and the pharmacy laws and regulations of the West Virginia board of pharmacy, as needed.

5.13.3. Pharmacy Supervision - The community mental health center pharmacy services shall be under the supervision, full- or part-time, as

needed, by a professionally competent and legally qualified pharmacist and shall be staffed in accordance with his professional recommendations.

5.13.4. Drug Formulary - The community mental health center medical staff with the advice and counsel of the pharmacist should establish a formulary of drugs to be used in the center; however, the existence of the formulary shall not preclude the use of drugs not included in the formulary.

5.13.5. Equipment and Supplies - There shall be equipment and supplies provided for the professional and administrative functions of the pharmaceutical service, as required by the center to ensure client safety through the proper storage and dispensing of drugs.

5.13.6. Dispensing of Drugs - Written policies and procedures that pertain to the intracenter drug distribution system shall be developed by the medical staff in cooperation with the pharmacist consultant and representatives of other disciplines, as necessary.

5.13.7. Administration of Drugs - Written policies and procedures that govern the safe administration of drugs shall be developed by the medical staff in cooperation with the pharmacist with representatives of other disciplines, as necessary.

5.13.8. Drug Orders - No drug shall be administered to a patient/client except upon written, dated, and signed order of a physician licensed to practice in the State of West Virginia.

5.13.9. Medication Errors - Medication errors shall be reviewed with the pharmacist and procedures revised, if indicated, to prevent recurrence.

5.13.10. Investigational Drugs - Investigational drugs properly labeled

shall be used only under the direct supervision of the principal investigator and should be approved by an appropriate medical staff committee. Nurses may administer these drugs only after they have been given basic pharmacological information about the drug. A central unit should be established where essential information on investigational drugs is maintained (for further guidance in the use of investigational drugs, refer to statement of principles involved in the use of investigational drugs in hospitals, approved by the american hospital association and the american society of hospital pharmacists (JCAH), and Section 10.11 of these regulations).

5.13.11. Methadone - Use of methadone shall be in compliance with Uniform Controlled Susbstances Act, Chapter 60-A, Code of West Virginia, 1971, federal food and drug administration regulations, and Section 6 of these regulations entitled "Alcohol and Drug Abuse Facilities and Program" (for further guidance, write to Food and Drug Administration, Bureau of Drugs, Methadone Maintenance Staff (BD-125), 5600 Fishers Lane, Rockville, Maryland, 20853).

5.14. Client Records

5.14.1. Supervision - Client records should be under the supervision of a registered record administrator who is a graduate of an approved school of registered record administrators and should be registered by the american association of medical record librarians, or an accredited records technician. If not, the individual in charge of the client record service should utilize the consultation services of a registered record administrator, or an accredited records technician.

5.14.2. Case Record for Every Client - There shall be a client record

maintained for every patient/client/trainee admitted to the community mental health center for treatment or emergency services.

5.14.3. Client Record Content - The client record shall contain sufficient information to identify the individual clearly, to justify the diagnosis and treatment, and to document accurately the results. Each client record shall be problem-oriented and contain as a minimum:

(a) Identification data including name, date and place of birth, address, race, social security number, socio-economic status and client's legal status;

(b) Bacic descriptive data concerning the patient;

(c) A summary of the evaluation process, including diagnosis, treatment recommendations, prognosis, and outcome;

(d) Initial and periodic physical and psychiatric examinations;

(e) A record of all psychological testing;

(f) Plan of treatment based on initial medical and psychiatric examinations within seven (7) days after admission indicating date next review is indicated;

(g) Signed and dated orders for:

(1) Treatment;

(2) Medications;

(3) Mechanical restraints which are time limited;

(4) Accident reports.

(h) If medication is administered, there should be a record of the dosage, duration of the administration, and results of the treatment;

(i) Copy of all consultation reports;

(j) A brief summary of the treatment process, and termination notes which should include a concise statement concerning the future prognosis of the client and the responsibilities for future care which the community mental health center should assume;

(k) All communications from, or with, family members, or caregiving persons in the community.

5.14.4. Preparation of Resumes - Supervisor of client records should be qualified to prepare brief resumes of the client's case for signature of physician or professional staff, indicating approval as to content, which may be needed for the referring physician, or agency, responsible for the subsequent care of the client.

5.14.5. Review of Client Records - There should be a periodical review of the client records by a committee of the professional staff or the professional staff as a whole.

5.14.6. Recording Care and Treatment - Client records should be considered scientific documents of care and treatment with all recording being kept current, accurate, and true.

5.14.7. Confidentiality - All client record information shall be kept confidential. Certain portions of the client record are so confidential that extraordinary means may be taken to preserve their privacy. In such cases, these portions may be stored separately. For quality review audit, the complete record shall be available.

5.14.8. Confidentiality of Client Records of Drug Abusers - Confidentiality of client records of drug abusers shall be in full compliance with Section 6 of these regulations.

5.14.9. Release of Client Records or Client Record Information - Client records or information from a client's record shall not be released except as follows:

(a) Pursuant to an order of a court of record;

(b) To the attorney of the client, whether or not in connection with pending judicial proceedings after securing positive identification that the individual is in fact the attorney of the client;

(c) With the written consent of the client or legal guardian to:

(1) Physicians and providers of health, social or welfare services involved in caring for or rehabilitating the client, such information to be kept confidential and used solely for the benefit of the client;

(2) Agencies requiring information necessary to make payments to or on behalf of the client pursuant to contract or in accordance with law. Only such information shall be released to third-party payers as is required to certify that covered services have been provided;

(3) Other persons who have obtained such consent.

(d) No client record, or part thereof, obtained by any agency or individual shall be released in whole or in part to any other individual or agency unless authorized by the written consent of the client or his legal representative.

5.14.10. Release of Client Records or Client Record Information of Drug Abusers - Release of client records or client record information of drug abusers shall be in full compliance with Section 6 of these regulations.

5.14.11. Client Record Information not to be Recorded in Other Clients' Records - Client records shall contain information relating to client's course

of care and treatment only. The behavior of no other client who is under treatment at the mental health facility shall be recorded in another client's record; except such information directly affecting the care and treatment of client in which case the other client shall not be identified in client record by name or number.

5.14.12. Client Record Filing System

(a) There shall be a system of identification and filing of client records to ensure rapid location and retrieval of client records at all times;

(b) When portions of the client record are filed in a separate locked file to safeguard confidentiality of the information, there shall be a system of identification and filing for these records the same as the other portion of the client's chart.

5.14.13. Indices - Client records should be indexed according to diagnosis and/or problems and case managers.

5.15. Activity Program and Services

5.15.1. Type and Scope of Services Defined - The type and scope of services of the activity or program should be clearly defined in writing.

5.15.2. Staffing - Qualified therapists, consultants, professional and nonprofessional volunteers, assistants and aides shall be adequate in number and be able to demonstrate competency to conduct the activities program.

5.15.3. Activities Programs - The activities services available should include, but not be limited to, programs of occupational therapy, industrial therapy, education, vocational training, recreation, habilitation and/or rehabilitation, music therapy, individual physical fitness routines, and other activities as dictated by client needs.

5.15.4. Program Related to Client Needs - Activities services should be provided to enable fulfillment of a specific and planned daily program for each client:

(a) The activities program shall be an integral part of the client's total milieu;

(b) The activities program shall be related to client needs for improvement of economic and social skills and encourage his re-integration and rapid return to independent community living; and should relate to interdisciplinary evaluation and comprehensive treatment planning;

(c) The activities services should be concerned specifically with the development of interpersonal and task skills;

(d) The activities services should utilize individual as well as group approaches to treatment and habilitation or rehabilitation problems.

5.15.5. Location - Activity services may be included in a community mental health facility, or may function separately in a freestanding activity center facility.

5.15.6. Activity Centers for the Emotionally Disturbed and/or Mentally Ill (Adults and/or Children)

(a) Activity centers for the emotionally disturbed and/or mentally ill should be operated by, or affiliated with, a community mental health center with attention to coordination of its services with those available in the community;

(b) The activity center for the emotionally disturbed and/or mentally ill should be directed by a registered occupational therapist, or by a properly trained specialist from one of the other fields of activities and rehabilitation;

(c) The minimum services of the activity center for the emotionally disturbed and/or mentally ill shall be to provide therapeutic activities and recreational programs to assist these individuals in the area of resocialization, utilizing special community programs such as foster grandparent services, when applicable;

(d) Activity center facilities shall comply with federal, state and local codes for construction and be in full compliance with these regulations, where applicable.

5.15.7. Activity Centers for the Mentally Retarded

(a) Activity centers for the mentally retarded should be operated by, or affiliated with, a community mental health center in order to coordinate its services with other services available in the community mental health center, as needed;

(b) The activity center for the mentally retarded should assist the individual in areas of self-care, socialization, maturation, and self-expression, language development, sensory training, and simple work skills. The center should provide activities and recreational programs;

(c) The minimum services of activity centers for the mentally retarded shall be therapeutic activities and recreational activities and utilize special community programs available such as foster grandparent services, when applicable;

(d) Activity center facilities for the mentally retarded shall comply with federal, state, and local codes for construction, and be in full compliance with these regulations, where applicable, and the standards set forth in the regulations for grants for constructing facilities for the mentally

retarded, Section 25.119, Appendix A, adopted by the West Virginia department of health (West Virginia state plan for mental retardation facilities construction program, as revised).

5.16. Physical Facilities And Safety

5.16.1. Site Location - The central mental health facility shall be no more than two hours driving time from all individuals within the catchment area and outreach facilities should be established as practicable within thirty minutes driving time of residents.

5.16.2. Structural Requirements

(a) Community mental health center facilities, including residential facilities for the mentally retarded, shall be structurally safe, meeting federal, state and local building codes, where applicable;

(b) Heating, ventilation and lighting shall be adequate to insure the comfort and safety of clients, residents and personnel.

5.16.3. Design - The design of the mental health facility should:

(a) Provide economically, adequate space for the functions defined in the type and scope of each program;

(b) Provide for adequate privacy to ensure the maintaining of dignity of individuals;

(c) Provide for separation of clients with respect to age, type of care which may be needed, and services needed by individuals under treatment;

(d) Ensure appropriate office and program space for the staffing and organizational pattern of the center, thus facilitating effective communication and functional use of the space;

(e) Be architecturally appropriate to the local geography and style:

(f) Provide conference rooms, group and individual interviewing, and therapy rooms designed to ensure functional and economical use;

(g) Provide day rooms, recreational areas, solarium, visitors' room, a gymnasium, or exercise area, designed to ensure versatile utilization by staff and clients.

5.16.4. Inpatient Facilities - Inpatient facilities shall be in compliance with federal, state, and local building codes and in compliance, where applicable, with West Virginia department of health regulations for hospitals, as amended. Sleeping units for inpatients should be:

(a) Single rooms shall be a minimum of 100 square feet of floor space, and multiple client rooms, 80 square feet of floor space per person to accommodate bed, nightstand, and chair, with additional square footage appropriate to additional equipment needed for the care of the client;

(b) Multiple client rooms should be designed to accommodate no more than four (4) individuals;

(c) At least one drinking fountain on each nursing unit and/or activity area shall be provided;

(d) Client equipment should be movable and in compliance with Section 702.2 of West Virginia regulations for licensing hospitals, as amended, where applicable;

(e) Appropriate provisions shall be made to ensure privacy in toilet and bathing areas for each sex. The following are minimum standards for these accommodations:

(1) One lavatory for each four (4) clients and one lavatory in each toilet area;

(2) One toilet including door and seat for each four (4) clients;

(3) One male and one female tub or shower with handrails for each ten (10) clients;

(4) At least one male and one female toilet unit in each nursing unit shall be provided to permit movement of wheelchairs, and handrails shall be provided on both sides for handicapped individuals;

(5) Individual racks for washcloths and towels;

(6) Larger tilted mirrors for clients in wheelchairs;

(f) Inpatient nursing units, or stations, shall be in compliance with West Virginia regulations for licensing hospitals, as amended, where applicable. They shall be centrally located to permit full view of recreation areas and have immediate access to client and treatment areas.

5.16.5. Residential Facilities - Residential facilities shall be in full compliance with Section 5.16 of these regulations, where applicable, and with federal, state, and local codes for construction of residential facilities, and should comply, where applicable, with standards for design, equipage, and safety of living units of the accreditation council for facilities for the mentally retarded, adopted May 5, 1971, with revisions:

(a) Residential facilities shall be completely furnished providing a homelike atmosphere for individuals in residence;

(b) Residential facilities should provide a laundry room equipped with washer, dryer, and ironing equipment which meet united laboratories safety standards.

5.16.6. Safety and Sanitation - The community mental health center facilities shall be operated so as to sustain sanitary characteristics:

(a) The dietary facilities shall comply with department of health regulations, where applicable, and shall be subject to routine inspections by the West Virginia department of health sanitarians, whose recommendations shall be mandatory for licensure;

(b) Housekeeping, laundry, and maintenance service functions shall be effectively organized, directed, and staffed by qualified personnel;

(c) Services of an exterminator to keep the facilities free of vermin, roaches, and any like infestations, shall be provided;

(d) The following shall be in full compliance with department of health regulations and/or state fire regulations:

(1) Water supply for consumption; and volume and pressure adequate for sewage disposal and fire fighting;

(2) Sewage disposal.

(e) Solid waste, including garbage, shall be collected and disposed of in a safe and sanitary manner, avoiding pollution of environs;

(f) All mental health facilities shall meet safety regulations of the state fire marshal;

(g) Emergency lighting system shall be provided in accordance with West Virginia regulations for licensing hospitals, where applicable. Alternate source of lighting may be provided by battery lamps, or flashlights which are regularly inspected and kept in condition at all times;

(h) Isolation room, or special care room, shall be provided which may be used for control of infection, or for privacy, as needed, for emo-

tionally disturbed individuals. Appropriate safety measures shall be incorporated into the physical design of some units, or areas, as appropriate to type of services housed;

(i) Responsibility for the control of infections within the mental health center facilities and the evaluation of infection potential of the related environment, shall be the responsibility of a multidisciplinary committee of the professional staff and chief medical officer or the medical consultant, as needed;

(j) Community mental health center facilities shall have written plans for the proper and timely care of casualties arising from both external and internal disasters, or civil disorder, and shall periodically rehearse such plans, at least twice annually. The disaster plan shall include alternative sources of all utilities, including water, and methods of emergency communications.

5.16.7. New Construction Standards

(a) New construction standards shall be in compliance with minimum standards, where applicable, for construction and equipment set forth in West Virginia state plan for construction of community mental health centers (Title II, Public Law 88-164, adopted by the West Virginia department of health, including revisions);

(b) New construction of mental health facilities for the mentally retarded shall be in compliance with standards set forth in the regulations for grants for constructing facilities for the mentally retarded, Section 54.119, appendix A, adopted by the West Virginia department of health (West Virginia state plan for mental retardation facilities construction program, as revised).

Section 6. Alcohol and Drug Abuse Treatment Facilities

6.1. General

6.1.1. License Required - All facilities and/or services or parts thereof, providing care and treatment for, or prevention of, alcoholism and/or drug abuse are required to be licensed by the department of mental health by virtue of authority of the legislature of West Virginia, Chapter 27, Article 9, Section 1, Code of West Virginia, 1931, as amended. License shall be issued to facilities and programs in compliance, where applicable, to these regulations and to the regulations of the state department of health for licensing hospitals, as amended, where applicable, and in full compliance with uniform controlled substances act, Chapter 60-A, Code of West Virginia, 1971.

6.1.2. Type and Scope of Service Defined - The type and scope of the alcoholism and/or drug abuse facility and/or service shall be clearly defined in writing.

6.1.3. Policies and Procedures - Policies and procedures for the operation of the facility shall be in writing and should include, but not be limited to:

Admission, release and transfer procedures in conformance with Sections 15, 16, and 17 of these regulations. Staffing patterns including aftercare counselors; procurement of emergency, first aid, or any medical services not provided in the facility or program; procurement of information and referral services; clinical records; food service; personnel policies; personnel records; financial records; pharmacy; procurement of supplies; fee schedules; housekeeping and laundry; maintenance; safety.

6.1.4. Educational Programs - All facilities and/or services, or parts thereof, providing care and treatment for, or prevention of, alcoholism and/or drug abuse shall carry out educational programs designed to prevent and deter misuse and abuse of controlled substances; and shall participate in, or affiliate with, research programs on misuse and abuse of controlled substances in compliance with Uniform Controlled Substances Act, Chapter 60-A, Code of West Virginia, 1971.

6.1.5. Administration of Drugs - All medications shall be given only upon the written order of a physician and under the supervision of a registered nurse currently licensed in West Virginia.

6.1.6. Procedures for Transfer - There shall be written procedures to ensure a smooth continuity of care for alcohol and drug abuse patients in transferring clients between services, as needed.

6.1.7. Medical Records - A medical record shall be maintained for each alcohol and drug abuse client in compliance with these regulations and should be problem oriented.

6.2. Confidentiality of Drug Abuse Records - Except as provided by federal regulation under Section 408 of Public Law 92-255 (drug abuse office and treatment act of 1972) as amended by Title 21, Part 401 - confidentiality of drug abuse patient records, effective upon publication in the federal register November 17, 1972, this Section 6.2. of these department of mental health regulations applies to records, or any part thereof, made on or after March 21, 1973, of the identity, diagnosis, prognosis, or treatment of any patients which are maintained in connection with the performance of any drug abuse prevention function authorized or assisted under the drug abuse office and treatment act of 1972.

(a) General - Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function (see Section 3 for definitions) shall be confidential, may be disclosed only as authorized by federal regulation, and may not otherwise be divulged in any civil, criminal, administrative, or legislative proceeding conducted by any federal, state, or local authority, whether such proceeding is commenced before or after November 17, 1982:

(b) Incompetent or deceased patients - In any case in which disclosure is authorized with the consent of the patient, such consent may be given by a guardian, conservator, or other court-appointed designee in the case of an incompetent patient, and by an executor, administrator, or other personal representative in the case of a deceased patient.

(c) Security precautions

(1) Appropriate precautions should be taken for the security of records to which this section applies. The following paragraphs of this section set forth examples of such precautions, but these should be added to or modified in the light of individual circumstances;

(2) The file of each patient maintained in connection with the performance of any drug abuse prevention function should be marked "confidential patient information," as should any record identifying an individual as a drug patient, including photographs, fingerprints, reports of skin abrasions indicating drug use, or other documentation of patient identification;

(3) Each file drawer, cabinet, or other container in which such

files are kept should be conspicuously labeled with a cautionary statement such as the following:

"Confidential patient information - Any unauthorized disclosure is a federal offense."

(d) Extent of disclosure - Any disclosure made under this Section 6.7., whether with or without the patient's consent, shall be limited to information necessary in the light of the need or purpose of the disclosure.

(1) Disclosure with written consent of patient.

a. To governmental personnel for purposes of obtaining benefits;

b. In connection with parole, probation or suspension of prosecution;

c. To legal counsel;

d. In connection with rehabilitation;

e. Medical personnel (see Section 3 for definitions) for diagnosis or treatment.

(2) Disclosure without consent of patient and without court authorization.

a. To medical personnel to meet medical emergency;

b. To qualified personnel for purposes of research, audits or program evaluation.

(3) Disclosure, court ordered - Court ordered disclosures must weigh the public interest and the need for disclosure against the injury (a) to the patient, (b) to the physician/patient relationship, and (c) to the treatment services. Any order for disclosure should relate only to the records (or a part thereof) of a specific patient.

(e) Form of consent - Where disclosure is authorized with the consent of the patient, such consent must, except as otherwise provided, be in writing and signed by the patient. Such consent must state:

(1) The name of the person or organization to whom disclosure is to be made;

(2) The specific type of information to be disclosed; and

(3) The purpose or need for such disclosure.

(f) Disclosure to medical personnel - With the patient's consent, disclosure to medical personnel is authorized for the purposes of diagnosis or treatment. The consent must be in writing and in the form prescribed in Section 6.2. (e) of these regulations. All medical personnel to whom disclosure is made shall be subject to all the federal and state regulations on confidentiality.

6.3. Detoxification Facilities

6.3.1. Scope of Service - Detoxification facilities or units providing medical management for alcohol and/or drug abusers shall provide inpatient care for medical management of acute withdrawal from alcohol and other drugs for a limited period of time as determined by patient need.

6.3.2. Location - A medical management facility may be located within a general hospital or may be a freestanding facility, but it should be affiliated with licensed community facilities and programs providing elements of care for mental disorders.

6.3.3. Qualified Staff - Medical management facilities shall be under the supervision of a physician licensed to practice medicine in the State of West Virginia, and staff with a competent administrator, adequate profes-

sional and nonprofessional personnel to provide accepted standards of safe patient care.

6.3.4. Nursing Service - The nursing service shall be under the direction or supervision of a registered nurse currently licensed in the State of West Virginia.

6.3.5. Patient Care Plan - A patient care plan shall be developed for patients admitted to medical management facilities coordinating the medical, nursing and aftercare elements of planned treatment.

6.3.6. Twenty-Four (24) Hour Supervision - Medical management facilities shall provide staff to cover twenty-four (24) hour supervision and care for patients.

6.3.7. Counseling Services - The medical management facility shall provide counseling services to patients by counselors with training and demonstrated ability in aiding patients to recognize the nature of their illness and the importance of a continuing program of the aftercare, treatment, and rehabilitation indicated.

6.3.8. Emergency Service - Contractual arrangements with a general hospital shall be made for emergency services, as needed, for medical management facilities not located within a general hospital.

6.4. Extended Care Treatment Facilities for Alcohol and/or Drug Abuse Patients

6.4.1. Scope of Service - Extended care treatment facilities for alcohol and/or drug abuse patients shall provide residential intensive treatment programs for a period of five weeks, or longer, as determined by patient need.

6.4.2. Location - An extended care facility for alcohol and drug abuse patients may be located on the grounds of a licensed mental health facility, psychiatric hospital, or other hospital, or may be licensed as a freestanding facility.

6.4.3. Staffing - The extended care facility for alcohol and drug abuse patients shall provide intensive treatment, as needed, by a treatment team consisting of at least a physician, social worker, psychologist, and a nurse.

(a) A psychiatrist's services shall be available as needed on a written contractual basis;

(b) A psychologist's services shall be available as needed on a written contractual basis;

(c) Social work services shall be supervised by an individual possessing a professional degree in social work of the master's level from an accredited school of social work.

6.4.4. Medical Responsibility - All medical treatment shall be under the supervision of a licensed physician.

6.4.5. Nursing Service - Nursing services shall be under the direction or supervision of a registered nurse currently licensed in the State of West Virginia.

6.4.6. Patient Care Plan - A patient care plan shall be developed for patients admitted to the alcohol and drug abuse extended care facility including, but not limited to:

(a) Medical and nursing services, as needed;

(b) Therapy through utilization of counseling, group and individual psychotherapy, if indicated;

(c) Psychology services providing testing, consultation, and psychological evaluation, as needed;

(d) Social services relating to intake social history, discharge planning, and coordinating helping services.

6.5. Domiciliary Facilities for Alcohol and/or Drug Abuse Patients

6.5.1. Scope of Service - Domiciliary facilities for alcohol and/or drug abuse patients shall include those facilities commonly referred to as fellowship homes, or halfway houses. The facility shall provide a community residential accommodation in a group setting for alcoholics and/or other drug dependent persons.

6.5.2. Location - The facility should be centrally located in a pleasant neighborhood convenient to community transportation. The exterior of the facility should conform with other homes in the area.

6.5.3. Rehabilitation Program - The domiciliary facility shall provide a comprehensive program for the rehabilitation of the individual in a homelike atmosphere which shall include, but not be limited to:

(a) Residential care;

(b) Guidance;

(c) Appropriate physical fitness routines established for each individual in accordance with age or physical problem limitations;

(d) Supervision; and

(e) Personal services relating to those areas of individual adjustment which enable the person to move to independent living in normal surroundings.

6.5.4. Bed Complement - The facility should have a bed complement of at least eight (8) and not exceed twenty (20) residents.

6.5.5. Space Allotment Requirements - There shall be space set aside for meetings, television, and reading, as well as office space.

6.5.6. Staffing - The facility shall be staffed to provide twenty-four (24) hour supervison, under the direction of a manager, or director, with background, education, experience and demonstrated ability commensurate with responsibilities of the position.

6.6. Alcohol and Drug Abuse Information Centers

6.6.1. Location - The alcohol and drug abuse information center may be a part of a community mental health center; however, it shall be a separate unit which provides special functions as the liaison agency between the alcohol and drug abuse treatment facilities and the community to be responsible for continuity of aftercare services for the person recovering from his illness.

6.6.2. Services Provided - The alcohol and drug abuse information center must provide guidelines, technical assistance, and training for other agencies and community organizations which are developing programs for the prevention, treatment and rehabilitation of alcoholics and drug abusers.

6.7. Methadone Treatment Programs - All methadone treatment programs including those administered by a centralized organizational structure consisting of a primary facility and other outpatient facilities, private practitioners, wherever such facilities are located, shall be subject to these regulations, which are promulgated by the department of mental health by the director, by virtue of appointment as the West Virginia State Authority by Governor Arch A. Moore, Jr., June 19, 1972.

6.7.1. Definitions - The following terms are defined in Section 3 of these regulations as set forth in the federal register No. 242, Part III, department of health, education, and welfare, food and drug administration, dated Friday, December 15, 1972, Volume 37:

Drug dependent

Detoxification treatment

Maintenance treatment

State authority

Methadone treatment medication unit

Program sponsor

6.7.2. Approvals Required

(a) If there is a centralized organizational structure consisting of a primary facility and other outpatient programs or "satellites," including all medical treatment units administering methadone, each separate program, whether an outpatient or a private practitioner, shall submit the application specified in federal food, drug and cosmetic act, Title 21, Chapter 1, Subchapter C, Part 130, as published in the federal register, Volume 37, No. 242-111, December 15, 1972. The applications shall be submitted simultaneously, in triplicate, to the food and drug administration and the West Virginia department of mental health;

(b) State and federal approval of treatment programs required - Treatment programs using methadone shall have been reviewed by the West Virginia department of mental health and must conform to these regulations for licensing psychiatric and other related facilities and programs, Chapter 27-9, Series I (1971) as revised, for conducting a methadone treatment

program. The food and drug administration must have received notification of the program's approval by the West Virginia department of mental health. Only after the West Virginia department of mental health has given its approval will the food and drug administration grant approval of the program.

6.7.3. Applications - The following applications shall be filed simultaneously with both the food and drug administration and the West Virginia department of mental health:

(a) Application for approval of use of methadone in a treatment program, Form FD 2632, to be filed in triplicate;

(b) Medical responsibility statement for use of methadone in a treatment program, Form FD 2633, to be completed and signed by each licensed physician authorized to administer or dispense methadone and submitted in triplicate. The names of any other persons licensed by law to administer or dispense narcotic drugs working in the program shall be listed, even if they are not at present responsible for administering or dispensing the drug;

(c) Hospital request for methadone for analgesia in severe pain and for detoxification and temporary maintenance treatment, Form FD 2636 to be filed in triplicate with the food and drug administration and the West Virginia department of mental health and approved by the food and drug administration before a hospital pharmacy may lawfully receive shipments of methadone for use as an analgesic for severe pain and for detoxification or temporary maintenance treatment. This form shall be completed and filed by a responsible hospital official;

(d) Medication declaration.

(1) All methadone maintenance program applications shall indicate whether medication will be administered or dispensed at the facility;

(2) If a facility in which medication is administered at a location not previously used for this purpose, application and prior approval from the food and drug administration and the drug enforcement administration shall be obtained before approval to operate may be granted by the West Virginia department of mental health.

6.7.4. Reports Required - The following forms shall be filed simultaneously with both the food and drug administration and the West Virginia department of mental health:

(a) Annual report for treatment program using methadone, Form FD 2634, to be completed in triplicate by the program sponsor for every program over which he has responsibility for each calendar year of operation. It shall be submitted in triplicate to the food and drug administration and the West Virginia department of mental health on or before January 30, of each year;

(b) Consent to methadone treatment, Form FD 2635, the first part of which shall be signed by all patients (including those under age 18) with full knowledge and understanding of its contents, and the parents or guardians of all patients under age 18 shall be required to sign the second part of this form;

(c) Drug experience report, Form FD 1639, shall be completed by the sponsor reporting any patient death which is considered methadone related to the food and drug administration and the West Virginia depart-

ment of mental health within two (2) weeks. This form shall also be used in reporting the birth of any child to a female patient, if the newborn is premature or shows any adverse reactions which, in the opinion of the attending physician, are due to methadone within one (1) month of the birth;

(d) Deletion of program - If a facility in which medication is administered or dispensed is deleted by a program, the food and drug administration and the department of mental health shall be notified within three (3) weeks. Addition or deletion of facilities which provide services other than administering or dispensing medication is permitted with notification within three (3) weeks to the food and drug administration and the department of mental health;

(e) Nursing station record

(1) At any location where methadone is administered there shall be a ledger, or other acceptable controlled substance record, which shall include at least, but not limited to, the following:

a. Number of methadone doses received;

b. Date and time received;

c. Strength per dose;

d. Name (or code number) of patient to whom each dose is given;

e. Time given;

f. Name, or initials, of person administering the methadone, indicating his/her registration or license and certification for administration of methadone (i.e., R.N., L.P.N., and C.M.A. - certified methadone agent);

g. Date and time methadone supply picked up by licensed pharmacist;

h. Signed receipt of licensed pharmacist to whom methadone supply is released.

(2) There shall be a separate page for each dose-size, and each dose-strength record, the same as any other controlled substance nursing station record.

(3) The nursing station control record for methadone shall be kept the same as any other controlled substance in full compliance with DEA regulations.

6.7.5. Revocation or Denial of Approval of a Methadone Treatment Program - The food and drug administration will revoke approval of a methadone treatment program when recommended by the West Virginia department of mental health.

6.7.6. Right of Appeal - If the West Virginia department of mental health denies or revokes a program, the program shall have a right of appeal to the food and drug administration. Prior to granting or withholding approval, the food and drug administration will consult with the drug enforcement administration to determine applicant compliance with federal controlled substances laws.

A program receiving complete or partial denial or revocation of approval by the West Virginia department of mental health may appeal to the federal food and drug administration unless the denial or revocation is based upon a state law or regulation.

6.7.7. Organizational Structure

(a) Each methadone maintenance program shall have an organizational structure which is an identifiable unified entity. Where two or more programs share a central administration, the person responsible for the organization (administrator) shall be listed as program sponsor for each separate program participating. The program sponsor shall be responsible for fulfillment of all recordkeeping and reporting requirements for such programs; however, the program shall continue to receive separate approvals from the drug enforcement administration, food and drug administration, and West Virginia department of mental health.

(b) Staffing requirements - As a minimum standard for the staffing of a treatment program, there shall be at least one full-time physician licensed by and registered by the state or federal law to order, dispense, and administer methadone, and there shall always be at least one medical or osteophatic physician available for initial medical evaluation and followup care and to supervise the patient medication schedule for each 300 patients.

(1) There shall be at least one registered nurse or licensed practical nurse certified for administration of methadone treatment up to, but not exceeding, 150 patients in a program;

(2) There shall be at least one counselor in a methadone treatment program to serve up to, but not exceeding, 75 patients; two counselors for 75-150 patients; three counselors for 150-225 patients; and four counselors for 225-300 patients;

(3) The director of the West Virginia department of mental health may require more staffing, dependent upon the operational pattern and population characteristics of the program;

(4) Educational training program - The program sponsor shall be responsible for providing specialized training programs for physician(s) and staff involved directly with detoxification or maintenance programs.

6.7.8. Requirements for Operation of a Methadone Treatment Program

(a) Facilities - A program shall have ready access to a comprehensive range of medical and rehabilitative services. The name, address, and description of each hospital, institution, clinical laboratory, or other facility available to provide the necessary services shall be given to the food and drug administration and the West Virginia department of mental health. The applicant shall demonstrate that he will have access to all necessary services. The physical facilities should be sufficiently spacious and well maintained to provide appropriate conditions for conducting individual and/or group counseling.

(b) Access to a range of services

(1) A treatment program shall provide a comprehensive range of medical and rehabilitative services to its patients. These services should be provided at the primary facility, but the program sponsor may enter into formally documented agreements with other public or private agencies, institutions, or organizations to render these services. Such services must be located so as to provide ease of access to the patient. Any service not furnished at the primary facility shall be listed and the agreements to furnish those services shall be documented, when application for approval is submitted to the food and drug administration and the West Virginia department of mental health;

(2) A methadone treatment program, in addition to providing medication and/or evaluation, shall provide as a minimum:

a. Counseling services;

b. Rehabilitative services;

c. Social services, including vocational, educational guidance, and employment placement;

(3) There shall be evidence that the services are fully available and are being utilized. Modification of the services shall be submitted, in triplicate, to the food and drug administration and the department of mental health as services are added or deleted.

(c) Patients to be treated, approximate number - The program sponsor shall submit to the food and drug administration and the West Virginia department of mental health an approximation of the number of patients who will be treated, based upon past history, addict population in the area, treatment capacity, or other relevant information.

(d) Hospital affiliation - If a program is not physically located within a hospital which has agreed to provide any needed medical care for drug related problems for the program's patients, there shall be a formal, documented agreement between the program sponsor and a responsible hospital official demonstrating that hospital care, both inpatient and out-patient, is fully available to any patient who may need it for such problems.

The program sponsor should enter into an agreement with the hospital official to provide general medical care for patients. Neither the program sponsor nor the hospital are required to assume financial responsibility for

the patient's medical care, but emergency care shall be given before discussion of a patient's financial ability to pay.

(e) Private practitioners - A private practitioner, if he conducts initial evaluation of patients, administers and dispenses medication, provides a comprehensive range of services and otherwise meets all the requirements for a methadone maintenance program as defined in federal food, drug and cosmetic act, Title 21, Chapter 1, Subchapter C, Part 130, published in the federal register, Volume 37, No. 242, Part III, December 15, 1972, shall be subject to West Virginia administrative regulations, department of mental health, Chapter 27-9, Series I, 1971, as revised, entitled "Regulations for Licensing Psychiatric and Other Related Facilities and Programs."

(f) Medical responsibility - One individual may assume primary medical responsibility for more than one program and be listed as medical director; provided, however, if an individual assumes medical responsibility for more than one program, the feasibility of such an arrangement shall be documented and attached to the application for approval by the drug enforcement administration, food and drug administration, and the West Virginia department of mental health.

(g) Pharmacy control record

(1) Security control - A pharmacy control record shall be kept for methadone the same as for any other controlled substance record in full compliance with the drug enforcement administration regulations showing at least, but not limited to:

a. Date of receipt of methadone;

b. Size of each container, if powder, number of grams;

c. Form (i.e., tablets, capsules, injectables) and number of units in each container;

d. Date, amount, and location to which any methadone is dispensed for administration;

e. Signature of certified agent to whom supply is dispensed indicating date and time methadone delivered to unit;

f. Date prepared mixture for oral dosage, showing vehicle, suspending agent, and amount of methadone mixture delivered.

(2) Oral preparation

a. A licensed pharmacist shall be responsible for all preparation of methadone for oral use;

b. Labeling - Oral methadone mixture shall be bottled and labeled immediately. Each label shall show: mix formula, number of doses in container, date of preparation, and name of pharmacist;

c. Pharmacy control record - dosage mixtures - A pharmacy control record shall be kept on a daily basis on all oral dose-preparation for methadone showing at least, but not limited to:

1. Date dosage mixture was made;

2. Number of grams used in each mixture;

3. Number of cc prepared for each bottle;

4. Strength of mixture;

5. Signature of licensed pharmacist preparing mixture.

(h) Authorized dispensers of methadone - Methadone will be administered or dispensed by a practitioner licensed or registered under appropriate state or federal law to order narcotic drugs for patients, or by an

agent of the practitioner, supervised by and pursuant to the order of the practitioner.

This agent may only be a licensed pharmacist, registered nurse, or licensed practical nurse. An agent shall be specifically certified by the medical director of the primary program. Such certification shall state that the licensed pharmacist, registered nurse, or licensed practical nurse is fully informed as to:

(1) Methadone dosage regulations;

(2) The required recordings which must be included in patient's clinical record; and

(3) Knowledgeable as to other records which may be necessary for drug security checks or other pertinent research data in combating drug abuse in West Virginia.

(i) Responsibility for administration of methadone - The licensed practitioner assumes responsibility for the amounts of methadone administered or dispensed and all changes in dosage schedule will be recorded and signed by the licensed practitioner.

(j) Detoxification services available - Any facility administering methadone shall have, in writing, well-defined detoxification procedures in which the staff has been well-trained so that detoxification services shall be available to any drug abuse patient in the program, if needed.

6.7.9. Minimum Admission Standards

(a) Voluntary participation - Each patient shall be fully informed concerning the possible risk associated with the use of methadone. Participation in any program shall be voluntary. The person responsible for the

program shall insure that all the relevant facts concerning the use of methadone are clearly and adequately explained to the patient before the signing of form FD-2635, "consent for methadone treatment," set forth in Section 6.7.9. (a) of these regulations.

(b) Selection of patients

(1) The mere use of a narcotic drug, even if periodic or intermittent, cannot be equated with narcotic addiction. Care shall be exercised in the selection of patients to prevent the possibility of admitting a person who was not first dependent upon heroin or other morphine-like drugs at least two (2) years prior to admission to maintenance treatment. This drug history and evidence of current physiologic dependence on morphine-like drugs shall be documented in the patient's medical record;

(2) An exception to the requirement for evidence of current physiologic dependence on narcotic drugs will be allowed only under exceptional circumstances. (For example, maintenance treatment may be indicated prior to or within one (1) week of release from a stay of one (1) month or longer in a penal or chronic care institution, if an individual has a predetention history of dependence upon heroin or other morphine-like drugs at least two (2) years prior to admission to the institution.) Justification for any such exception shall be noted in the patient's record.

(c) Patients under 18 - The safety and effectiveness of methadone when used in the treatment of adolescents has not been proven by adequate clinical study. Special procedures are therefore necessary to assure that patients under age 16 will not be admitted to a program and that patients between 16 and 18 years of age be admitted to maintenance treatment only under limited conditions.

(1) Patients between 16 and 18 years of age who are enrolled and under treatment in approved programs on the 15th of December 1972, may continue in maintenance treatment. No new patients between 16 and 18 years of age may be admitted to a maintenance treatment program after that date unless a parent, legal guardian, or responsible adult designated by the department of mental health completes form FD 2635, "consent to methadone treatment";

(2) Methadone treatment of new patients between the ages of 16 and 18 years will be permitted after December 15, 1972, only with a documented history of two or more unsuccessful attempts at detoxification and a documented history of dependence on heroin or other morphine-like drugs beginning two (2) years or more prior to application for treatment;

(3) No patient under age 16 may be continued or started on methadone treatment after December 15, 1972, but these patients may be detoxified and retained in the program in a drug-free state for follow-up and aftercare;

(4) Patients under age 18 who are not placed in maintenance treatment may be detoxified;

(5) Detoxification may not exceed three (3) weeks.

A repeat episode of detoxification may not be initiated until four (4) weeks after the completion of the previous detoxification.

(d) Denial of admission - If in the professional judgment of the medical director a particular patient would not benefit from methadone treatment, he may be refused such treatment even if the patient meets the admission standards.

6.7.10. Minimum Procedures for Ongoing Care - Dosage and Administration Requirements

(a) Form

(1) Packaging - The methadone shall be administered or dispensed in oral form only when used in a treatment program. Hospitalized patients under care for a medical or surgical condition are permitted to receive methadone in parenteral form, when, in the attending physician's professional judgment, it is deemed advisable. Although table syrup concentrate or other formulations are permitted to be distributed to the program, all oral medications shall be administered or dispensed in a liquid formulation. The dosage will be formulated in such a way as to reduce its potential for parenteral abuse and accidental ingestion and packaged for outpatient use in special packaging as required by Section 295.2, federal food, drug, and cosmetic act, Title 21. Any take-out medication shall be labeled with the treatment center's name, address and telephone number;

(2) Licensed pharmacists' responsibilities - (See Section 6.7.8. (g) of these regulations)

(b) Detoxification treatment - In detoxification, the patient may be placed on a substitutive methadone administration schedule when there are significant symptoms of withdrawal. The dosage schedules indicated below are recommended but could be varied depending upon clinical judgment.

Initially, a single oral dose of 15-20 milligrams of methadone will often be sufficient to suppress withdrawal symptoms. Additional methadone may be provided if withdrawal symptoms are not suppressed or whenever symptoms reappear.

When patients are physically dependent on high doses of methadone, it may be necessary to exceed these levels. Forty (40) milligrams per day in single or divided doses will usually constitute an adequate stabilizing dose level.

Stabilization can be continued two (2) to three (3) days and then the amount of methadone will normally be gradually decreased. The rate at which methadone is decreased will be determined separately for each patient. The dose of methadone can be decreased on a daily basis or in two (2) day intervals, but the amount of intake shall always be sufficient to keep withdrawal symptoms at a tolerable level.

In hospitalized patients a daily reduction of 20 percent of the total daily dose usually will be tolerated and will cause little discomfort.

In ambulatory patients, a somewhat slower schedule may be needed. If methadone is administered for more than three (3) weeks, the procedure is considered to have progressed from detoxification or treatment of the acute withdrawal syndrome to maintenance treatment, even though the goal and intent may be eventually total withdrawal.

(c) Maintenance treatment - In maintenance treatment the initial dosage of methadone should control the abstinence symptoms that follow withdrawal of narcotic drugs, but should not be so great as to cause sedation, respiratory depression, or other effects of acute intoxication.

It is important that the initial dosage be adjusted on an individual basis to the narcotic tolerance of the new patient. If such a patient has been a heavy user of heroin up to the day of admission, he may be given 20 milligrams four (4) to eight (8) hours later, or 40 milligrams in a single

oral dose. If he enters treatment with little or no narcotic tolerance (e.g., if he has recently been released from jail or other confinement), the initial dosage may be one-half these quantities. When there is any doubt, the smaller dose should be used initially. The patient should then be kept under observation, and, if symptoms of abstinence are distressing, additional 10 milligram doses may be administered as needed. Subsequently, the dosage should be adjusted individually, as tolerated and required, up to a level of 120 milligrams daily. For daily dosages above 100 milligrams, patients shall ingest medication under observation six (6) days per week. These patients will be allowed take-home medication for one (1) day per week only. Those patients in treatment on the date this regulation becomes effective (December 15, 1972) who are receiving a take-home dose of more than 100 milligrams per day shall have their dosage level reduced to 100 milligrams per day or less by June 13, 1973.

A daily dose of 120 milligrams, or more, shall be justified in the patient's medical record.

For daily dosages above 120 milligrams, prior approval from West Virginia department of mental health and the food and drug administration shall be obtained beginning on June 13, 1973.

A regular review of dosage level should be made by the responsible physician with careful consideration given for reduction of dosage as indicated on an individual basis.

A new dosage level is only a test level until stability is achieved.

(d) Frequency of attendance; take-home medication - In maintenance treatment the patient will initially ingest the drug under observation

daily, or at least six (6) days a week for the first three (3) months. It is recognized that diversion occurs primarily when patients take medication from the clinic for self-administration.

After demonstrating satisfactory adherence to the program regulations for at least three (3) months, and showing substantial progress in rehabilitation by participating actively in the program activities and/or by participation in education, vocation, and homemaking activities, those patients whose employment, education, or homemaking responsibilities would be hindered by daily attendance may be permitted to reduce to three (3) times weekly the times when they must ingest the drug under observation.

They shall receive no more than a two (2) day take-home supply.

With continuing adherence to the program's requirements and progressive rehabilitation for at least two (2) years after entrance into the program, such patients may be permitted twice weekly visits to the program for drug ingestion under observation with a three (3) day take-home supply.

Prior to reducing the frequency of visits, documentation of the patient's progress and the need for reducing the frequency of visits shall be recorded.

The requirements and schedule of when the drug must be ingested under observation may be relaxed if the patient has a serious physical disability which would prevent frequent visits to the program facility. The food and drug administration and the West Virginia department of mental health shall be notified of such cases.

(e) Additional medication in exceptional circumstances - Additional

medication may be provided in exceptional circumstances such as acute illness, family crises, or necessary travel when hardship would result from requiring the customary observed medication intake for the specific period. In these circumstances the reasons for providing additional medication will be recorded.

In circumstances of severe illness, infirmity or physical disability, an authorized individual (e.g., a licensed practitioner) may deliver or obtain the medication.

6.7.11. Referrals to Medication Treatment Units - See Section 6.7.13. (b) for responsibilities of primary facility when making referrals to medication treatment units.

6.7.12. Treatment of Pregnant Patients - Caution shall be taken in the maintenance treatment of pregnant patients. Dosage levels shall be maintained as low as possible if continued methadone treatment is deemed necessary.

It is the responsibility of the program sponsor to assure that each female patient is fully informed concerning the possible risks to a pregnant woman or her unborn child from the use of methadone.

6.7.13. Methadone Treatment Medication Unit - See Section 3, definitions.

(a) Referral

(1) The patient shall be stablized at his optional dosage level before he may be referred to a medication unit;

(2) Since the medication unit will not provide a range of services, the program sponsor shall determine that the patient to be referred is not

in need of frequent counseling, rehabilitation and other services which are only available at the primary program facility;

(3) The nature of the patient's progress shall be entered in the patient's medical record.

(b) Responsibility for patient - After a patient is referred to a medication unit, the primary program sponsor shall retain continuing responsibility for the patient's care including, but not limited to:

(1) Assurance that patient reports weekly for urinalysis at either the primary facility or the medication unit; and

(2) Assurance that patient receives needed medical social services at least monthly at the primary facility.

(c) Services of methadone treatment medication unit - The services of the methadone treatment medication unit shall be limited to:

(1) Administering or dispensing of medication in full compliance with these regulations;

(2) Collection of urine for urine testing in accordance with procedures set forth in Section 6.7.14. of these regulations.

Agencies or individuals providing other services in addition to the above shall be considered a program and shall be required to submit an application for separate approval. However, the limitation of treatment medication unit services does not limit the physician's primary responsibilities for requiring additional ancillary services in the primary program if, in his opinion, patient exhibits a need therefor.

(d) Prior approvals required - No methadone treatment medication unit shall be established, maintained, or operated in the State of West Vir-

ginia without prior approval for each such unit from both the food and drug administration and the department of mental health, except as provided for in Section 6.7.6. of these regulations.

(e) Revocation of approvals, effect of - If a primary program's approval is revoked by the food and drug administration, the approval of the medication unit shall be automatically revoked. If a specific medication unit's approval is revoked, the approval of the primary program will remain in effect unless it is also revoked.

(f) Methadone supply to medication treatment units

(1) The medication treatment unit will receive its supply of the drug directly from the stocks of the primary facility;

(2) Only persons permitted to administer or dispense the drug or security personnel licensed or otherwise authorized by the West Virginia state law may deliver the drug to the medication unit.

6.7.14. Urine Testing

(a) In maintenance treatment, a urinalysis will be performed randomly at least weekly for morphine and monthly for methadone, barbiturates, amphetamines, and other morphine-like drugs;

Those patients receiving their doses of the drug from methadone medication units will also adhere to this schedule.

The urine shall be collected at the program's primary facility, or at the methadone medication unit.

(b) Method of collection - Urine shall be collected in the presence of a male attendant or female attendant to minimize falsification of the samples. The reliability of this collection procedure shall be documented in

the patient's medical record by the attendant;

(c) Laboratories

(1) Laboratories used for urine testing shall participate in and be approved by any proficiency testing program designated by the food and drug administration. Any changes made in laboratories used for urine testing shall have prior approval of the food and drug administration;

(2) Availability of laboratory services - There shall be provision made for approval twenty-four (24) hour laboratory services for all methadone use facilities and programs.

6.7.15. Patients' Medical Records - An adequate clinical record will be maintained for each patient. The record shall include, but not be limited to, the following:

(a) Part I of "consent for methadone treatment" - Form No. 2635, signed by all patients including those under 18 years of age, with evidence of patient's full understanding of the information and explanation relative to the possible risks associated with the use of methadone;

(b) Part II of "consent for methadone treatment" - Form No. 2635, signed by parents or guardians of patients under age 18;

(c) Personal history - The personal history shall include age, sex, education level, employment history, past history of drug abuse of all types and prior treatment for drug abuse, to prevent the possibility of admitting a person who was not first dependent upon heroin or other morphine-like drugs at least two (2) years prior to admission to a maintenance treatment program. Justifications for exceptions to physiologic addiction standards should be well documented in patient's personal history;

(d) Medical history - A thorough medical history record shall be completed for each patient accepted for admission;

(e) Physical examination - The findings of a comprehensive physical examination shall be recorded in the medical record;

(f) Laboratory or other special examinations indicated in the judgment of attending physician; provided, however, that there shall be at least, but not limited to:

(1) A complete blood count;

(2) Liver function tests; and

(3) A serologic test for lues shall be a part of the admission evaluation.

(g) The date of each patient visit to the program;

(h) The amount of methadone administered or dispensed, dated and signed by the agent administering;

(i) Validation of urine samples by attendant;

(j) The results of each urinalysis;

(k) A detailed account of any adverse reactions, showing evidence that food and drug administration Form no. FD-1639, "drug experience report," has been filed with the food and drug administration and the West Virginia department of mental health within two (2) weeks after such reaction;

(l) Any significant physical or psychological disability;

(m) An account of the patient's progress, and any other relevant aspects of the treatment program;

(n) The type of rehabilitative and counseling efforts employed as well as effectiveness of such efforts;

(o) Absences from the program should be noted and reported promptly to the program sponsor for followup through social service;

(p) A readmission form shall be placed in each medical record for patients to return to the program after an absence of two (2) weeks or more;

(q) Annual evaluation - An annual evaluation of the patient's progress will be recorded in the medical record;

(r) Drug experience record - A "drug experience report," Form FD-1639, shall be completed by the sponsor of the program reporting any patient death which is considered methadone related, to the food and drug administration and the West Virginia department of mental health within two (2) weeks. This form shall also be filed in a similar manner to report drug reactions, and the birth of any child to a female patient, if the newborn is premature or shows any adverse reactions which, in the opinion of the attending physician, are due to methadone within one (1) month of the birth;

(s) Referrals to methadone medication treatment units

(1) Evidence that patient is not in need of frequent counseling, rehabilitative, or other services;

(2) Concrete evidence that patient has demonstrated progress towards rehabilitation;

(3) Evidence that patient reports weekly for urinalysis at either the primary facility or the medication treatment unit;

(4) Record of needed medical and social services at least monthly at primary facility. If such services are not needed, the patient's record shall show evidence that such services were not needed.

(t) Dosage records

(1) A daily dose of 120 milligrams or more shall be justified in the medical record;

(2) For daily dosages above 120 milligrams, prior approval from the West Virginia department of mental health and the food and drug administration beginning on March 15, 1973;

(3) For take-home doses above 100 milligrams per day, prior approval from the West Virginia department of mental health and the food and drug administration shall be obtained beginning on June 13, 1973.

(u) Prior to reducing the frequency of visits, documentation of the patient's progress and the need for reducing the frequency of visits shall be recorded in the patient's medical record;

(v) When additional medication is provided in exceptional circumstances such as acute illness, family crises, or necessary travel, the reasons for providing additional medication shall be recorded in the patient's medical record.

6.7.16. Discontinuation of Methadone Use

(a) All patients in treatment will be given careful consideration for discontinuation of methadone use, especially after reaching a 10-20 milligram dosage level;

(b) Social rehabilitation shall have been maintained for a reasonable period of time;

(c) Upon successfully reaching a drug-free state, the patient should be retained in the program for as long as necessary to assure stability in the drug-free state. The frequency of his required visits shall be adjusted at the discretion of the director.

6.7.17. Record of Drug Dispensing/Record Retention - Accurate records traceable to patients shall be maintained showing dates, quantity, and batch or code marks of the drug dispensed. These records shall be retained for a period of three (3) years.

6.7.18. Security of Drug Stocks - The security standards for the distribution and storage of controlled substances as required by the drug enforcement administration shall be met by the program. Primary facilities which provide twenty-four (24) hour detoxification and/or maintenance services shall provide adequate twenty-four (24) hour security dependent upon volume of patients in the program and need therefor.

6.7.19. Inspection of program - Inspection of a program shall be made by the West Virginia department of mental health, by the food and drug administration, and by the drug enforcement administration in accordance with federal and West Virginia mental health licensing regulations.

6.8. Pharmacy

6.8.1. Scope of Service - The scope of the pharmaceutical service shall be consistent with the medication needs of the patients and shall include a program for the control and accountability of drug products throughout the center.

6.8.2. Legal Compliance - Alcoholism and drug abuse centers maintaining pharmacy services of any type or scope shall meet the requirements

applicable as set forth in Part VI, Section A, West Virginia regulations for licensing hospitals, promulgated by the West Virginia state department of health, and the pharmacy laws and regulations of the West Virginia board of pharmacy, as amended.

6.8.3. Pharmacy Supervision - The alcoholism and drug abuse center pharmacy services shall be under the supervision, full or part time, as needed, by a professional, competent, and legally qualified pharmacist and shall be staffed in accordance with his professional recommendations.

6.8.4. Drug Formulary - The alcoholism and drug abuse center medical staff with the advice and counsel of the pharmacist should establish a formulary of drugs to be used in the center; however, the existence of the formulary shall not preclude the use of drugs not included in the formulary.

6.8.5. Equipment and Supplies - There shall be equipment and supplies provided for the professional and administrative function of the pharmaceutical service, as required by the center to ensure client safety through the proper storage and dispensing of drugs.

6.8.6. Dispensing of Drugs - Written policies and procedures that pertain to the intracenter drug distribution system shall be developed by the medical staff in cooperation with the pharmacist consultant and representatives of other disciplines as necessary.

6.8.7. Administration of Drugs - Written policies and procedures that govern the safe administration of drugs shall be developed by the medical staff in cooperation with the pharmacist with representatives of other disciplines, as necessary.

6.8.8. Drug Orders - No drug shall be administered to a patient/client except upon written, dated and signed order of a physician licensed to practice in the State of West Virginia.

6.8.9. Medication Errors - Medication errors shall be reviewed with the pharmacist and procedures revised, if indicated, to prevent recurrence.

6.8.10. Investigational Drugs - Investigational drugs properly labeled shall be used only under the direct supervision of the principal investigator and should be approved by an appropriate medical staff committee. Nurses may administer these drugs only after they have been given basic pharmacological information about the drug. A central unit should be established where essential information on investigational drugs is maintained. (For further guidance in the use of investigational drugs, refer to statement of principles involved in the use of investigational drugs in hospitals, approved by the american hospital association and the american society of hospital pharmacist, (JCAH), and Section 10.11 of these regulations.)

6.8.11. Methadone - Use of methadone shall be in compliance with uniform controlled substances act, Chapter 60-A, Code of West Virginia, 1971, and federal food and drug administration regulations and Section 6 of these reulations entitled "alcohol and drug abuse facilities and programs." (For further guidance, write to Food and Drug Administration, Bureau of Drugs, Methadone Maintenance Staff (BD-125), 5600 Fishers Lane, Rockville, Maryland, 20853.)

6.9. Patients'/Clients' Rights - Every alcohol or drug abuse facility or program shall be in full compliance with administrative regulation 27-9,

Series I, 1971, as revised, pertaining to patients' rights, set forth in said administration regulation 27-9, Section 10, entitled, "humanities."

Section 7. Psychiatric Unit or Service in a General Hospital

7.1. General - All general hospitals should have a well defined plan for receiving, management, and disposition of psychiatric patients. The feasibility of establishing a psychiatric unit, or service, in a general hospital should depend upon;

(a) Local need for the service in the general hospital;

(b) Availability of other facilities;

(c) Availability of staff; and

(d) Orientation of the medical staff profession in the hospital and community.

7.2. License Required - Psychiatric unit, or service, in a general hospital to contribute to the care and treatment of mentally ill, or mentally retarded, or prevention of such disorders, is required to be licensed by the department of mental health by virtue of authority of the legislature of West Virginia, Chapter 27, Article 9, Section 1, Code of West Virginia, 1931, as amended.

7.3. Type and Scope of Service Defined - The type and scope of the psychiatric unit, service, or services, provided in the general hospital shall be clearly defined, in writing, and shall be in compliance with these regulations, where applicable.

7.4. Hospital Program Integrated with Community Mental Health Center Programs - The elements of care provided in the psychiatric unit, or by services, should be an integral part of the community mental health

center program, if any, and provide services, as needed, on a contractual basis for inpatient, partial hospital, and medical management services for emergencies related to detoxification of alcoholics and drug addicts.

7.5. All Elements of Service to be Made Available - The psychiatric unit, or service, in a general hospital should provide, or make provision for, all elements of services, as needed, by the mentally ill/mentally retarded patient during hospitalization.

7.6. Compliance with Section 8 and 10 Where Applicable - The psychiatric unit, or service, in a general hospital shall comply with Section 8 and Section 10 of these regulations, where applicable.

7.7. Organization and Management

7.7.1. Organizational Plan - There shall be a written organizational plan of the psychiatric unit, or service, setting forth, clearly and specifically, the policies and procedures which should include, but not be limited to:

(a) Responsibilities of the governing body including future planning towards unmet mental health/mental retardation needs in the catchment area served, and establishment of set priorities in meeting such needs;

(b) Responsibilities of the clinical services involved in the program;

(c) Responsibilities of each category of personnel;

(d) Inter-relationships among the hospital services;

(e) Relationship of the hospital to outside resources including specific affiliation with other cooperating agencies;

(f) Methods of coordinating all segments of the program;

(g) Periodic review of what the hospital is doing to identify and meet the psychosocial needs of all patients in the hospital, and how it is meeting community needs, and how it fits into and contributes to federal, state and local mental health/mental retardation needs.

7.7.2. Emotionally Ill Patients, Alcoholics, and Drug Abuse Patients -There should be a written plan for the care and/or for referral of patients who are emotionally ill, or who become emotionally ill while in the hospital, as well as for the care and/or appropriate referral of persons who suffer the results of alcoholism or drug abuse.

7.8. Admissions and Referrals

7.8.1. Policies and Procedures - Policies and procedures for the admission of patients to the general hospital shall include special provisions for the admission and referral of psychiatric patients. (see Section 8.4.)

7.8.2. Referral Procedures - Referral procedures shall be in writing, stating resources for prompt referral for those services the hospital does not provide.

7.8.3. Limitations on Admissions - Any limitations on admissions imposed by the physical construction of a psychiatric unit, limitations in the training and experience of its staff, or other limitations shall be clearly stated in the hospital program submitted for licensure.

7.9. Medical Staff

7.9.1. Supervision of Psychiatric Service and Consulting Psychiatric Assistants - There should be a psychiatrist in charge of the psychiatric unit in a general hospital. If the hospital does not have a staff psychia-

trist, an american board certified psychiatrist should be available for consultation. If the hospital is conducting a minimal psychiatric service (see Section 3, definitions), and a qualified psychiatrist is not available, a qualified clinical psychologist may be used as a consultant or a mental health professional of any disciplines needed, may be used as approved by the director of the department of mental health.

7.9.2. Supervision of Psychiatric Unit - The psychiatric unit shall be organized as any other medical service of the hospital. One member of the psychiatric staff, where applicable, shall be appointed on a fixed or rotating basis to serve as chief of unit. He shall assume the responsibility for ensuring that high standards of patient care are carried out by appropriate procedures.

7.9.3. Supervision of Minimal Psychiatric Service - If only minimal psychitric services are provided in the general hospital, there shall be a physician immediately available at all times who is capable of an initial evaluation and of the ordering of psychotropic drugs when needed.

7.9.4. Medical Staff Bylaws, Rules and Regulations

(a) The medical staff bylaws, rules and regulations shall include the psychiatric unit, or service, the same as any other medical service of the hospital;

(b) Medical staff bylaws, rules and regulations shall include conditions for use of methadone in hospitals for analgesia in severe pain, for detoxification, and for temporary maintenance treatment which are in full compliance with uniform controlled substances act, Chapter 60-A, Code of West Virginia, 1971, as amended, drug enforcement administration regula-

tions, and Title 21, Chapter 1, Subchapter C, Part 130, food and drug administration regulations for methadone use, as revised, and Section 5.13.11 and Section 6 of these regulations, where applicable.

7.9.5. Psychiatric Patient Special Needs - The chief of the psychiatric unit, or service, shall assume the responsibility for ensuring that the special needs of the psychiatric patients are met through close liaison with appropriate hospital administrative officers and other departments of the hospital.

7.9.6. Reciprocation of Consultation Services - The psychiatric staff should provide consultation services to other services of the hospital upon request, and in return obtain consultation from other hospital specialists upon request.

7.9.7. Psychiatric Staff Participation in In-Service Education and Training Programs - The psychiatric staff of the hospital shall participate in the hospital's in-service education and training programs, including but not limited to, in-service training of all hospital personnel, as well as education of medical students, interns, and students in clinical psychology, social work, nursing, and other health professions.

7.10. Diagnosis and Treatment - There shall be written policies for the care and treatment of patients admitted to the psychiatric unit, or service, in compliance with Section 8.5 of these regulations, where applicable. The psychiatric plan of treatment shall be in writing in each patient's medical record.

7.11. Nursing Service

7.11.1. Psychiatric Nursing Service Supervision - The nursing service

of the psychiatric unit should be supervised by a qualified registered nurse who has had training in the management of psychiatric patients.

7.11.2. Adequate Nursing Personnel - There should be qualified nursing and allied personnel trained in the management of psychiatric patients adequate in number to provide a quality of psychiatric nursing service on psychiatric unit, or service, as defined in the type and scope of service provided.

7.11.3. Specials for Disturbed Patients - There shall be available at all times nurses, or attendants, who have been trained to special a disturbed patients, adequate in number to provide services as needed in the psychiatric program in the general hospital.

7.11.4. Nursing Care Plan - There shall be a nursing care plan integrated with the psychiatric plan of treatment in compliance with Section 8.7.14. of these regulations, where applicable.

7.11.5. Orientation to Psychiatric Unit, or Service, for Nursing Service Personnel - The nursing service personnel in the psychiatric unit, or service, shall be adequately oriented as to their responsibilities in the service before assignment to the unit, or service, is made.

7.11.6. Nursing Service Records

(a) There shall be an efficient system of clinical and administrative nursing records and reports, and up-to-date nursing policy and procedure manuals;

(b) At any location where methadone is administered there shall be a nursing station record in full compliance with Section 6.7.4. (e) of these regulations.

7.11.7. Authorized Dispensers of Methadone - Methadone will be administered or dispensed by a practitioner licensed or registered under appropriate state or federal law to order narcotic drugs for patients, or by an agent of the practitioner, supervised by and pursuant to the order of the practitioner.

This agent may only be a licensed pharmacist, registered nurse, or licensed practical nurse. An agent shall be specifically certified by the medical director of the primary program. Such certification shall state that the licensed pharmacist, registered nurse, or licensed practical nurse is fully informed as to:

(a) Methadone dosage regulations;

(b) The required recordings which must be included in patient's clinical record; and

(c) Knowledgeable as to other records which may be necessary for drug security checks or other pertinent research data in combating drug abuse in West Virginia.

7.12. Social Work Service

7.12.1. Social Work Supervision - The social work service should be supervised by an individual possessing a professional degree in social work at the master's level from an accredited school of social work.

7.12.2. Social Workers Training in Psychiatric Service - When social work services of the hospital are not maintained specifically for the psychiatric unit, or service, the social workers shall be trained to meet the special needs of the psychiatric patients.

7.12.3. Provision for Social Work Service - If the hospital does not

maintain a social work service, provision should be made for this service, as needed.

7.13. Psychological Services

7.13.1. Psychological Service Supervision - The psychological service should be supervised by an individual possessing at least a doctoral degree in psychology from an american psychological association approved program in clinical psychology, or its adjudged equivalent or has been certified in the appropriate specialty by the american board of examiners in professional psychology, and licensed by the West Virginia state board of examiners for professional psychologists.

7.13.2. Psychologists Trained in Psychiatric Service - When psychological services of the hospital are not maintained specifically for the psychiatric unit, or service, the psychologists shall be trained to provide the special services needed in the care and treatment of psychiatric patients.

7.13.3. Provision for Psychological Services - If the hospital does not maintain a psychological service, provision should be made for the service, as needed.

7.14. Medical Records

7.14.1. Conformance with Psychiatric Records Standard - Medical records for patients admitted to the psychiatric unit, or service, of the hospital shall conform to medical requirements of Section 8.15. and 6.1.7. of these regulations, where applicable. Medical records should be problem oriented.

7.14.2. Confidentiality

(a) Certain portions of the medical record of the psychiatric pa-

tient are so confidential that extraordinary means may be taken to preserve their privacy. In such cases, these portions may be stored separately. For review purposes of the medical staff, the complete record shall be available.

(b) The confidentiality of drug abuse records shall be in compliance with Section 6.2. of these regulations.

7.15. Physical Facilities and Safety

7.15.1. Compliance with West Virginia Regulations for Licensing Hospitals - The physical facilities for the psychiatric unit for existing facilities shall be in conformance with West Virginia regulations for licensing hospitals, as amended, promulgated by the West Virginia state department of health.

7.15.2. Construction of New Psychiatric Units - For construction of new psychiatric hospital units in general hospitals and as reference for improvement of the psychiatric unit in the general hospital, Appendix "A" of the public health service regulations, Part 53, as amended shall be used.

7.15.3. Special Care Room - There shall be a special care room available where a disturbed patient can be housed which should be located near the nursing station for purposes of observation of patient's needs, and to include the patient within a hospital group at all times.

7.15.4. Infection Control - Responsibility for the control of infection within the hospital, and for the evaluation of infection potential of the related environment, shall be vested in a multi-disciplinary committee of the medical staff (see Section 8.19.6).

7.15.5. Safety - If the general hospital does not have written and periodic practiced plans for the proper and timely care of casualties arising

from both external and internal disasters, including civil disorder, the psychiatric service shall include in their unit, or service, written procedures and plans for care of such casualties and an orderly plan of evacuation of patients in case of necessity.

7.16. Pharmacy

(a) Hospitals maintaining pharmacy services of any type or scope shall meet the requirements applicable as set forth in Part VI, Section A, West Virginia regulations for licensing hospitals, promulgated by the West Virginia state department of health, and the pharmacy laws and regulations of the West Virginia board of pharmacy, as amended;

(b) Methadone use - Form FD 2636, "hospital request for methadone for analgesia in severe pain and for detoxification and temporary maintenance treatment," shall be filed in triplicate with the food and drug administration and the West Virginia department of mental health, and approved by the food and drug administration and the West Virginia department of mental health before a hospital pharmacy may lawfully receive shipments of methadone for use as an analgesic for severe pain and for detoxification or temporary maintenance treatment. This form shall be completed and filed by a responsible hospital official;

(c) Prior to filling prescriptions for a physician for methadone in the treatment of hospital inpatients or outpatients the hospital pharmacist shall require a statement from such physician indicating that all such orders or prescriptions written shall be limited to use for analgesia in severe pain; and further agree to substantiate such use, in writing, in all inpatient hospital medical records as well as maintaining outpatient clinical records, to

substantiate such use and that such substantiating records will be made available upon request of the administrator of the hospital;

(d) Pharmacy control records - Pharmacy control records shall be maintained in full compliance with drug enforcement administration regulations, federal food and drug administration regulations for methadone use, and Section 6.7.8 (g) of these regulations.

Section 8. Psychiatric Hospitals

8.1. General

8.1.1. Primary Functions - The primary functions of the psychiatric hospital -- to diagnose, treat, and restore mentally disordered persons to optimal level of functioning and return to the community -- should, whether state or privately owned, include programs to:

(a) Provide general psychiatric inpatient, outpatient, partial hospitalization, emergency services for psychiatric emergencies and medical management for detoxification of alcoholics and drug addicted persons, and consultation and education programs, with maximum utilization of community mental health centers and community facilities and organizations contributing to the care and treatment of mentally ill or mentally retarded, or prevention of such disorders;

(b) Provide specialized services in the care and treatment of the mentally ill and mentally retarded individuals including, but not limited to:

(1) Adolescent program;

(2) Adult mentally ill;

(3) Alcohol and drug abuse treatment;

(4) Chronically mentally ill;

(5) Criminally mentally ill;

(6) Emotionally disturbed children;

(7) Geriatric mentally ill;

(8) Rehabilitation services;

(9) Totally disabled retarded.

(c) Provide public education in the prevention of mental illness as a part, or implementation, of a community mental health center program, if any;

(d) Provide data and facilities and/or programs for self-evaluation, research, and development in the care, treatment, and prevention of mental illnesses.

8.1.2. Compliance with Applicable Standards - The psychiatric hospital shall comply with the standards set forth in these regulations which are included in the type and scope of service defined in hospital programs for which application is made to the department of mental health for license.

8.1.3. Compliance with Department of Health and Fire Regulations - All hospitals required to be licensed under the provisions of these regulations shall comply with, and conform to, all laws of the State of West Virginia, West Virginia regulations for licensing hospitals, adopted and promulgated by the state department of health, and all rules and regulations which provide minimum standards for the prevention of fire and for the protection of life and property against loss or danger by fire or panic. A certificate of approval shall be obtained from the state fire marshal by any institution required to be licensed. Written approval of the institution shall be filed with the department of mental health and a copy of such certificate

shall be posted in a conspicuous place on the premises of the licensed facility.

8.1.4. Availability of Services - Psychiatric hospitals should make their services available on a regularly scheduled contractual basis as needed by the mentally ill, or mentally retarded, in programs of treatment in licensed mental health facilities in the community.

8.1.5. Medicare and Medicaid Standards - Each psychiatric hospital licensed by the department of mental health should meet the standards for admission of medicaid and/or medicare patients.

8.1.6. Compliance with Sections 10, 12, and 13 - All psychiatric hospitals shall be in full compliance with Sections 10, 12 and 13 of these regulations, where applicable.

8.2. Organization and Management

8.2.1. Governing Body Organized - There shall be an effective, organized governing body legally responsible for the conduct of the psychiatric hospital for the care and treatment of mentally ill/mentally retarded individuals. The governing body may be a governmental unit or a board of trustees.

8.2.2. Governing Body Bylaws - The governing body shall adopt bylaws in accordance with legal requirements and with its community responsibility, identifying the purposes of the psychiatric hospital and the means of fulfilling them, keeping in mind the primary functions of a psychiatric hospital -- to diagnose, to treat, and to restore mentally disordered persons to an optimal level of functioning and return to the community. The governing body bylaws are essential to govern and maintain control of

the hospital. They should include, but not be limited to, the following:

(a) Definition of powers and duties of the governing body officers, its committees, and the executive officer of the hospital;

(b) Qualifications for membership, type of membership, method of selecting members, officers, and chairmen of committees, and terms of appointment, or election;

(c) Method for periodic selection of new members reflecting a broad representation of the community;

(d) Provision for indoctrination, orientation, and continuing education of governing body members;

(e) Definition of the authority and responsibility delegated to the executive officer of the hospital and the clinical director;

(f) Provide for periodic review of the bylaws;

(g) Provide for review periodically of each department of the hospital, to evaluate its efficiency in providing quality services;

(h) Provision for approval of bylaws of auxiliary organizations;

(i) Provision for rotation of membership.

8.2.3. Meeting Attendance Requirements - The governing body shall adopt a schedule of meeting attendance requirements and the methods of recording minutes of proceedings.

8.2.4. Special Board Meetings

(a) Budgets - The governing body should hold special board meetings devoted to annual budget projections to provide the highest possible standard of care;

(b) Long range planning - Special governing body meetings devoted to long-range planning to provide future consumer needs based upon professional analysis of reliable data should be held periodically, at least quarterly, and as needed.

8.2.5. Appointment of Executive Officer - The governing body shall appoint an executive officer whose qualifications, authority and duties shall be defined in writing, and adopted by the governing body. Inasmuch as a sound administrative program is important to the care of patients with mental disorders, a physician who has had training in psychiatry and in administration should serve as the superintendent.

8.2.6. Clinical Director - The clinical director should be certified by the American Board of Psychiatry and Neurology, or should be board eligible. In the event the psychiatrist in charge is board eligible, there should be evidence of consultation given to the clinical program on a continuing contractual basis from a psychiatrist certified by the american board of psychiatry and neurology.

The clinical director should provide the governing body with a monthly report reflecting the quality of care.

8.2.7. Staffing

(a) The governing body should provide professional staff with the number of qualified professional, technical, and supporting personnel and consultants required to carry out an intensive and comprehensive treatment program that includes evaluation of individual needs, establishment of treatment and habilitation and/or rehabilitation goals and implementation directly, or by contractual arrangement, of a broad range therapeutic pro-

gram including at least: professional psychiatric; medical; surgical; nursing; social work; psychological; and other disciplines of care and activity therapies as required to carry out an individual treatment plan for each patient;

(b) Each physician providing services to patients shall be fully licensed to practice medicine in the state of West Virginia, or be temporarily licensed to practice in the mental facility under the direct supervision of a physician fully licensed to practice in the state. A physician who is not fully licensed must be proceeding in an orderly and reasonable fashion toward the achievement of full licensure.

8.2.8. Governing Body and Ethics of Medical Profession - The governing body shall require that the medical staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional and ethical practice, and that each member observe all ethical principles of his profession.

8.2.9. Evaluation of Professional Competence - The governing body shall delegate to the medical staff the authority to evaluate the professional competence of staff members and applicants for staff privileges; however, the governing body shall render full decision relating thereto.

8.2.10. Governing Body to Approve Medical Staff Bylaws, Rules and Regulations - The medical staff bylaws, rules and regulations shall be subject to governing body approval, which shall not be unreasonably withheld. These shall include an effective formal means for the medical staff to participate in the development of hospital policy relative to both hospital management and patient care.

8.2.11. Governing Body Committees - The governing body should develop whatever committees necessary to fulfill its responsibilities and to assess the results of its programs which should include, but not be limited to: executive committee, planning committee, or a joint conference committee.

8.2.12. Governing Body Responsibilities Through Its Executive Officer Through its executive officer, the governing body should:

(a) Provide for the control and use of the physical and financial resources of the hospital;

(b) Provide appropriate physical resources required to meet the needs of the patients, and shall participate in planning to meet the health needs of the community;

(c) Provide written personnel policies and practices that adequately support sound patient care. Personnel policies should be frequently reviewed, at least annually, and date of reviews and revisions should be indicated on the written policies; and procedures for notifying personnel of changes in established personnel policies should be provided;

(d) Provide a written plan of organization of the hospital which includes all departments functioning in the hospital, and which indicates all categories of personnel employed in the hospital and the lines of communication. The organizational plan shall be periodically reviewed and revised as needed, showing dates of reviews and revisions;

(e) Require that the sections of the organizational plan and job descriptions pertaining to each department of the hospital shall be placed in the supervisor's office of the department to which it related and job descriptions shall be furnished to all employees;

(f) Require that the organizational plan be the product of the combined efforts of the total professional and technical department heads of the hospital, subject to governing board approval;

(g) Provide a master manual of administrative policies and procedures for each department of the hospital. The manual of policies and procedures shall be periodically reviewed and revised, as needed, showing dates of reviews and revisions;

(h) Require that the sections of the manual of policies and procedures pertinent to each department of the hospital shall be placed in the supervisor's office of the department to which it relates, and shall be available to all personnel in that department upon request;

(i) Require that the policies and procedures manual be the product of the combined efforts of the total professional and technical department heads of the hospital, subject to governing board approval;

(j) Provide for continuing programs of in-service education for the development and maintenance of a high standard of performance of nonprofessional duties to implement and carry out programs of care developed by the professional staff.

8.3. Medical Staff

8.3.1. Medical Staff Organized - The medical staff shall be organized to accomplish its required functions; it shall provide for the election or appointment of its officers, executive committee, department heads and/or service chiefs.

8.3.2. Medical Staff Bylaws, Rules, and Regulations - The medical staff shall develop and adopt bylaws, rules, and regulations to establish a

framework for self-government and a means of accountability to the governing body.

8.3.3. Committees of the Medical Staff

(a) Participation in patient care committee work - The medical staff shall participate in the maintenance of high professional standards by representation on committees concerned with patient care whether the patient care functions are activated by organization of the following separate committees: executive, credentials, medical records, asepsis, and utilization reivew; or by a committee of the whole, there shall be recorded documentation of these activities;

(b) Joint conference committee - There shall be a formal and official means of liaison among the medical staff, the governing body, and the executive officer to provide a channel for medico-administrative advice through a joint conference committee which should meet at least four times annually.

8.3.4. Participation in Securing New Medical Staff Members When Needed - The medical staff shall participate in activities to recruit new staff members, as needed, to provide adequate staff to carry out an active program of treatment for individuals admitted to the hospital.

8.3.5. Clinical Director - In facilities where the chief administrative officer, or executive officer, is not a psychiatrist, there should be a clinical director certified by the american board of psychiatry and neurology, or board eligible (see Section 8.2.5. and Section 8.2.6.).

8.3.6. Neurology - If a qualified neurologist is not on the staff of the hospital, contractual arrangements should be made for scheduled services, as needed.

8.3.7. Flexibility of Organization on Treatment Units or Services The medical staff organization should provide for flexibility of organization on every treatment unit, or service, of the hospital to meet changing methods of treatment indicated by erratic symptoms as they appear.

8.4. Admissions to Psychiatric Hospital

8.4.1. Admissions and Discharges Through Community Mental Health Centers Recommended - All admissions and discharges to psychiatric hospitals, located in catchment areas served by licensed community mental health centers, should be coordinated with the centers upon admission and through information and referral service upon discharge.

8.4.2. Admission Screening To Ensure Use of Primary Care Services Available in Home Community - Recognizing the importance of effective types of early treatment in a community environment, all psychiatric hospitals should provide a screening procedure to ensure a patient's admission to the preferred site and type of service for the specific and best possible care indicated by his total admission evaluation, keeping in mind the community mental health center elements of service available in patient's home community.

8.4.3. Admission Policies and Procedures - Each psychiatric hospital shall establish, in writing, its admission policies and procedures, the range of diagnostic and treatment services it offers, and the manner in which these are routinely accomplished, including, but not limited to, the following:

(a) A basic definition setting forth the areas of competence (what the mental hospital provides and for whom);

(b) A detailed statement of the goals the facility has set in accomplishing its tasks and the identification of its limitation;

(c) A statement of the range of diagnostic and evaluation procedures the mental hospital is prepared to render and the range of treatment services offered within the facility, or by an affiliate, specifying each affiliate and its services;

(d) Specific procedures setting forth description as to manner in which the preservation of the dignity of the patient is to be maintained;

(e) Statement of methods of communication routes between the patient's family and other persons significant in patient's life;

(f) Assurances to patients being admitted that proper attention will be given to his comfort and ease to establish a positive relationship to overcome fears, anxieties and resentments of the patient, his family, and friends;

(g) Procedures for referring patients to another resource for care as an alternate to admission, or as a supplemental treatment during patient's hospital stay, and referral to another resource for aftercare upon discharge;

(h) Procedures for emergency admissions, medical certification, voluntary, and involuntary admissions in compliance, where applicable, with Sections 15 and 16 of these regulations;

(i) Procedures for admission of persons charged or convicted of a crime in compliance, where applicable, with Section 17 of these regulations;

(j) Procedures for emergency referral; and

(k) Statement of conditions under which hospital will accept referrals from other resources.

8.4.4. Compliance with Federal, State and Local Statutes - Provision shall be made for conformance with federal, state and local statutes for admission of patients to a psychiatric hospital which are current, and provision for change of admission policies as existing federal, state and local statutes are amended, or new ones adopted.

8.4.5. Patients Admitted Only on Physician's Orders - All patients shall be admitted by a member of the medical staff, and shall be required to have an admitting diagnosis to justify hospital admission in the initial diagnostic process.

8.4.6. Special Care Patients - Special care patients known to be, or possibly of being, of danger to themselves or others shall be admitted to the most secure place and supervised until a determination has been made as to the diagnosis and treatment needed.

8.4.7. Emergency Care Not Denied on Basis of Residence Requirement The emergency services of the hospital shall not be denied to any person residing in the area served by the hospital on the ground that such person does not meet a requirement of residence in such area.

8.5. Diagnosis and Treatment

8.5.1. Admitting Diagnosis - Admitting psychiatric and physical evaluations, including a neurological examination, when indicated, should be completed and recorded within twenty-four (24) hours of admission.

8.5.2. Social and Psychological Evaluation - Social and phychological evaluations shall be an integral part of the diagnostic process and should

be completed as soon as possible after patient's admission.

8.5.3. Provisional Diagnoses - Provisional diagnoses shall be made at least every three (3) months and such additional informative observations as to patient's condition shall be recorded in patient's medical record.

8.5.4. Final Diagnosis - The final diagnosis shall be set forth clearly in the medical record which shall be completed upon discharge to be promptly available as needed in aftercare treatment programs.

8.5.5. Nomenclature - All diagnoses shall be rendered in standard nomenclature as provided in the american psychiatric association's latest edition of the diagnostic and statistical manual of mental disorders and/or the latest edition of the international classification of diseases.

8.5.6. Non-Psychiatric Physician's Care - General practitioners and other non-psychiatric physicians shall be allowed, when qualified, to follow and assist in the care of their patients, provided however, they are working under the supervision of a member of the psychiatric staff of the hospital.

8.5.7. Coordination, Communication, and Collaboration of Treatment Planning Efforts - There shall be, in writing, a workable method to provide appropriate coordination, communication, and collaboration among all staff members contributing to the evaluation, treatment planning and treatment effort, as needed by the patient including, though not limited to, individual, family and group therapy, play therapy, behavior modifications, indicated somatic therapies such as chemotherapy, and appropriate occupational and recreational therapies, utilizing the information and referral services, as needed.

8.5.8. Non-Psychiatric Illnesses - Prompt diagnosis and effective treatment of medical and surgical contingencies that may occur may be needed by patients hospitalized for mental disorders; therefore, there shall be the same range of services available for treatment of a nonpsychiatric illness and maintenance of their general welfare as would be available to them in an accredited general hospital whether they are available within the psychiatric facility or by contractual arrangement in a nearby community hospital.

8.5.9. Medical and Surgical Services - Medical and surgical services provided within the psychiatric hospital shall be subject to these regulations and the West Virginia Regulations for Licensing Hospitals and all its references, promulgated by the West Virginia department of health.

8.5.10. Oxygen Therapy - Oxygen therapy, when needed, shall be ordered by a physician, in writing, dated, and signed, in the medical record, showing specific dosages of medication or mixtures of gasses, and given by a licensed oxygen therapist or a registered nurse certified by the medical staff as to adequate training to administer oxygen therapy.

8.5.11. Special Medical and Para-Medical Services

(a) Neurological services - Neurological examinations should be included in psychiatric hospital services as well as additional staff of technicians and diagnostic tools and equipment including an electroencephalograph to provide an accredited neurological service. In the absence of this service, there would be written arrangements with a nearby department to carry out these tests when they are indicated;

(b) Dental, podiatric care - Psychiatric hospitals providing long-term treatment shall provide for emergency dental care and prophylatic examinations and hygiene to each patient periodically, at least every six months, and the services of a podiatrist should be made available.

8.5.12. Unit System of Administration - Hospitals where treatment programs are organized into separate units within which patients are admitted, and treated, for total length of stay, the unit staff and personnel shall be supervised by a psychiatrist with a flexible organization to meet the changing methods of treatment indicated by erratic symptoms as they appear.

8.5.13. Determining Need for Somatic Treatment

(a) Positive criteria shall be established to determine need for drug therapy, electroconvulsive therapy, and other somatic treatment modalities which shall be given only upon the written specific order and under the direct supervision of a physician after evaluation of the positive criteria determining need. Where possible, the evaluation should include the recommendation of the total professional care team providing treatment to the patient;

(b) Standard routines shall be established, in writing, and followed for preparation of patient for such somatic treatments, and the immediate post-treatment recovery phase;

(c) Routines for these treatments shall be reviewed periodically to ensure they are current and in keeping with generally accepted standards of practice;

(d) Adverse reactions, sensitivities to specific drugs and other pertinent information shall be recorded in the patient's medical record immediately.

(e) Patients shall have right to refuse somatic treatment which is not a reasonable and customary part of his treatment plan (see Section 10.7.).

8.5.14. Psychiatric Plan of Treatment - There shall be a psychiatric plan of treatment and/or training in writing for each patient based on the initial medical and psychiatric evaluation of his condition, his treatment, or training needs, his potential for habilitation and/or rehabilitation, and the resources of the facility to meet these needs. The treatment and/or training plan shall be developed within seven (7) days of admission and shall include, but not be limited to, the following:

(a) A statement of the nature of the problems and needs of the patient;

(b) A definition of the psychodynamics;

(c) 1. A statement of the rationale and plan of treatment, training, and management including goals;

2. A description of intermediate and long-range treatment goals, with a projected timetable of their attainment;

(d) A description of the staff's involvement with the patient in order to attain the treatment goals;

(e) The plan shall specify the use of specific modalities, psychotherapy, drug therapy, appropriate physical fitness routines and other measures to be incorporated into the total plan;

(f) The plan shall include projections of anticipated aftercare to ensure continuity of care patient will need;

(g) There shall be frequent reviews and revisions of the psychiatric plan of treatment as patients' needs for care change;

(h) If the problem-oriented system of care is utilized, patient problem lists shall be current and treatment and progress notes shall be numbered and dated in relation to the problems.

8.5.15. Emergency Drugs and Supplies - Emergency drugs, equipment, and supplies shall be assembled and available for immediate use, reviewed periodically to ensure they are current and in keeping with generally accepted standards of practice.

8.5.16. Experimental Treatment

(a) All patients in mental health facilities shall have the right not to be subjected to experimental research without the express and informed consent of the patient and of his guardian or next of kin, after opportunities for consultation with independent specialists with legal counsel (see also Section 10.11.2.);

(b) Experimental treatment shall be in full compliance with the principles of the statement on the use of human subjects for research of the american association of mental deficiency, and with the principles for research involving human subjects required by the United States department of health, education, and welfare;

(c) Investigational drugs properly labels shall be used only under the direct supervision of the principal investigator and should be approved by an appropriate medical staff committee. Nurses may administer these

drugs only after they have been given basic pharmacological information about the drug. A central unit should be established where essential information on investigational drugs is maintained. (For further guidance, refer to statement of principles involved in the use of investigational drugs in hospitals, approved by the american hospital association and the american society of hospital pharmacists.)

8.5.17. Methadone - Uses of methadone shall be in compliance with uniform controlled substances act, Chapter 60-A, Code of West Virginia, 1971, as amended, drug enforcement agency regulations under Title 21, Chapter 1, Subchapter C, Part 130, as revised, and Section 6 of these regulations, where applicable. (For further guidance, write to Food and Drug Administration, Bureau of Drugs, Methadone Maintenance Staff (BD-125), Fishers Lane, Rockville, Maryland, 20857).

8.6. Emergency Service

8.6.1. Type and Scope of Service Defined - The type and scope of the emergency service of the psychiatric hospital shall be clearly defined, in writing. If the hospital does not provide for twenty-four (24) hour psychiatric emergency services, it should provide for day and early evening hours -- preferably from 7 a.m. to 11 p.m. The service should be coordinated with the local police department to effect a close and effective working relationship.

8.6.2. Integration With Community Mental Health Center Program - A psychiatric hospital emergency service shall make every effort to integrate the service with community mental health programs, if available, and other community and law enforcement agencies to provide the continuing back-up

intensive care needed for the psychiatric emergency.

8.6.3. Plan of Organization in Writing - The psychiatric hospital shall provide an emergency service organizational plan, in writing, identifying the emergency services, its role in the community planning, and its relationship to other community emergency services, and providing adequate staff for round-the-clock professional coverage.

8.6.4. Emergency Service Roster - A roster shall be posted in the emergency service area listing duty staff and professional and consulting staff on first and second call to insure a patient will be seen and treated within a reasonable time.

8.6.5. Emergency Service Policies - There shall be written policies specifying the extent of treatment to be carried out in the emergency service. Such policies shall be approved by the medical staff and reviewed periodically, and revised as necessary, showing dates of reviews and revisions.

8.6.6. Emergency Service Procedures - There shall be written procedures including, but not limited to, the following:

(a) Specification of staff coverage and consultants on call;

(b) Instructions relative to identification of patient's personal physician and the transmission of relevant reports;

(c) Plans for communication with the nearest poison control center, and with police policies, and local help authorities relative to accident victims and to individuals in other reporting situations such as being victims of suspected criminal acts;

(d) Procedures for prompt treatment of the following types of emergencies: suicidal, anxious persons showing panic confusion or bizarre behavior; intoxicated persons as the result of alcohol or drugs; the aggressively mentally ill individuals; the return of the known mentally ill individual; and the reception of the mentally ill to relieve a family tolerance problem.

8.6.7. Emergency Service Medical Records - A medical record shall be kept on every individual receiving emergency service and shall become a permanent record of the psychiatric hospital. The record shall include, but not be limited to, the following:

(a) Identification data including the patient's legal status;

(b) The time of arrival and the time of discharge;

(c) By what means patient was transported to the emergency service;

(d) Pertinent history including emergency care given prior to the arrival of the patient at the psychiatric hospital emergency service;

(e) A description of significant clinical data;

(f) The treatment given in the emergency service;

(g) The condition of the individual on transfer to inpatient service or discharge;

(h) The final disposition of patients discharged, including instructions given to the patient in writing;

(i) The records are not complete until signed by the professional staff member rendering the care and responsible for its clinical accuracy.

8.6.8. Emergency Service Record Filing - The patient's emergency service record shall be incorporated in his previous medical records, if he has one; made a part of his inpatient medical record if he is admitted to the hospital; and upon discharge, record is retained in the hospital medical record room.

8.6.9. Instructions to Patient Upon Discharge - Instructions given to patient upon discharge from the emergency service shall be given, in writing, dated, and signed and a copy of such instructions shall be made a part of the patient's emergency medical record.

8.6.10. Emergency Service Record Review - A selection of emergency medical records shall be made for periodical review by the appropriate medical staff record review committee.

8.7. Nursing Service

8.7.1. Director of Nursing Service - The director of nursing service in a psychiatric hospital shall be graduated from a school of professional nursing, currently licensed to practice professional nursing by the State of West Virginia, with adequate experience demonstrating ability to assume the responsiblities of directing the nursing service in the management of mentally ill/mentally retarded patients. Based on credentials of education, experience and demonstrated ability, the director of nursing service should be qualified in the fields of psychiatric nursing and administration, and have the ability to organize, coordinate, and evaluate the work of the service. She should be responsible to the physician responsible for clinical services, for developing and implementing policies and procedures of the service within the hospital and in the community.

8.7.2. Registered Nurses' Responsibilities

(a) The registered nurse shall be responsible for determining nursing care needs, the professional skill and judgment required, and the assignment and supervision of nursing tasks that can be safely performed by other nursing personnel;

(b) There should be sufficient number of licensed registered nurses on duty at all times to plan, assign, supervise, and evaluate nursing care, as well as to assure that patients receive the nursing care that requires the judgment and specialized skills of a registered nurse;

(c) In all instances, a registered psychiatric nurse should plan, supervise and evaluate the nursing care of each patient;

(d) Registered nurses shall be currently licensed in the State of West Virginia with experience demonstrating ability to assume the responsibilities of the nurse member of the professional nursing staff of the hospital.

8.7.3. Licensed Practical/Vocational Nurses - Licensed practical or vocational nurses, psychiatric aides, and other ancillary nursing personnel should be qualified by education, training, experience and demonstrated abilities to give such nursing care; their performance should be supervised by a registered psychiatric nurse.

8.7.4. Clinical Psychiatric Nurse - There should be a qualified registered nurse licensed in the State of West Virginia with a master's degree in clinical psychiatric nursing on the staff of the psychiatric hospital. The clinical psychiatric nurse may assume responsiblities in areas of clinical practice, nursing administration, clinical supervision, consultant, or director of education.

8.7.5. Organization Plan of Nursing Service - The nursing service shall have a current written plan of organization that delineates its functional structure and mechanisms for cooperative planning and decision making which is an integral part of the overall organizational plan of the hospital. It should include:

(a) The staffing plan for nursing personnel throughout the hospital and individual staffing patterns for each treatment unit which reflect consideration of the nursing goals, standards of psychiatric nursing practice, and of characteristics of the patient assignment;

(b) Functions for which nursing service is responsible, and positions required to carry out such functions;

(c) The functions, responsibilities, and desired qualifications of each classification of personnel which should, in turn, be reflected in job descriptions for each position classification;

(d) The lines of communication within nursing service;

(e) The relationships of nursing staff in the participation and evaluation of the total therapeutic plan for patient care;

(f) The coordination of nursing service activities with those of other services of the hospital;

(g) The individual differences and influences of emotional, physical, economic, cultural, and socio-environmental forces in the care of the psychiatric patient.

8.7.6. Nursing Service Committees - The organizational plan for nursing service should provide for committees to facilitate the establishment and attaining of goals and objectives of nursing services; and for nursing

service representation in any planning, decision making, and formulation of policies that affect the operation of the nursing service, the nursing care of patients, or patient environment.

8.7.7. Policies and Procedures of Nursing Service - A written manual of nursing care and administration policies and procedures shall be developed to provide the nursing staff with acceptable methods of meeting its responsibilities and achieving projected goals in accordance with nurse practice act of West Virginia, including, but not limited to, the following:

(a) Noting physicians' orders;

(b) Management of agitated and disturbed patients;

(c) Assigning nursing care of patients;

(d) Medication administration including reporting of medication errors;

(e) Charting by nursing personnel;

(f) Infection control, including policies and procedures for sending specimens or cultures to laboratory;

(g) Patient safety, including provisions for ingress and egress to special care rooms at all times.

8.7.8. Availability of Nursing Policies and Procedures Manual - The nursing care manual shall be available to the nursing staff in every nursing care unit and service areas, and other services and departments of the hospitals.

8.7.9. Periodic Review of Manual - The nursing care manual shall be periodically reviewed and revised as necessary in cooperation with representatives of the medical staff and other professional disciplines in the care of psychiatric patients.

8.7.10. Continuing Program of Nursing Education - There should be a formal continuing program for staff education and training, including orientation, in-service education, and a program for continuing education. These programs should contribute toward staff development and toward the preparation of staff members for greater responsibility in psychiatric nursing. Educational resources from both inside and outside the hospital should be utilized.

8.7.11. Orientation for Nursing Service Personnel - Orientation programs for new nursing personnel should be planned in advance, including at least a written outline designed to ensure a thorough orientation for each new nursing service employee. Orientation programs should include an adequate training program for aides who have no previous training which provides classroom and clinical experience, including also a method of evaluating both the participants, the program, and the program's effect on patients.

8.7.12. In-service Education - In-service education programs should be provided for the improvement of nursing care and service through increased proficiency and to keep the nursing staff up-to-date on new and expanding psychiatric nursing care programs, and on new techniques, equipment, facilities, and concepts of treatment and care.

8.7.13. Nursing Service Library - Professional books and current periodicals should be made available to nursing personnel and appropriate reference material should be supplied for each nursing unit and special care room.

8.7.14. Nursing Care Plan - There should be a written nursing care plan for each patient which is coordinated and integrated with the psychiatric plan of treatment and other multi-disciplines of therapy the patient is receiving. The nursing care plan should include, but not be limited to:

(a) Nursing care needed, how best accomplished, what methods and approaches believed to be most successful, and modifications necessary to ensure best results;

(b) Medication, treatment;

(c) Nursing program;

(d) Long-term goals -- including discharge plans;

(e) Short-term goals;

(f) Patient family therapy programs;

(g) Socio-psychological needs of patient.

The nursing care plan should give evidence that planning has been done to make sure the patient receives appropriate nursing, and also serve as an effective method of communicating pertinent information to all nursing personnel concerned with the patient.

8.7.15. Initiating of Nursing Care Plan - The nursing care plan should be initiated upon the admission of patient and be part of the psychiatric treatment program.

8.7.16. Availability of Nursing Care Plan - The nursing care plan should be available to all nursing personnel, reviewed and revised as necessary.

8.7.17. Nursing Care Records - Nursing care records and reports should be maintained that reflect patient's progress, and that the nursing care, as planned, is being carried out.

8.8. Social Work Service

8.8.1. Social Work Supervision - The social work service should be supervised by an individual who has a master of social work degree and a minimum of four years' professional experience, two of which have been under the supervision of a certified social worker. One year of this experience should have been in a psychiatric setting.

8.8.2. Type and Scope of Social Work Service Defined - The type and scope of the psychiatric social work service shall be defined in writing. The service should be available to patients in order to fulfill all assigned responsibilities related to the specific needs of the patient and his family, and to assist in the development and effective utilization of community resources.

8.8.3. Responsibilities of Psychiatric Social Work Service - In an organized psychiatric social work service department within a psychiatric hospital, the responsibilities of the service should include:

(a) The securing of information and gaining understanding of the psychodynamic implications of patient's development and current life situation;

(b) Participation with other mental health professionals in assessing the factors that affect the social functioning of the patient and his family;

(c) Helping plan appropriate action to assist the family and to help the patient make the best adjustment of which he is capable;

(d) Adapting the methods of social case-work, group work and community organization to the specific psychiatric setting to help implement treatment plans;

(e) Working with other agencies to facilitate the smooth movement of patients in and out of the psychiatric hospital from pre-admission to aftercare;

(f) Work directly with patient, his family, and the community in aftercare rehabilitation programs, and in planning interagency relationships; and

(g) Promotion and organization of community mental health programs and activities, and in the extension of the psychiatric hospital programs into the community, including such activities as consultation, administration, education, and research.

8.8.4. Psychiatric Social Work Service Records - Record entries of psychiatric social work service personnel should include:

(a) Psychosocial and developmental study information for appropriate patients;

(b) Social work therapy and rehabilitation of patients;

(c) Home environmental investigations for attending physicians;

(d) Cooperative activities with community agencies;

(e) Social service summaries;

(f) Follow-up reports of discharged patients confirming disposition, when obtained.

8.8.5. Provision for Social Work Service - If the hospital does not maintain a social work service, provision of the service may be secured by:

(a) A social worker employed on a full-time or part-time basis; or

(b) Consultant services;

However, arrangements for such services should be defined in a written agreement that outlines the role and responsibility of both the psychiatric hospital and the agency.

8.9. Psychological Services

8.9.1. Type and Scope of Psychological Service Defined - The type and scope of the psychological service shall be defined in writing. Services may include, but not be limited to:

(a) Direct service to patients;

(b) Assistance in diagnosis and dynamic formulation developed as a result of psychological testing;

(c) Teaching of clinical psychology research methods and the theory and data pertaining to learning and perception;

(d) Research on personality and psychopathology; and

(e) Assessment of treatment results.

8.9.2. Psychological Service Supervision - The psychological service should be supervised by an individual possessing at least a doctoral degree in psychology from an American Psychological Association approved program in clinical psychology, or its adjudged equivalent, or has been certified in the appropriate specialty by the american board of examiners in professional psychology, and licensed by the West Virginia state board of examiners for professional psychologists.

8.9.3. Psychological Service Staffing - The psychological service staff, including staff psychologists, consultants, technicians, and supporting personnel, should be adequate in number and by qualification to plan and carry out assigned responsibilities needed by the type and scope of the hospital program.

8.9.4. Provision for Psychological Service - If the hospital does not maintain a psychological service, provision should be made for the service, as needed.

8.10. Religious Services

8.10.1. The Chaplain - Psychiatric hospital chaplains, whether full-time or part-time, should be fully ordained clergy with approved college and seminary training and pastoral experience, as well as ecclesiastical endorsement of their denomination. The psychiatric hospital chaplain should have specialized training and experience in psychiatric hospital ministry, preferably clinical experience under guidance.

8.10.2. Meeting Religious Needs of Patients - The religious needs of hospitalized patients should be met through services of worship, opportunity to observe sacramental occasions, observances of holy days and days of obligation, individual pastoral contacts between patients and the chaplain, and whatever other means may be available.

8.10.3. Space for Religious Purposes - Chapels, or rooms, should be set aside in the hospital for religious purposes. Properly equipped consultation areas should also be provided for chaplains' consultations.

8.11. Laboratory Service

8.11.1. Laboratory Service to be Provided - There shall be a clinical laboratory in the psychiatric hospital or an arrangement with a nearby laboratory to provide essential testing services.

8.11.2. Provision for Laboratory Service - If the laboratory service is not available within the psychiatric hospital, there shall be a written plan for the provision of such services as needed.

8.11.3. Accredited Laboratory Service - The laboratory, whether maintained within the psychiatric hospital or whether such services are contracted with an outside facility, must meet the minimum requirements of the Joint Commission on Accreditation of Hospital Laboratories, and in full compliance with food and drug administration regulations under Title 21, Chapter 1, Subchapter C, Part 130, as revised, when utilized for urinalyses for morphine, barbiturates, amphetamine and other drugs as part of a methadone treatment program.

(a) The services of a qualified pathologist shall be available on a scheduled basis;

(b) Regular calibration of the laboratory equipment shall be made and recorded; and

(c) Periodic checks of the accuracy of the work performed shall be made and recorded; and

(d) Blood storage refrigerators must maintain temperature uniformly at betweem 2 and 6C, monitored and verified by a recording thermometer, and meet other applicable standards of the Joint Commission on Accreditation of Hospital Laboratories.

8.11.4. Compliance with State Regulations - Laboratory and book supply service shall meet the West Virginia department of health regulations for licensing hospitals, as amended, where applicable.

8.11.5. Chief Laboratory Technician - The chief laboratory technician of the laboratory should be a medical technologist who has been certified by the board of registry of medical technologists of the american society of clinical pathologists.

8.11.6. Asepsis Committee Responsibility - The chief technician and/or pathologist shall attend all asepsis committee meetings, as needed.

8.11.7. Laboratory Staffing - The number of technicians needed shall be adequate to carry out the volume and type of procedures and examinations, the number and kind of autopsy and surgical tissues examined, the spacing of demands for laboratory examinations, and other pertinent factors; the services of a bacteriologist for hospital infection control as well as for patient examinations for diagnostic purposes may be required.

8.12. Radiology Services

8.12.1. Provision for X-Ray Services - There shall be an x-ray department or a written plan reflecting a contractual agreement with a nearby facility to provide radiological services needed.

8.12.2. Accredited X-Ray Service - The x-ray service, whether maintained within the mental hospital or obtained by outside arrangement, shall be provided by a department that meets the minimum standards of the Joint Commission on Accreditation of Hospitals for the department of radiology:

(a) The services of a qualified radiologist shall be available on a scheduled basis;

(b) He shall interpret films that require specialized knowledge;

(c) There shall be at least one technician registered or eligible for registration by the american registry of radiologic technologists; and

(d) There shall be observance of the proper safety precautions in the use of all equipment.

8.13. Pharmacy

8.13.1. Scope of Pharmacy Service Defined - The scope of the pharmaceutical service shall be defined, in writing, consistent with the medication needs of the patients, and include a program for the control and accountability of drug products throughout the hospital.

8.13.2. Supervision of Pharmacy - The pharmaceutical service shall be directed by a professionally competent and legally licensed pharmacist and shall be staffed by a sufficient number of competent personnel in keeping with the size and scope of services of the psychiatric hospital.

8.13.3. Policies and Procedures of Pharmacy Service - Written policies and procedures that govern the safe administration of drugs shall be developed by the medical staff in cooperation with the pharmacist with representatives of other disciplines, as necessary.

8.13.4. Medication Errors - Medication errors shall be reviewed with the pharmacist and procedures revised, if indicated, to prevent recurrence.

8.13.5. Drug Formulary Recommended - The hospital staff, with the advice and counsel of the pharmacist, should establish a formulary of drugs to be used in the hospital, however, the existence of the formulary shall not preclude the use of drugs not included in the formulary.

8.13.6. Investigational Drugs - Investigational drugs properly labeled shall be used only under the direct supervision of the principle investigator and should be approved by an appropriate medical staff committee. Nurses may administer these drugs only after they have been given basic pharmacologic information about the drug. A central unit should be established where essential information on investigational drugs is maintained. (For further guidance, refer to statement of principles involved in the use of

investigational drugs in hospitals, approved by the american hospital association and the american society of hospital pharmacists, Washington, D.C., and Section 10.11, of these regulations.)

8.13.7. Methadone - Use of methadone shall be in compliance with uniform controlled substances act, Chapter 60-A, Code of West Virginia, 1971, federal food and drug administration regulations, and Section 6 of these regulations where applicable. (For further guidance, write to Food and Drug Administration, Bureau of Drugs, Methadone Maintenance Staff (BD-125), 5600 Fishers Lane, Rockville, Maryland, 20857.)

8.13.8. Compliance with State Laws and Regulations - Psychiatric hospitals, operating a pharmacy or maintaining only a drug storage and administration service, shall meet all the requirements set forth in Part VI, Section A, West Virginia regulations for licensing hospitals and the pharmacy laws and regulations of the West Virginia board of pharmacy, as amended.

8.13.9. Adequate Facilities and Equipment - There shall be equipment and supplies provided for the professional and administrative functions of the pharmaceutical service as required to ensure patient safety through the proper storage and dispensing of drugs.

8.13.10. Administrative Check - A periodic spot check shall be made by the executive officer, or his designee, of the accuracy of established controls in the handling of narcotics and controlled substances.

8.14. Psychiatric Hospital Services

8.14.1. Essential Elements of Care - As a first step in psychiatric hospital care and treatment, all psychiatric hospitals should establish the

following services, or affiliate with a licensed mental health facility providing such services:

(a) Emergency services to include, but not limited to, the medical management of detoxification and round-the-clock services needed for the psychiatric emergency;

(b) Outpatient services;

(c) Partial hospitalization;

(d) Acute inpatient services;

(e) Consultation and education; keeping in mind the utilization of domiciliary facilities, nursing home services, home nursing care services through a licensed community mental health center program, if it is available.

8.14.2. Adolescent Program

(a) A program for the care and treatment of adolescents should be under the direction of a psychiatrist with special training in care and treatment of mental disorders of the adolescent, or a demonstrated ability and special interest in the restoration of the mentally disordered adolescent to an optimal level of functioning and return to his home community;

(b) The adolescent program unit should be provided with a full staff of medical, nursing, social work, psychology service, and activity therapy personnel, with special interests in the care and treatment of adolescents;

(c) The adolescent program in a psychiatric hospital should be carried out in a special unit divided, if possible, into two sections: the early adolescents (13-15 years of age) and late adolescents (16-18 years of age);

(d) The full range of the psychiatric hospital services and standards as required by these regulations shall be available to these special patients the same as other patients admitted to the hospital;

(3) The rights and human dignity of these patients shall be respected at all times, in accordance with Section 10 of these regulations, where applicable.

8.14.3. Adult Mentally Ill

(a) The hospital program for the care of adult mentally ill shall be under the direct supervision of a psychiatrist;

(b) Provision shall be made for full compliance with Section 10 of these regulations;

(c) Adult mentally ill patients admitted involuntarily shall be provided the full range of psychiatric hospital services the same as voluntary admissions, with special services focused towards acceptance of care and treatment needed;

(d) The adult mentally ill patient care program should be organized and carried out in special units, if possible, divided into sections conducive to providing the type of care and treatment needed.

8.14.4. Alcohol and Drug Abuse Treatment Units

(a) The alcohol and drug treatment units shall be subject to these regulations, where applicable, and the regulations of the state department of health for licensing hospitals, as amended, where applicable, and in full compliance with uniform controlled substances act, Chapter 60-A, Code of West Virginia, 1971;

(b) The alcohol and drug treatment units shall participate in, or affiliate with, research programs on misuse and abuse of controlled substances in compliance with uniform controlled substances act, Chapter 60-A, Code of West Virginia, 1971;

(c) The full range of the psychiatric hospital services and standards as required by these regulations shall be available to these special patients the same as other patients admitted to the hospital;

(d) There shall be written procedures to ensure a smooth continuity of care for alcohol and drug abuse patients in transferring patients between elements of services, as needed;

(e) The psychiatric hospital providing medical management, commonly known as detoxification, care during the acute withdrawal from alcohol and other drugs shall establish written procedures defining the scope of the service and methods of patient's acute care, usually from five to ten days;

(f) Written procedures shall be developed for the medical management of the acute withdrawal period, including recommendations and counseling for aftercare treatment;

(g) Extended care treatment for the alcohol and drug abuse patients should be provided on a contractual basis in a licensed extended care facility, if available, in patient's home community;

(h) An extended care treatment unit in, or affiliated with, the psychiatric hospital should be in compliance with Section 6 of these regulations, where applicable;

(i) Domiciliary care for the alcoholic or drug abuse patients should be provided on a contractual basis in a licensed domiciliary facility, if available, in patient's home community;

(j) Domiciliary care treatment facilities, commonly referred to as halfway homes, operated as a part of, or affiliated with, the psychiatric hospital should be in compliance with Section 6 of these regulations where applicable;

(k) Alcohol and drug abuse information centers located in, or affiliated with, the psychiatric hospital shall be in compliance with Section 6 of these regulations, where applicable.

8.14.5. Chronically Mentally Ill

(a) The hospital program for the chronically mentally ill shall be under the direct supervision of a psychiatrist;

(b) The chronically mentally ill patient shall be provided the full range of psychiatric services the same as other patients hospitalized;

(c) Provision shall be made for full compliance with Section 10 of these regulations;

(d) The chronically ill patient care program should be organized to ensure flexibility in care as indicated by needs of each patient with special focus at time of periodic review on evaluation of treatment;

(e) The chronically ill patient shall receive all disciplines of care and treatment indicated by the orders reflected in his patient care plan which shall be reviewed and revised the same as other patients hospitalized.

8.14.6. Criminally Mentally Ill

(a) The hospital program for the criminally mentally ill shall be

under the direct supervision of a psychiatrist;

(b) The criminally mentally ill patient shall be provided the full range of psychiatric services the same as other patients hospitalized;

(c) For his own protection, and the protection of others, the criminally mentally ill patient shall be admitted directly to the secure unit in the hospital until a determination has been made as to his needs for, and degree of, restraint required, as indicated by his condition, in full compliance with Section 10 of these regulations;

(d) The criminally mentally ill patient shall be provided full and complete medical and psychiatric evaluation by the total medical and psychiatric treatment team including a neurological examination, if indicated;

(e) The criminally mentally ill patient care plan shall be promptly and carefully planned providing a professionally supervised program of treatment, to preclude the use of unnecessary restraints as soon as possible after admission;

(f) The criminally mentally ill patient aftercare program shall be carefully developed to include the establishment of controls to ensure humane, but prompt, back-up procedures, if indicated, for protection of the patient and the general public.

8.14.7. Emotionally Disturbed Children

(a) The hospital program for the care and treatment of the emotionally disturbed child shall be under the direct supervision of a psychiatrist;

(b) Provision shall be made for full compliance with Section 10 of these regulations;

(c) The emotionally disturbed child shall be provided the full range of psychiatric hospital services the same as other patients;

(d) The emotionally disturbed child care program should be organized and carried out in special units, if possible, providing private rooms when necessary, and separation of patients as to age and type of care and treatment indicated.

8.14.8. Geriatric Mentally Ill

(a) The geriatric mentally ill patient program shall be under the direct supervision of a psychiatrist;

(b) Provision shall be made for full compliance with Section 10 of these regulations;

(c) The geriatric mentally ill patients shall be provided the full range of psychiatric hospital services the same as other patients;

(d) The geriatric mentally ill patient care program should be organized and carried out in a special section of the hospital approved for the admission of medicare patients.

8.14.9. Totally Disabled Retarded

(a) The hospital program for the care and treatment of the totally disabled retarded patient shall be under the direct supervision of a psychiatrist;

(b) Provision shall be made for full compliance with Section 10 of these regulations;

(c) The totally disabled retarded patient shall be provided the full range of psychiatric hospital services the same as other patients;

(d) The totally disabled retarded patient care program shall be

organized and carried out to provide humane care and treatment indicated by patient need at all times.

8.14.10. Rehabilitation Services

(a) There shall be a written organization plan which identified the rehabilitation services and its place in the overall hospital organizational plan, defines the responsibility, authority and relationship of all positions within the service and which is periodically reviewed and revised;

(b) The rehabilitation service shall be under the direction of a psychiatrist, or a physician who is an active member of the medical staff and who, on basis of training and experience, is competent in rehabilitation medicine; or a medical staff committee composed of physicians knowledgeable in the needs of the local patient population and the ability of the psychiatric hospital to meet these needs;

(c) All disciplines of therapy provided must be by or under the supervision of licensed or registered personnel in accordance with state laws and regulations;

(d) The staffing requirements of rehabilitation service will depend upon the scope and volume of services offered and utilized. An adequate staffing pattern should provide professional, supportive and clerical personnel in numbers sufficient to achieve the goals and objectives of the hospital program;

(e) The staff of the rehabilitation service should include the services of a qualified vocational rehabilitation counselor whose involvement with patient should begin at time patient is admitted to the hospital;

(f) The rehabilitation service in the psychiatric hospital should provide, but not be limited to, the following disciplines:

(1) Physical therapy;

(2) Occupational therapy;

(3) Speech and hearing;

(4) Testing, fitting, or training in the use of prosthetic and orthotic devices;

(5) Prevocational conditioning;

(6) Recreational therapy;

(7) Vocational training (in combination with other rehabilitation services);

(8) Personal and work adjustment services;

(9) Extended employment for the severely handicapped who cannot be readily absorbed in the competitive labor markets;

(10) Dental services;

(11) Podiatric services.

(g) The rehabilitation service policies and procedures shall be in writing and shall include, but not be limited to:

(1) Scope of service;

(2) Responsibility for patient transportation to and from the service;

(3) Method by which the medical and treatment orders and information shall be transferred to and from the service;

(4) Responsibilities for recording all treatments in the patient's medical record.

(h) The rehabilitation process provided by the service shall start with the patient's admission to the hospital;

(i) All therapy treatments shall be given only on the written, dated and signed order of a physician and a record of each treatment shall be written in the patient's medical record, dated, and signed;

(j) All patients receiving rehabilitation services should receive total evaluation by the total rehabilitation team, (the physician, psychologist, nurse, social worker, vocational rehabilitation counselor, and representatives of other therapeutic disciplines needed by the patient) at least monthly unless an extended time is recommended by the patient's physician in writing in the patient's medical record;

(k) All treatments shall be only on the order of a physician and recorded in the patient's medical record;

(l) Patients requiring rehabilitation service transferred from general or special hospitals, should be accompanied by their medical chart showing level of rehabilitation accomplished before admission;

(m) The rehabilitation service shall be easily accessible by any means of transportation ordinarily available to the various patients needing such services;

(n) There shall be adequate space and equipment for the reception, examination and treatment of patients, for the related clerical work and for conference or teaching sessions;

(o) The equipment should be adequate and of a type, quantity, and quality to provide safe and effective patient care;

(p) All equipment shall be calibrated according to manufacturer's directions and should be periodically serviced as part of a preventive maintenance program.

8.14A. Animal Therapy

8.14A.1. All programs of formal animal therapy in any facility or program administered by or licensed by the department of mental health shall have written policies and procedures which shall include, but not be limited to:

(a) License and full compliance with West Virginia law;

(b) Inoculations for distemper, hepatitis, and periodic checks for internal parasites;

(c) Keeping animals out of the food preparation and dining areas of all facilities.

(d) Animal training as a part of all animal therapy programs.

8.14A.2. Dogs Preferred for Animal Therapy - Use of aminals in a therapy program for mentally ill, mentally retarded, or addicted, should be limited to dogs and started at the age of seven (7) months.

8.14A.3. Neutering - Dogs and/or cats used in animal therapy should be neutered.

8.15. Medical Records

8.15.1. Supervision - Medical records should be under the supervision of a registered record administrator who is a graduate of an approved school of registered record administrators and should be registered by the american association of medical record librarians, or an accredited records technician. If not, the individual in charge of the medical record service

should utilize the consultation services of a registered record administrator or an accredited records technician.

8.15.2. Case Record for Every Patient - There shall be a medical record maintained for every patient admitted to a psychiatric hospital for examination, treatment, or emergency services.

8.15.3. Medical Record Content - The medical record shall contain sufficient information to identify the individual clearly, to justify the diagnosis and treatment, and to document accurately the results. Each patient record should be problem oriented and contain as a minimum:

(a) Identification data including name, date and place of birth, address, race, social security number, socio-economic status and patient's legal status;

(b) Basic descriptive data concerning the patient;

(c) A summary of the evaluation process, including diagnosis, treatment recommendations, prognosis, and outcome;

(d) Initial and periodic physical and psychiatric examinations;

(e) A record of all psychological testing;

(f) Plan for treatment based on initial medical and psychiatric examinations within seven (7) days after admission indicating date next review is indicated;

(g) Signed and dated order for:

(1) Treatment;

(2) Medications;

(3) Mechanical restraints and seclusion which are time limited;

(4) Accident reports.

(h) When medication is administered, there shall be a record of the dosage, duration of the administration, and results of the treatment;

(i) Copy of all consultation reports;

(j) A brief summary of the treatment process, and termination notes which should include a concise statement concerning the future prognosis of the patient and the responsibilities for future care which the hospital should assume;

(k) All communications from, or with, family members or caregiving persons in the community.

8.15.4. The patient's medical record shall show a provisional, or admitting, diagnosis at time of admission and include the diagnosis of intercurrent diseases as well as the psychiatric diagnoses.

8.15.5. The history, physical examination, and psychiatric evaluation should provide sufficient detail to enable another physician to assume the care of the patient, a consultant to give a satisfactory opinion after his examination, or the physician who made the entries to determine, at any future date, just what the condition of the patient was and what procedures were performed.

8.15.6. The psychiatric evaluation, including medical history, should contain a record of the mental status of the patient, time of onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation and an inventory of the patient's assets in descriptive, not interpretive fashion.

8.15.7. The social service records, including reports of interviews with patients, family members and others, providing assessment of home

plans and family attitudes, and community resource contacts, as well as a social history, should be included in the patient's medical record.

8.15.8. Specific interagency mental health services available in patient's home community should be recorded in patient's medical record.

8.15.9. The medical record shall include reports of consultation, psychological evaluations, neurological examinations, reports of electroencephalograms, clinical laboratory and x-ray tests, dental records, and reports of other special studies or consultations requested.

8.15.10. The psychiatric plan of treatment, based on patient's initial medical and psychiatric examinations, the inventory of his assets and problems, shall be recorded within seven (7) days after admission.

8.15.11. The nursing care plan shall be written for each patient and shall be coordinated and integrated with the psychiatric plan of treatment.

8.15.12. The treatment received by the patient shall be documented in such a manner and with such frequency as to assure that all active therapeutic efforts such as individual and group psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, industrial or work therapy, nursing care and other therapeutic interventions are included, as given.

8.15.13. Progress notes shall be recorded by the physician, nurse, social worker, and when appropriate, by others significantly involved in active treatment modalities. Their frequency should be dependent upon the condition of the patient, but should be recorded at least weekly for the first two months, and at least once a month thereafter, and should contain recommendations for revisions in the treatment plan as well as precise as-

sessment of the patient's progress in accordance with the original, or revised, treatment plan.

8.15.14. If the medical records are problem oriented, all problems, orders, and progress notes should be numbered and dated, the problem numbers indicating the key index to the patient's care (e.g., progress note #1, and order #1, must relate to problem #1 only).

8.15.15. The discharge summary shall include a recapitulation of the patient's hospitalization and recommendations for appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

8.15.16. Certification that physicians' orders have been carried out must be shown by signature, or initials, of registered nurse responsible.

8.15.17. The patient shall receive a complete diagnostic workup before surgery (or dental work when a general anesthetic is indicated), except in cases of grave emergency, and such information should be reflected in the medical record.

8.15.18. All tissues removed in surgery must be sent to the laboratory, and the patient's record shall include a acknowledgment that the tissue has been received and a gross description included in the record. Microscopic examinations should include a description of the finding.

8.15.19. Operative notes shall contain both a description of the findings and a detailed account of the techniques used, and the tissues removed.

8.15.20. Final diagnoses shall be definitive and based upon the terms specified in the american psychiatric association diagnostic and statistical manual of mental disorders and/or the international classification of diseases.

8.15.21. Autopsy findings, when an autopsy is performed, shall include a complete protocol of findings. In case of suicide, a psychological autopsy report should be included.

8.15.22. Telephone orders should be signed within twenty-four (24) hours by responsible physician.

8.15.23. Medical records of patients seen on an outpatient basis and in the emergency department shall be made.

8.15.24. Medical record department should maintain statistical data relating to patient's inpatient care to ensure a prompt interchange of such data as patient's transfer from hospital to aftercare agencies, maintaining strict confidentiality as to patient information.

8.15.25. The supervisor of the medical records department should be qualified to prepare brief resumes of the patient's record for signature of physician or professional staff, indicating approval as to content, which may be needed for the referring physician, or agency, responsible for the subsequent care of the patient.

8.15.26. Confidentiality - All patient record information shall be kept confidential. Certain portions of the patient's record are so confidential that extraordinary means may be indicated to preserve their privacy. In such cases, these portions may be stored separately. For quality review audit, the complete record shall be available.

8.15.27. Confidentiality of Medical Records of Drug Abusers - Confidentiality of medical records of drug abusers shall be in full compliance with Section 6.2. of these regulations.

8.15.28. Release of Medical Records or Medical Record Information - Medical records or information from a medical record shall not be released except as follows:

(a) Pursuant to the order of a court of record;

(b) To an attorney of the patient, whether or not in connection with pending judicial proceedings after securing positive identification that the individual is in fact attorney for the patient;

(c) With the written consent of the patient or legal guardian to:

(1) Physicians and providers of health, social or welfare services involved in caring for or rehabilitating the patient, such information to be kept confidential and used solely for the benefit of the patient;

(2) Agencies requiring information necessary to make payments to or on behalf of the patient pursuant to contract in accordance with law. Only such information shall be released to third-party payers as is required to certify that covered services have been provided;

(3) Other persons who have obtained such consent.

(d) No patient medical record, or part thereof, obtained by any agency or individual shall be released in whole or in part to any other individual or agency unless authorized by the written consent of the patient or his legal representative.

8.15.29. Release of Patient Records or Patient Medical Record Information of Drug Abusers - Release of patient medical records or patient medical record information of drug abusers shall be in full compliance with Section 6.2. of these regulations.

8.15.30. Patient Medical Record Information Not to be Recorded in Patient's Medical Records - Patient's medical record shall contain information relating to patient's course of care and treatment only. The behavior of no other patient who is under treatment at the hospital shall be recorded in another patient's record; except such information directly affecting the care and treatment of patient, in which case the other patient shall not be identified in patient record by name or number.

8.15.31. Medical Record Filing System

(a) There shall be a system of identification and filing of medical records to ensure rapid location and retrieval of patient records at all times;

(b) When portions of the patient's medical record are filed in a separate locked file to safeguard confidentiality of the information, there shall be a system of identification and filing for these records the same as the other portion of the patient's chart.

8.15.32. Indices - Patient medical records should be indexed according to diagnosis and/or problems and physicians.

8.15.33. The medical record shall be the property of the hospital.

8.15.34. The medical record shall be in full compliance, where applicable, with Part VI, Section C, of West Virginia regulations for licensing hospitals promulgated by the state department of health.

8.16. Educational Programs

8.16.1. Psychiatric hospitals where children and adolescents are hospitalized shall have an educational program for patients.

8.16.2. The educational programs shall be developed and maintained in response to the hospital's patient needs.

8.16.3. The educational programs shall be under the direction of teachers licensed by the West Virginia board of education, and comply fully with the regulations of the West Virginia board of education for special education, training and certification to meet patients' needs.

8.16.4. Arrangements shall be made with the West Virginia department of education for students to receive recognition, or credit, for courses or grades successfully completed while hospitalized.

8.17. Orientation and Education

8.17.1. Orientation - Orientation programs shall be planned to ensure a thorough orientation for new employees, members of advisory groups, and volunteers. The orientation program plan should be written and appropriate programs should be presented to appropriate groups.

8.17.2. Coordination of Orientation Programs with Job Description - Orientation and education programs should be coordinated with and serve as an implementation of job descriptions.

8.17.3. Inservice Training and Education

(a) There should be a continuing program for inservice training to emphasize the therapeutic roles of all personnel, whether they deal directly with patients or indirectly, while working in patient zones, such as housekeepers, janitors, laundry or dietary personnel;

(b) Inservice training programs should be written and organized as to types of training, to whom the programs are presented, and should include at least, but not be limited to: hospital policies, procedures, and

goals; first aid, disaster plan; use of fire fighting equipment, fire drills, and evacuation procedures.

8.17.4. Facilities Without Organized Education Departments - In absence of organized education departments, educational programs for hospital personnel should be the combined responsibility of all hospital departments rather than loading all such responsibilities on one specific department, such as nursing service -- where programs of inservice training and retraining for improvement of patient care is an important and continuing process.

8.17.5. Workshop and Conference Participation - Provision should be made for employees, professional and nonprofessional, to attend and/or participate in meaningful educational programs and workshops sponsored by universities, colleges, and professional associations which have been certified as to content and which are specifically related to the responsibilities of personnel attending.

8.18. Dietary Service

8.18.1. The food service shall be in full compliance with the West Virginia regulations for licensing hospitals, where applicable.

8.18.2. The dietary department should be directed by a full-time person who is knowledgeable in administrative and organizational aspects of dietary management and food service administration.

8.18.3. At least one therapeutic dietitian, preferably one who has met the american dietetic association standards for qualifications, should serve the facility on a full-time or part-time basis. A part-time dietitian should maintain a written record of services rendered on each visit to the hospital.

8.18.4. The director of the dietary department shall be currently informed as to the federal, state and local regulations pertinent to the operation and management of a dietary department of a hospital and current standards of the american psychiatric association and the Joint Commission on Accreditation of Hospitals.

8.18.5. Long- and short-term goals of the department shall be established, in writing, to include the meeting of standards set forth in Section 8.18.4 as soon as possible, with measurements established for review of degree of accomplishment.

8.18.6. There shall be a written plan of organization of the dietary department indicating routes of intra-departmental communication.

8.18.7. The organizational plan and job descriptions should be available to all personnel in the department.

8.18.8. The organizational plan should be reviewed periodically to reflect current needs. The job description changes should be made to conform with changes in the organizational plan.

8.18.9. There shall be written policies and procedures for the dietary department to guide all dietetic personnel in the performance of their duties. The policies and procedures should be developed in cooperation with personnel from appropriate departments or services including, when appropriate, representatives from the medical staff. There shall be periodic review and revision of policies and procedures.

Interpretation: Written policies should include provision for physicians' dietetic orders to be recorded in patients' charts by a physician before a diet is served to any patient, and the method for communication of

orders from the physician to the dietary department, and from the dietary department to the physician when requested by the physician or when significant to the patients' welfare, shall be clearly delineated. There shall be procedures for evaluating the nutritional adequacy of patient diets, and for ordering diet supplements by joint consideration of representatives of the medical staff, dietetic staff and nursing service, utilizing the current "recommended dietary allowances" of the food and nutrition board, national research control. The system for providing and recording preventive maintenance service to facilities and equipment shall be included as well as other policies and procedures to meet goals of the dietary department.

8.18.10. Food shall be served in a relaxed atmosphere, at hours which are realistic to welfare of patients.

8.18.11. Food acceptance studies shall be conducted regularly.

8.18.12. All dietary needs of inpatients shall be met by an accredited method of preparation of tasty food, adequate in nutritious and caloric content and attractively served.

8.18.13. Quality food supplies shall be maintained at all times.

8.18.14. The dietary department shall be appropriately located and the floor plan of the department and type, size, and placement of equipment should permit efficient food preparation and distribution, effective sanitation and safety.

8.18.15. Well maintained equipment shall be kept in sanitary condition at all times.

8.18.16. Refrigerators should be equipped with thermometers and high temperature alarms.

8.18.17. Working surfaces should be cleaned and sanitized after each use.

8.18.18. Separate cutting boards should be used for red meats, poultry, and salads; prepared foods should not be cut on same boards as raw foods preparation.

8.18.19. Plastic ware and china which has lost its glaze or is chipped should be destroyed and replaced.

8.18.20. Condensation and growth of molds on walls, ceilings, and foods, or other surfaces, should be prevented.

8.18.21. Dishwashing equipment and techniques should assure sanitized service ware and prevent recontamination.

8.18.22. Disposable containers and utensils should not be reused.

8.18.23. Regular sanitary inspections shall be made to guarantee proper methods of food handling, distribution and dishwashing are observed.

8.18.24. An educational program shall be provided for all dietetic employees which should include at least the following:

Orientation to the hospital;

Food inspection;

Food handling techniques;

Proper cleaning of foods;

Safe operation of dietary equipment.

8.18.25. A dietary reference library including an up-to-date diet manual approved by the medical staff and dietetic services shall be conveniently located and used.

8.19. Physical Facility and Safety

8.19.1. Compliance with West Virginia Regulations for Licensing Hospitals - The physical facilities for psychiatric hospitals for existing facilities shall be in conformance with West Virginia regulations for licensing hospitals, as amended, promulgated by the West Virginia department of health.

8.19.2. Construction of new Psychiatric Hospitals - For construction of new psychiatric hospitals and as reference for improvement of the psychiatric hospital Appendix "A" of the public health service regulations, part 53, as amended, shall be used.

8.19.3. Special Care Rooms - There shall be special care rooms available where a disturbed patient can be housed which should be located near the nursing stations for purposes of observation of patient's needs, and to include the patient within a hospital group at all times.

8.19.4. Safety and Sanitation - The hospital shall be equipped, operated and maintained so as to sustain its safe and sanitary characteristics and to minimize all health hazards in the hospital for the protection of both patients and employees.

8.19.5. Service Departments - Housekeeping, laundry, maintenance and central service functions shall be effectively organized, directed, and staffed by qualified personnel.

8.19.6. Infection Control - Responsibility for the control of infection within the hospital and for the evaluation of the infection potential of the related environment, shall be vested in a multi-disciplinary committee of the medical staff (asepsis committee, section 8.3.3.(a)).

8.19.7. Disaster Plan - The hospital shall have written plans for the proper and timely care of casualties arising from external, internal disas-

ters, and civil disorders, and shall periodically rehearse these plans.

8.19.8. Separation of Patients - There should be space provided for separation of patients with respect to age, type of care needed, and services required to provide a functional facility in which flexibility in the organization of care and treatment is possible.

8.19.9. Children's Rooms - No child (under eighteen (18) years of age) shall be housed in any area also occupied by any patient over eighteen (18) years of age.

Section 9. Facilities for the Mentally Retarded

9.1. General

(a) Compliance with these regulations - All facilities for the mentally retarded shall be in full compliance with Sections 5, 8, 10, 12, and 13, where applicable.

(b) Pharmacy services.

(1) In order to contribute to improve resident care and to promote optimal response to drug therapy by the residents, through the full utilization of the knowledge and skills of a pharmacist, a licensed pharmacist's services shall be provided by or under the direction of a licensed pharmacist commensurate with the drug therapy program in the facility, and Section 5.8., standards for residential facilities for the mentally retarded of the Joint Commission on Accreditation shall be followed, where applicable;

(2) Day care center drug therapy.

a. It shall be the responsibility of the attending physician and licensed pharmacist to establish procedures for the receipt and administration of medications to residents in a day care center;

b. Provision shall be made for delivery of drugs to the day care center in the pharmacist's sealed package;

c. Each medication container shall show at least: name of drug, strength, dosage, date of prescription, amount of number of doses in container, plus any other labeling requirement if medication is subject to DEA regulations or FDA regulations;

d. Only appropriately trained staff shall be allowed to administer drugs in a day care center. In the absence of a registered nurse or a licensed practical nurse in a day care center program, the individual responsible shall be trained by a physician and such training shall be certified in the administration of specific medications such individual is permitted to administer. Neither prescriptions for medications which are time limited nor injectable shall be administered in a day care center except by a registered nurse or a licensed practical nurs.

(3) Medications shall not be administered to any resident other than the one for whom they were prescribed.

(c) No medication shall be administered in a facility for the mentally retarded without the written consent of the parent or legal guardian.

(d) All medications administered at a facility for the mentally retarded shall be prescribed by a physician licensed to practice in West Virginia with request to licensed pharmacist to label medication container in compliance with these regulations.

(e) All facilities for the mentally retarded including day care centers shall maintain at least, but not be limited to, the following records:

(1) Reports of accidents, seizures, illnesses, and treatments thereof, and immunizations;

(2) Record of all periods of restraint, with justification and authorization for each;

(3) Report of regular, at least annual, review and evaluation of the program developmental progress, and status of each resident;

(4) Specific and factual observations of the resident's response to his program, recorded with sufficient frequency to enable evaluation of its efficacy;

(5) Record of significant behavior incidents;

(6) Record of family visits and contacts;

(7) Record of attendance and leaves;

(8) Correspondence;

(9) Periodic updating of the information recorded at the time of admission;

(10) Appropriate authorizations and consents.

9.1.1. Comprehensive Centers for the Mentally Retarded

(a) The comprehensive center for the mentally retarded shall define the type and scope of each of its services, in writing.

(b) The comprehensive center for the mentally retarded shall provide within the center, or on a written contractual basis, the elements of services set forth in Section 5 of these regulations, where applicable, including residential care.

(c) If a community mental health center program provides services within the same catchment area defined in the West Virginia state plan for

construction of community mental health centers and/or mentally retarded facilities, the comprehensive center for the mentally retarded shall contract for services needed in preference to duplicating services in the community mental health center.

(d) The comprehensive center for the mentally retarded shall be in full compliance with Section 5, 8, 10, 12, and 13 of these regulations, where applicable.

(e) The center should be accessible to those individuals in the catchment area it serves, as needed.

(f) There shall be an organized governing body which has full authority and legal responsibility for the conduct of the comprehensive center for the mentally retarded (see Section 5.1.13 of these regulations). The governing body may be a governmental unit or a board of trustees.

(g) The governing body shall appoint an executive officer of the comprehensive center for the mentally retarded whose qualifications, background, training and demonstrated ability are commensurate with his duties and responsibilities of administering the center.

(h) Each comprehensive center for the mentally retarded shall have a master plan of organization which includes all functions of the organization of the center, and which indicates all categories of personnel employed and the lines of communication. The organization plan shall be in writing, and periodically reviewed and revised, as needed, showing dates of reviews and revisions.

(i) Each comprehensive center for the mentally retarded shall have a manual of policies and procedures for each function of the center

and the systems established for an orderly and safe operation of the center. The manual of policies and procedures shall be in writing and preiodically reviewed and revised, as needed, showing dates of reviews and revisions.

(j) Policy manual - A manual of policies and procedures should, where applicable, include, but not be limited to, the following:

(1) Admission procedures;

(2) Health, hygiene and grooming;

(3) Methods for compliance with humanities, Section 10;

(4) Staffing patterns;

(5) Resident and patient medical records;

(6) Food service;

(7) Personnel policies;

(8) Personnel records;

(9) Financial benefits - determining eligibility of residents for benefits, procedures to assure residents receive funds due and available to them, protection of patients' funds;

(10) Financial records - provision for annual audits;

(11) Procurement of supplies;

(12) Procurement of medical services, if needed;

(13) Information and referral services, when needed;

(14) Contracted services;

(15) Nursing and/or first aid services;

(16) Vocational education and training;

(17) Provision for vocational rehabilitation, when indicated;

(18) Habilitation education and training;

(19) Recreational activities;

(20) Physical fitness routines;

(21) Residential facilities operation and management;

(22) Maintenance of buildings and grounds;

(23) Housekeeping;

(24) Transportation;

(25) Safety, including disaster plan, drills in case of internal/external disasters, and civil disorders;

(26) Control of infection and provision for isolation, if needed.

(k) The comprehensive center for the mentally retarded shall maintain its facilities in good repair and operating condition.

(l) The center serving food as a part of its program will be subject to Section 8.18. of these regulations, where applicable.

(m) The center shall have a summary of federal, state, and local laws and regulations relating to mental retardation and to the function of the facility.

(n) The center shall be subject to Section 5.15.7. and Section 5.16., where applicable.

9.2. Residential Facilities for the Mentally Retarded

9.2.1. Primary Functions - The primary functions of a residential facility for the mentally retarded shall be to:

(a) Maximize the human qualities of the resident/student;

(b) Increase the complexity of his behavior; and

(c) Enhance his ability to cope with his environment.

9.2.2. Normalization - The facility shall accept and implement the principle of normalization (see Section 3, definitions).

9.2.3. Labels - The names of the facilities, the labels applied to users, and the way the users are interpreted to the public should be appropriate to their purposes and not emphasize "mental retardation" or "deviancy." Residents should not be referred to as "patients" except in a hospital-medical context; as "kids" or "children" if they are adults, or as "inmates." As suggested alternatives, they may be referred to as "trainee," "clients," "patrons," "consumers," "guests," "students," or "pupils."

9.2.4. The facility shall maintain a current descriptive list of community resources.

9.2.5. There shall be public education to encourage the integration of residents/students to participate and utilize community resources relating to education, social, vocational, religious, and professional services and group activities available.

9.2.6. Short and long term goals shall be geared to move residents/student from:

(a) More to less structured living;

(b) Larger to smaller facilities;

(c) Larger living units to smaller living units;

(d) Group to individual residence;

(e) Dependent to independent living;

(f) Segregated to integrated living.

9.3. Day Care Center for Mentally Retarded Children

9.3.1. The day care center for the mentally retarded child shall:

(a) Provide a developmental program for the child while he is at the center which will assist him in reaching his maximum capabilities;

(b) Delay or provide an alternate to the need for institutionalizing a child, preserving the basic philosophy that the child should remain in the home and community as long as these provide a better basis for development than that which can be provided in a institution;

(c) Provide counseling services for the parents;

(d) Provide relief for the parents a portion of the day, allowing the mother and other members of the family an opportunity for other activities.

9.3.2. The day care center providing care for the mentally retarded child shall define the type and scope of each of its services which should include, but not be limited to, the training programs for: self-care, socialization; maturation; and self-expression.

9.3.3. The day care center for the mentally retarded shall provide a program of parent education which shall include, but not be limited to:

(a) Enlightenment regarding the nature, causes, and consequences of mental retardation;

(b) The basic goals of the program which are especially important to their child; and

(c) Home activities to complement the day care program.

9.3.4. Day care centers subject to standards and licensing requirements of the West Virginia department of welfare providing care primarily for severely and profoundly mentally retarded children shall be subject to

these regulations requiring license by the West Virginia department of mental health.

9.3.5. Child care centers (see Section 3., definitions) subject, or not subject, to licensure by the West Virginia department of welfare, shall be subject to these regulations within the meaning of the terms as defined in Chapter 27, Article 9, Section 1, Code of West Virginia, as amended.

9.3.6. There shall be an organized governing body which has full authority and legal responsibility for the conduct of the day care center for the mentally retarded. The governing body may be a governmental unit or a board of trustees.

9.3.7. The governing body of the day care center for mentally retarded children shall be subject to Section 5.1.13. of these regulations, where applicable.

9.3.8. The membership of the governing body shall consist of representatives of community agencies who serve the retarded and their families and other professional people whose knowledge about children will aid in determining sound programming for the day care center.

9.3.9. The governing body of the day care center for mentally retarded children shall appoint a qualified practitioner to carry out the type of program for which the facility was constructed, and provide adequate numbers of nonprofessional personnel to assist in the operation of the facility.

9.3.10. A representative of the parents' council shall be appointed as an ex officio member of the governing body to ensure continuing communication between the governing body and the parents' council.

9.3.11. A representative of the parents' council shall be appointed as an ex officio member of the governing body to ensure continuing communication between the governing body and the parents' council.

9.3.12. Parents' Council

(a) The purpose of the parents' council shall be to function as a supportive group to the day care center for mentally retarded children and actively represent the concerns of parents to both the executive officer of the center and the president of the governing body. It shall also assist the center and the community in planning and initiating comprehensive programs to meet the needs of the retarded children in the community.

(b) The parents' council shall be incorporated as a nonprofit organization in order to receive and disburse gifts made to the center.

(c) The parents' council shall be organized and adopt bylaws, rules and regulations in order to conduct the business of the council in an orderly and legal manner, including, but not limited to, provisions for regular meetings, recording of minutes, fiscal records, audits, and education relating to center policies as to parents' responsibilities when a child requires administration of medication at the day care center. It shall be subject to Section 5.1.13 of these regulations, where applicable.

(d) The bylaws, rules and regulations of the council shall be approved by the department of mental health.

(e) The membership of the parents' council shall include all parents of children being served by the center and may, at the option of the council, include parents whose children are eligible for and awaiting admission to the center.

9.3.13. Plan of Organization - Each day care center for mentally retarded children shall have a master plan of organization which includes all functions of the center and which indicates all categories of personnel employed and the lines of communication. The organizational plan shall be in writing and periodically reviewed and revised, as needed, showing dates of reviews and revisions.

9.3.14. Policy Manual - Each day care center for mentally retarded children shall have a manual of policies and procedures for each function of the center and the systems established for an orderly and safe operation of the facility. The manual of policies and procedures shall be in writing and periodically reviewed and revised, as needed, showing dates of reviews and revisions. The manual of policies and procedures shall include, but not be limited to:

(a) Admission procedures;

(b) Staffing patterns;

(c) Clinical records.

(1) There shall be an individual care record for each resident in the day care center for the mentally retarded, which will indicate all of the resident's problems as well as the care, treatment, and progress achieved in the center program.

(2) Medications administered in a day care center.

a. All medications administered at a day care center shall be prescribed by a physician licensed to practice in West Virginia, and administered by a registered nurse, licensed practical nurse, or a responsible person certified by a physician for the administration of specific drugs.

b. Each child receiving more than one medication shall have a separate container for medications on which the child's name is clearly indicated.

c. Each medication bottle, or container, shall contain no more than two (2) weeks supply and be delivered directly to the day care center in an unopened package which has been sealed by the licensed pharmacist.

d. Each prescription container shall be labeled in conformance with Section 9.1.(b) (2)c. of these regulations.

e. Neither medications requiring stop orders nor injectables may be administered in a day care center except by a registered nurse or a licensed practical nurse under the direct orders of a physician.

f. Medications subject to controlled substance regulations shall be in full compliance with the Drug Enforcement Agency Regulations.

g. All medications administered in a day care center for the mentally retarded shall be recorded in each individual resident's clinical record showing amount, date, and time of aministering, and signed by the individual administering, also showing the certification for administering drugs.

(d) Food service;

(e) Personnel policies;

(f) Personnel records;

(g) Financial records;

(h) Fee schedules;

(i) Maintenance of facility;

(j) Safety;

(k) Procurement of first aid or medical services when needed;

(l) Nursing and/or first aid service;

(m) Control of infection;

(n) Procurement of supplies;

(o) Information and referral services when needed;

(p) Housekeeping and laundry;

(q) Transportation.

9.3.15. The organizational plan, job descriptions, and manual of policies and procedures shall be available to all personnel.

9.3.16. The day care center for the mentally retarded children shall be maintained in good repair and good operating condition.

9.3.17. Day care centers for mentally retarded children shall be subject to periodic inspections by authorized representatives of the department of mental health.

9.3.18. Day care centers for mentally retarded children serving food as part of their program will be subject to Section 8.18 of these regulations, where applicable.

9.3.19. The state and local legal requirements for heating, lighting and ventilation shall be met.

9.3.20. The state and local regulations for water supply, sewage disposal, plumbing, and screening shall be met.

9.3.21. The day care centers for mentally retarded children shall be subject to Section 5.15 and Section 5.16 of these regulations, where applicable.

9.3.22. When the services of foster grandparents are utilized in the

day care center for mentally retarded children, all applications shall be approved by the director, Foster Grandparent Program, Department of Mental Health, 1800 Washington Street, East, Charleston, West Virginia.

9.3.23. Orientation, inservice training, and continuing education of foster grandparents employed in day care centers for the mentally retarded children shall be subject to approval of the project director, foster grandparent program.

Section 10. Humanities

10.1. Discrimination

10.1.1. All mental health facilities shall make available all services to persons in need without discrimination because of race, creed, color, sex, age, national origin, marital status, lack of wealth or duration of residence.

10.1.2. No qualified person shall be discriminated against on account of race, creed, color, sex, age, national origin, marital status or previous mental condition, with respect to employment in a mental health facility.

10.2. Civil Rights of Patients/Clients

10.2.1. Every patient/client in any facility operated, or licensed to operate, by the department of mental health shall be permitted to exercise all of his civil rights, including but not limited to, civil service status and appointment, the right to register and vote at elections, the right to acquire and dispose of property, executive instruments, enter into contractual relationships, to marry and obtain a divorce, to hold professional or occupational or vehicle operator's licenses, unless he has been adjudicated incompetent in a separate proceeding pursuant to Article 11, Chapter 27, Code of West Virginia, 1931, as amended, and the county court has made a

specific finding that such individual is incompetent to exercise the specific right or category of rights.

10.2.2. It shall be the responsibility of the facility's executive officer to assure that each patient is informed of his rights and the responsibility of the unit team to make all necessary arrangements to allow the exercise of his rights.

10.3. Right of Privacy - A patient shall have a right to as much privacy as the area in which he is residing will allow, and he shall have the right to move about freely unless his safety is threatened.

10.4. Patient's Right to Treatment

10.4.1. Patient Entitled to Humane Care - Every patient in any facility licensed to operate by the department of mental health shall be entitled to care and treatment suited to his needs and administered promptly in a skillful, safe and humane manner by trained personnel.

10.4.2. Right to Adequate Treatment

(a) No individual shall be admitted to a mental health facility for the purpose of confinement only. There shall be evidence of a treatment program which should include at least, but not limited to, the following:

(1) Treatment based on appropriate examination and diagnosis by a staff member operating within the scope of his professional license;

(2) A written, individual treatment plan that the chief medical officer of the facility shall cause to be developed within seven days of the patient's admission to a mental health facility, specifically tailored to the individual's needs in accordance with Section 10.5.;

(3) Evidence in each patient's medical record that the plan of

treatment is being carried out;

(4) A psychiatric examination at least every three months to determine the need for continued hospitalization and to determine the success or need for changes in the treatment plan;

(5) A physical examination at least every six months;

(6) Evidence that some of the recognized procedures applicable to treatment of mental illness have been administered to the patient, such as individual psychotherapy, group therapy, family therapy, physical therapy, appropriate physical fitness routines, and chemotherapy.

(b) Every individual admitted to a mental health facility shall be entitled to care and treatment in accordance with accepted medical practice standards. If any of the rights set forth in these regulations related to treatment are not afforded, then the reasons for such restriction must be specified in the patient's treatment plan in the patient's clinical record.

Specific reasons for noncompliance, or threatened noncompliance, with this section of these regulations shall be enumerated in license survey reports.

10.5. Right to Participate in Treatment Plan - Every individual admitted to a mental health facility shall be entitled to participate in the development of his individual treatment plan and shall be notified of its content as well as of all proposed changes in that plan, including, but not limited to, plans for continued hospitalization, discharge, transfer to another facility or ward, changes in the therapy program and changes in medication.

10.6. Physical Treatment - Every patient in a state hospital shall have

the right to receive prompt and adequate treatment for episodes of physical illness.

10.7. Right to Refuse Treatment

(a) Every patient/client in a mental health facility shall have the absolute right to refuse any form of therapy which is not a part of his individual treatment plan, including medication and, unless it is documented in the medical record that the part of the treatment plan or medication to which the individual objects is an absolute necessity, it shall not be permitted;

(b) Except when an individual is unconscious or in like dire emergencies, every patient in a mental health facility shall have the absolute right to refuse a course of treatment, therapy and/or medicine other than that which is usual and customary for his condition, and such individual shall not be subjected to such without his express and specific consent;

(c) Refusal of medication and/or treatment which are not a part of his individual treatment plan shall be made in writing, dated, signed by the patient, witnessed, and made a part of his medical record;

(d) If a patient/client refuses a specific treatment, or medication, while capable of evaluation of the consequences of refusal of any type of treatment, including the medication, and later becomes incompetent to judge, his refusal while competent shall stand; provided however, notification is made to next of kin or legal guardian to be given opportunity to take legal action to reverse patient's decision unless the treatment or medication is an emergency or life saving course of treatment.

10.8. Right to Protection from Unnecessary Treatment - Any patient

in any facility operated, or licensed to operate, by the department of mental health, shall be entitled to evaluation of positive criteria established to determine need for drug therapy, electroconvulsive therapy, or other somatic treatment modalities before inclusion in the patient's treatment plan. If indicated, the evaluation should include the recommendations of the total professional care team providing treatment to the patient.

10.9. Removal from Therapeutic Program - No patient, adult, adolescent, or child, shall be removed from a therapeutic program except when such removal is dictated by clear psychiatric considerations, or when the patient so loses his ability to control his behavior that participation constitutes a danger to the program and/or to other patients. When a patient's behavior deteriorates to this degree, increased attention shall be devoted to his psychiatric needs avoiding a disciplinary regime consisting of rejection and/or denial maneuvers.

10.10. Right to Private Physician - Patients shall have the right, at their own expense, to the services of a private doctor licensed to practice medicine in the State of West Virginia. A private physician may visit a patient at any reasonable time.

10.11. Experimental Treatment

10.11.1. All patients in mental health facilities shall have the right not to be subjected to experimental research without the express and informed consent of the patient, and his guardian or next of kin, after opportunity for consultation with independent specialists and with legal counsel.

10.11.2. Experimental treatment consents for patients who have been

adjudicated incompetent and the court appointed committee's authority extends to give consent to experimental treatment, such committee may give consent after opportunity for consultation with independent specialists and with independent legal counsel.

10.11.3. Experimental treatment shall be in full compliance with the principles of the statement on the Use of Human Subjects for Research of the American Association on Mental Deficiency, and with the principles for research involving human subjects required by the United States department of health, education and welfare.

10.11.4. The methods of obtaining informed consent for experimental treatment shall be reviewed and approved by the hospital's patient advocate committee, or patient advocate. The hospital's patient advocate committee, or patient advocate, may review the procedures surrounding the application of the experimental treatment upon written request of such committee, or advocate, to the research review board; provided however, an informed member of the research review board conducts the review to ensure full understanding and knowledge of all aspects of the experimental treatment.

10.12. Medications

10.12.1. All patients of mental health facilities operated by or licensed to operate by the department of mental health have a right to be free from unnecessary or excessive medication.

10.12.2. Medication shall not be used as punishment, for the convenience of the staff, as a substitute for program, or in quanities that interfere with the patient's treatment program.

10.12.3. Every individual admitted to the mental health facility shall

have the right to know what medication he is taking, the dosage, the purpose of the medication and any possible side effects.

10.13. Mechanical Restraints and Seclusion

10.13.1. Use of Mechanical Restraints

(a) Mechanical restraints shall not be used for the purpose of punishment. Mechanical restraints shall only be applied to a patient upon the dated and signed order written in the patient's medical record by his attending physician. A copy shall be given to the chief medical officer;

(b) All orders for mechanical restraints shall be written by the patient's attending physician for a specified time, in no event to exceed twelve hours. A succinct statement justifying the patient's medical need for such restraint for the period indicated shall be included in the order.

10.13.2. Use of Seclusion

(a) Under no circumstances may seclusion be utilized as punishment for social misbehavior;

(b) Seclusion is a treatment modality and shall, therefore, be a medical responsibility;

(c) A physician's seclusion order shall be valid only for twenty-four hours, but may be renewed by written order of the physician.

10.13.3. Pro Re Nata Orders - No pro re nata orders for seclusion or restraint shall be permitted and no such order shall be honored by the ward staff.

10.13.4. Seclusion Reports - In every instance in which a patient is placed in seclusion, a full report shall be made, in triplicate, by the physician, describing the circumstances and the purpose for which seclusion is

ordered. One copy of the report shall be forwarded to medical records, one to the clinical director, and one shall be placed in the patient's ward chart. The physician's seclusion report shall include at least, but not limited to:

(a) Justification for the seclusion;

(b) The degree of security required;

(c) The items which a patient may have while in seclusion.

10.13.5. Seclusion Room Checks - The registered nurse in charge of the unit, or shift, shall be responsible for assuring that the following seclusion room checks are carried out:

(a) All seclusion rooms shall be checked at the beginning of each shift, whether patients are reported in seclusion or not;

(b) Each patient in seclusion shall be checked no less frequently than fifteen (15) minutes.

10.14. Clinical Record, 27-5-9(e) - A clinical record shall be maintained at a mental health facility for each patient/client treated by the facility. The record shall contain at least, but not limited to, the following:

(a) Admission date;

(b) Legal status;

(c) Care and treatment of patient including all pertinent documents relating thereto;

(d) Results of: (1) periodic examination; (2) individualized treatment programs; (3) evaluations and re-evaluations; (4) orders for treatment; (5) orders for application for mechanical restraint; (6) acci-

dent reports, all signed by the personnel involved.

10.15. Confidentiality of Records

10.15.1. A patient's clinical record shall be confidential and shall not be released by the department of mental health or its facilities or employees to anyone outside the department except as follows:

(a) Pursuant to an order of a court of record;

(b) To the attorney of the patient, whether or not in connection with pending judicial proceedings after securing positive identification that the individual is in fact the attorney of the patient;

(c) With the written consent of the patient or his legal guardian to:

(1) Physicians and providers of health, social or welfare services involved in caring for or rehabilitating the patient, such information to be kept confidential and used solely for the benefit of the patient;

(2) Agencies requiring information necessary to make payments to or on behalf of the patient pursuant to contract or in accordance with law, with written warranty that such information is not released to any other person or organization or made a part of any central data bank. Only such information shall be released to third party payers as is required to certify that covered services have been provided;

(3) Other persons who have obtained such consent.

(d) No patient record, or part thereof, obtained by any agency or individual shall be released in whole or in part to any other individual or agency, unless authorized by the written consent of the patient or his legal representative.

10.15.2. Confidentiality of Drug Abusers' Record - In addition to the foregoing Section 10.15.1., the medical records, or any part thereof, the identity, diagnosis, prognosis, or treatment of any drug addicted patient, which are maintained in performance of any drug abuse prevention or treatment for addiction shall be confidential and may be disclosed only as authorized by Federal Regulations.

10.15.3. Governing Bodies not Entitled to Patient Record Information - Members of governing bodies, whether operating or advisory, shall not be entitled to privileged information relative to patients. It shall be the responsibility of the staff to use discretion in discussing policies and procedures relating to governing body responsibilities, not to violate the confidentiality of specific patients.

10.16. Patients' Right to Unrestricted Communication

(a) Every patient shall be entitled to communicate by sealed mail, or otherwise, with any persons, including official agencies inside, or outside, the mental health facility. This right may not be denied, restricted, or infringed in any manner;

(b) Unless the patient requests return address to be withheld, it shall be the responsibility of the mental health facility to ensure the name and return address are inscribed legibly on all out-going patient mail;

(c) Mail returned by recipients to a patient marked "refused" shall be returned, unopened, to the patient by his attending physician;

(d) Patients shall have the unimpeded and uncensored right to access to a public telephone for the purpose of calling whomever they wish. If it is necessary for a patient to be accompanied to the public telephone by

a staff member, or assistance of a staff member is needed in making a call, the necessary arrangements shall be made by the unit team, and the confidentiality of the patient's conversation shall be fully protected by staff member assisting. In no case shall a patient wait more than twelve (12) hours to make a phone call after a request has been made;

(e) If it is necessary to deviate from the policies outlined in this subsection, a written statement including the justification, and by whom made, will be entered in the patient's chart and will expire one week from date.

10.17. Patient Visitors

(a) Every patient shall have the right to receive, or refuse, visitors in accordance with hospital policy, unless his mental condition is such that in the judgment of his physician, such visits would be detrimental.

(b) A complete report relative to the restriction of visitation privileges and the reasons therefor, shall be made a part of the patient's medical record, signed and dated by the patient's attending physician, and reflected in the patient's nursing care plan, and shall expire one week from the date of execution.

10.18. The Patient may not be Denied Right to see Attorney, Religious Advisor or Family Member

(a) The patient may not be denied the right to receive visits from his attorney, or religious advisor, or a member of the patient's immediate family. If in the judgment of the patient's physician the visit would be detrimental and patient agree to a postponement, the visit may be postponed

but the persons shall have the right to see the patient for purposes of observation only.

(b) If there appears evidence which would indicate a patient's rights are being abused, or violated, by his attorney or religious advisor, the patient shall have the right of protection by appropriate hospital staff to intervene, or proctor the patient's visits with such persons.

10.19. Personal Clothing, Prosthetics, and Possessions

10.19.1. Every patient shall be entitled to the possession and wearing of his own personal clothing, dentures, eyeglasses, hearing aid, orthopedic appliances, and other personal possessions such as diaries, Bibles, or other books, not withheld for safekeeping by the hospital or patient's family. The patient's attending physician must justify, in writing, withholding aforementioned articles in patient's medical record; such statement to be dated, signed, and reviewed monthly, showing dates and signatures of such reviews, to show that possession of such personal effects would be harmful to himself or others.

10.19.2. Policies and procedures for the maintenance of personal wearing apparel shall be established, in writing, and shall be the combined responsibility of nursing service, laundry service, business manager, and the executive officer of the hospital.

10.20. Violation of a Patient's Rights

10.20.1. A report shall be made within twenty-four (24) hours to the executive officer of a facility of all violations, or suspected violations, of patient's rights. A complaint may be made by a patient, employee or any other individual.

10.20.2. The executive officer of the facility shall make a thorough investigation and written report of his findings without delay.

10.20.3. The executive officer of the facility shall make a written, dated, signed record of action taken to preclude a repetition of such violations, or suspected violation, relative to the specific patient involved, or any other patient.

10.20.4. The executive officer's report of the incident shall be identified by hospital case number only, and a succinct notation of the incident and effect of incident on the illness or treatment shall be made in patient's medical record.

10.20.5. Every psychiatric hospital should create a position for at least one patient advocate whose primary responsibility should be to act on behalf of patients in case of violation of a patient's humane or civil rights, or suspected violation of a patient's humane or civil rights.

10.20.6. If the action of the executive officer of a mental health facility, taken on behalf of a patient or patients, regarding a violation of patients' rights is unfavorable, insufficient, or not forthcoming within a reasonable time, the patient, the patient advocate, may appeal to the director of the department of mental health.

10.21. Right of Appeal for Release 27-58-8 - If a patient makes appeal to the clinical director and no action is taken, or unfavorable action is taken, for his release from the hospital, patient may make appeal to the review board of appeal and shall be fully assisted by hospital staff in making such appeal.

10.22. Responsibility of Employees - Every person employed by a

mental health facility operated by the department of mental health, or by any facility licensed by the department of mental health, shall be responsible for carrying out his duties and responsibilities with due regard for both the intent of this regulation and the application of the express provision of this regulation as it pertains to any person covered herein. All employees, including patient advocates, shall take all actions required to protect the rights of patients without fear of reprisals in regard to their employment, pay or otherwise.

10.23. Patients' Labor, Earnings, and Funds

10.23.1. Patient Labor

(a) No patient shall be required to perform labor against his will;

(b) Privileges or release from the hospital shall not be conditioned upon the performance of labor covered by this provision;

(c) Patients may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29, U.S.C.S. 206 and the state minimum wage law.

(1) If a patient does work, he shall be paid the minimum wage in accordance with federal labor standards;

(2) The hospital may, thereafter, assess or collect the reasonable cost of room, board, and other services actually provided a patient worker; provided however, such charges do not exceed seventy-five (75%) per cent of patient worker's disposable income.

10.23.2. Personal Housekeeping - Patients may be required to perform tasks of a personal housekeeping nature, such as the making of one's own bed.

10.23.3. Access to Personal Funds - There shall be procedures, in writing, to ensure patient's reasonable access to his personal funds.

(a) Patients not adjudicated incompetent shall have access to their funds whenever and in any amount they so wish unless their use of funds prove detrimental to course of treatment. In such cases, patient's attending physician shall document in the patient's medical record the withholding of funds for a limited period of time;

(b) Patients adjudicated incompetent shall have the same access to their funds as above, subject to reasonable limitations by their committee, or legal guardian. In such cases, patients medical record shall document such withholding of, or limitations set, for access to their funds.

10.23.4. A patient or relative may be required to pay for care and treatment in a state hospital according to the ability to pay; however, no patient shall be denied treatment because they are not able to pay.

10.24. Juveniles' Additional Rights

10.24.1. No child (under eighteen (18) years of age) shall be housed in any area also occupied by any patient over eighteen (18) years of age in a state hospital.

10.24.2. The child's program of education shall, in the opinion of the attending physician, be compatible with the patient's mental condition and his treatment program, and otherwise be in the patient's best interest.

10.24.3. No juvenile patient shall be deprived of the right to attend school in the regular public school system unless the attending physician determines the individual is incapable of coping with the public school situation (including the special education classes offered in the locality) and

such determination is concurred in by the chief medical officer. Such a determination shall be entered upon the individual's clinical record and shall be valid for a period of ninety days.

10.24.4. The juvenile patient's treatment plan shall be consistent with the chronological, maturational, and developmental level of the patient.

10.24.5. Provision shall be made for recreational and play opportunties in the open air and otherwise.

10.24.6. Arrangements for regular contact between the facility and the family of the patient shall be recorded in each juvenile patient's clinical record.

10.25. Rights with Respect to Disciplining Children

10.25.1. Discipline, child care, and child guidance shall be handled with kindness and understanding with a program planned to minimize need for punishment or severe discipline.

10.25.2. No child shall be subjected to cruel, harsh, humiliating, petty, severe, or provoction treatment, or corporal punishment inflicted in any manner upon the body.

10.25.3. No child shall be subjected to verbal abuse, threat or derogratory remarks about him or his family.

10.25.4. No child shall be deprived of meals as punishment.

10.25.5. Disciplinary measures shall be designed and administered in such ways as to help the individual to assume responsibility for his own acts.

10.25.6. The facility shall establish simple and understandable rules for both children and staff that set the limits of behavior required for the

protection of the group and individuals within the groups.

10.25.7. The facility shall designate only highly responsible adults, usually the staff person most directly responsible for the personal care of the child, to handle discipline matters, never delegating discipline to persons who are "strangers" to the child, or to a child's peer, or peers.

10.25.8. The facility shall require that matters of personal discipline be pertinent and relevant to the particular problem and the child involved.

10.25.9. The facility shall require that discipline be maintained with discretion without bias, and without prolonged delay on the part of the adult involved.

10.25.10. No child shall be withdrawn from any therapy program as a displinary measure.

10.26. Incarceration of Individuals in a Jail or Penal Institution Awaiting Examinations is Prohibited, 27-5-3 - All facilities operated by the department of mental health, or licensed by the department of mental health, shall have a responsibility to disseminate information to the general public and meet with community agencies, health officers, social service caseworkers, and law-enforcement officers regarding Chapter 27, Article 5, Section 3, Code of West Virginia, 1931, as amended, which absolutely prohibits the incarceration in a jail or penal institution any individual taken into custody and detained for examination to determine whether in fact his actions (which appear to, or are alleged to, cause serious harm to himself or others) are due to mental illness, mental retardation, or addiction.

10.27. Patient to Receive Copy of his Rights set forth in these Regulations, 27-5-9(f) - Every patient, upon his admission to a hospital and at

any other reasonable time, shall be given a copy of the rights afforded under these regulations in accord with Chapter 27, Article 5, Section 9, Code of West Virginia, 1931, as amended.

(Intent: The term "patient" as used in Section 10.27 shall include patient, patient's family, and/or legal guardian.)

Section 11. Psychiatric and Psychological Services Within a County School District

11.1. Type and scope of a psychiatric and/or psychological service within a West Virginia county school system shall be clearly defined in writing.

11.2. There shall be full compliance with Section 10 of these regulations.

11.3. The policies and procedures for the utilization of psychiatric and/or psychological services shall be in writing, and shall include, but not be limited to, the following;

(a) Procedures for referral of pupils to the psychiatric or psychological service;

(b) Consultation and education services provided the teachers within the county school system by the psychiatrist or psychologist;

(c) Utilization of essential elements of care and treatment provided by the local community mental health center in the catchment area in which the school system is located;

(d) Consultation and education services provided family of pupils under treatment;

(e) Clinical records;

(f) Fee schedules, if any.

11.4. The psychiatric or psychological services in the county school system shall be provided by, or under the supervision of, a psychiatrist or psychologist currently licensed in the State of West Virginia.

11.5. There shall be evidence of evaluation of the psychiatric or psychological services program within a county school system in compliance with Section 11 of these regulations, where applicable.

11.6. Annual reports shall be made to the department of mental health on forms provided by the director.

11.7. The department of mental health data collection forms shall be completed and submitted promptly.

Section 12. Transportation

12.1. Transportation of Children

12.1.1. Mental health facilities or programs owning vehicles to provide transportation of children shall comply with West Virginia school transportation laws, rules, and regulations, where applicable.

12.1.2. Drivers of any type vehicle to transport sick, crippled, mentally ill/mentally retarded children shall meet West Virginia civil service minimum requirements for ambulance driver, or equal.

12.1.3. The driver of a vehicle transporting children shall be at least twenty-one years of age and not over sixty-five years of age at the time of employment, and shall meet the personnel and health qualifications required for school bus drivers.

12.1.4. The driver shall hold an appropriate license, depending upon the type of vehicle used in transporting children.

12.1.5. West Virginia school transportation laws, rules and regulations pertaining to insurance shall be followed.

12.1.6. An attendant shall be assigned to enforce safety regulations in the vehicle at any time children are being transferred.

12.1.7. The attendant shall see that:

(a) Each child boards or leaves the vehicle from the curb side of the street and a responsible person is present to take charge of a child when delivered to his home or other facility;

(b) Good order is maintained on the bus;

(c) The vehicle is not overcrowded.

12.1.8. The driver shall be responsible for keeping the vehicle clean, polished, and in perfect operating condition at all times.

12.1.9. Vehicle maintenance problems not correctable by the driver shall be reported, in writing, to driver's immediate supervisor with copy to the executive officer of the facility or program.

12.1.10. The vehicle shall be thoroughly inspected at least every six months, or sooner if indicated, for mechanical flaws which, if found, shall be corrected immediately.

12.1.11. The vehicle shall be equipped with:

(a) Safety locking devices on doors;

(b) A mounted tire, ready for service, and jack;

(c) "Stop" and "children's medi-bus" written on back of vehicle;

(d) A first aid kit;

(e) Blinkers.

12.2. Ambulance Service

12.2.1. Ambulance service provided by mental health facilities shall be in full compliance with West Virginia motor vehicle laws relating to emergency transportation.

12.2.2. Drivers of automobiles, trucks, ambulances or other types of vehicles to transport sick and/or mentally ill/mentally retarded individuals shall meet West Virginia civil service minimum employment requirements or equal.

12.2.3. Ambulance rigs shall be well maintained at all times.

12.2.4. Ambulance drivers shall start ambulance daily, or more often if indicated, to ensure its readiness for service if needed.

12.2.5. Tires shall be inspected each time an ambulance is serviced for signs of need for replacement, balancing, or alignment. When tread becomes worn on ambulance tires, they shall be replaced immediately.

12.2.6. Ambulance rigs shall be thoroughly inspected at least every six months, or every 1,000 miles, or sooner, if indicated, for mechanical flaws which, if found, shall be corrected immediately.

12.2.7. Ambulance maintenance problems not correctable by the driver shall be reported, in writing, to driver's immediate supervisor with copy to the executive officer of the facility or program.

12.2.8. Ambulances shall be provided with at least a driver plus one attendant.

12.2.9. Ambulance drivers and attendants shall be trained in first aid procedures.

12.2.10. Ambulance attendants shall be selected in accordance with type and condition of individual to be transferred.

12.2.11. Ambulances shall be equipped with:

(a) Safety locking devices on doors;

(b) Mounted tire, ready for service, and necessary tools for tire changing;

(c) Flashing lights and siren warning device in accordance with state emergency transportation regulations;

(d) Stretcher equipped with safety belt;

(e) Linen;

(f) Travel pack;

(g) Bed pan, urinal, and emesis basin;

(h) Portable oxygen;

(i) Leather cuffs;

(j) Suction equipment.

Section 13. Evaluation and Research

13.1. General

13.1.1. If the comprehensive mental health plan for the State of West Virginia is to be effectively implemented, a data system capable of program monitoring, evaluation, development, and research should be developed to embrace all hospitals, centers, institutions or parts thereof, providing inpatient, outpatient, or other services to contribute to the care and treatment of mentally ill, mentally retarded or addicted, or prevention of such disorders.

13.1.2. Administrative statistics should be goal-related and include data describing the characteristics of facilities, patients served, and whether the services are meeting the needs of the population of the catchment area.

13.1.3. A cost accounting system should be integrated into the overall data system used to implement the comprehensive mental health plan for West Virginia.

13.1.4. The regulations contained in Section 13 of these regulations shall be considered as a spear-head toward the development of goals and objectives and measurements to determine whether each facility and program in each catchment area is achieving through mental health services what the area needs. They should be considered as educational with respect to the accomplishments of the total department of mental health of which each licensed facility and program is an integral part. They are designed as guidelines in the development of a data system which will produce valuable data which will contribute to needed research and development programs in the field of mental health.

13.2. Identification of Goals

13.2.1. Each mental health facility should prepare a statement of goals indicating for each goal the observable correlates, concomitant events and areas of impact which will likely be in evidence as progress is made toward the goal.

13.2.2. Each mental health facility should determine methods for measurements of goals started.

13.2.3. A budget should be estimated and/or applied to the activities related to the accomplishment of stated goals.

13.3. Areas of Evaluation

13.3.1. In order to ensure statewide congruence of goal direction to provide specific criteria which will define measurable areas of evaluation,

each facility should review the special needs of patients, special interests of patients, professional and business staff, as well as patients' families, publics in which the families are dwelling and the publics existing (conforming and non-conforming) in the catchment area.

13.3.2. Outcome studies anticipated planned by the department of mental health should be provided with data from each licensed facility or program relating to:

(a) Goals for individual patients;

(b) Goals for facility or programs; and

(c) Goals for local mental health agencies.

13.3.3. The following list of indices should be considered for measures of goal accomplishment:

(a) Index of subsystem interaction and collaboration among community and state agencies providing mental health professionals;

(b) Index of treatment of mentally disordered within their home community;

(c) Index of investment in mental health;

(d) Index of role diversification of mental health professionals;

(e) Index of alcoholism, drug abuse, children with problems, and other high risk target group treatment provisions;

(f) Index of early intervention efforts;

(g) Index of equitable services;

(h) Index of accessibility of services;

(i) Index of treatment scheduling;

(j) Index of use of improvement criteria in treatment decisions;

(k) Index of time limited therapy referrals;

(l) Index of long-term therapy referrals;

(m) Index of therapy "dropouts";

(n) Index of staff hours per patient served;

(o) Index of staff hours per "consultee" served;

(p) Index of staff hours per unit of service;

(q) Index of units of services per patient served;

(r) Index of paperwork delay (chart completeness);

(s) Index of knowledge of available services;

(t) Index of receptivity to treatment;

(u) Index of screening effectiveness;

(v) Index of high risk group prevention efforts;

(w) Index of community social disruption, disorganization;

(x) Index of public resources used by high risk groups;

(y) Index of data use;

(z) Index of service utilization;

(aa) Index of inappropriate referrals;

(bb) Index of referral completeness (continuity of care, including after-care);

(cc) Index of goal-directed therapy;

(dd) Index of goal-directed physical fitness referrals.

13.4.1. Evidence of Evaluation

13.4.1. Each mental health facility or program subject to these regulations shall show evidence of developing a psychiatric utilization review and evaluation project to establish techniques for utilization review and patient care evaluation.

required to be licensed by the department of mental health by virtue of authority of the Legislature of West Virginia, Chapter 27, Article 9, Section 1, Code of West Virginia, 1931, as amended.

14.1.2. Rehabilitation centers shall have a well defined plan for receiving, management, and disposition of mentally ill/mentally retarded individuals.

14.1.3. The rehabilitation center providing habilitation/rehabilitation services for mentally ill/mentally retarded individuals shall comply with standards set forth in these regulations, where applicable, relating to the type and scope of services defined in the rehabilitation program for which application is made for license to the department.

14.2. Organization and Management

14.2.1. There shall be an effective governing body legally responsible for the conduct of the rehabilitation center. The governing body may be a governmental unit or a board of trustees.

14.2.2. The governing body structure shall be in compliance with Section 5.1.13. of these regulations, where applicable.

14.2.3. The governing body shall adopt bylaws in accordance with legal requirements and with its community responsibility, identifying the purposes of the rehabilitation center and the means of fulfilling them.

14.2.4. The governing body, through its chief executive officer, shall take all reasonable steps to conform to all applicable federal, state, and local laws and regulations including those relating to licensure under these regulations and the West Virginia Regulations for Licensing Hospitals adopted and promulgated by the state department of health, as amended,

and federal, state, and local fire and safety regulations.

14.2.5. The governing body shall require that the professional staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practice.

14.2.6. The governing body, through its chief executive officer, shall provide an organization plan and policies and procedures for each function of the center and the system established to ensure an orderly and safe operation.

14.3. Professional Staff

14.3.1. There shall be a competent professional staff of physicians, psychologists, social workers, registered nurses, and vocational rehabilitation counselors, as needed, with training and experience in the development and management of rehabilitation plans of service in which the disabled, mentally ill/mentally retarded individual is viewed as a whole, as well as other qualified professional personnel representing the multi-disciplines rehabilitation process as dictated by patient needs.

14.3.2. Centers contributing to the treatment of mentally ill/mentally retarded individuals shall provide the services of a psychiatrist on a contractual basis, as needed.

14.3.3. Each member of the professional staff of the center shall be registered, licensed, or certified currently by the appropriate licensing agency or registry of the State of West Virginia.

14.3.4. The professional staff of the center shall be organized to accomplish its required functions in the habilitation/rehabilitation of the mentally ill/mentally retarded individuals.

14.3.5. There shall be regular professional staff conferences established for the evaluation and review of rehabilitation progress of each patient, and review of plans of services as needed. These conferences shall be attended by a representative of each discipline of treatment provided.

14.3.6. The professional staff organization shall strive to create and maintain an optimal level of professional performances in pooling information, interpretations, and opinions for the development of rehabilitation plans of services.

14.3.7. There shall be a continuing program of professional education, or maintenance of a record to show the participation of professional staff in such programs.

14.4. Rehabilitation Services

14.4.1. Medical Service - Medical services in a rehabilitation center not operated in connection with a hospital shall provide medical supervision, availability by agreement of medical consultants, and evaluation and services suitable to the needs of the disabled persons to be served. A qualified psychiatrist shall be available for mentally ill/mentally retarded individuals as needed.

14.4.2. Social Services - Social service should provide evaluation and services in the amounts and variety appropriate to the rehabilitation needs of the individuals to be served. Social workers should possess a professional degree in social work at the master's level from an accredited school of social work.

14.4.3. Psychological Services - Psychological service should be pro-

vided by a professional psychologist possessing at least a master's degree in psychology from an American Psychological Association approved program in clinical psychology or its adjudged equivalent; and shall be licensed or certified by the West Virginia state board of examiners for professional psychologists. The service should constitute an integral part of the overall professional service, including, but not limited to, direct services to patients, assistance in the diagnostic process, and assessment of treatment results, with supporting personnel adequate in number and qualifications sufficient to achieve the functions and goals of the facility.

14.4.4. Nursing Services - Nursing service shall be provided in accordance and in compliance with Section 8 as applicable to the type and scope of the services of the facility.

14.4.5. Clinical Laboratory - Clinical laboratory services shall be provided as applicable to the type and scope of the services provided by the rehabilitation center in accordance with Section 8.11 of these regulations.

14.4.6. Pharmacy Service - If the rehabilitation center program requires pharmaceutical services and/or the administration of drugs, the pharmacy or drug room shall comply with Section 8.13 of these regulations, where applicable.

14.4.7. Radiology Services - If the rehabilitation center requires radiology services, these services shall be in compliance with Section 8.12 of these regulations, where applicable.

14.4.8. Dietary Service - The dietary services of the rehabilitation center shall comply with Section 8.18 of these regulations, where applicable.

14.4.9. Additional disciplines of services shall be dictated by the type and scope of the program provided by the rehabilitation center, the needs of the individual being served, and shall include, but not be limited to, the availability of the following:

(a) Physical therapy;

(b) Occupational therapy;

(c) Speech and hearing;

d) Prevocational conditioning;

e) Recreational therapy;

f) Individual physical fitness routines;

(g) Vocational rehabilitation;

(h) Personal and work adjustment services;

(i) Extended employment for the severely handicapped who cannot be readily absorbed in the competitive labor markets;

(j) Testing, fitting, or training in the use of prosthetic and orthotic devices;

(k) Optical aids evaluation;

(l) Dental services;

(m) Podiatric services.

4.4.10. Rehabilitation Evaluations - An evaluation of the course of progress in a rehabilitation process of mentally ill, mentally retarded, addicted individuals, as well as in preventive treatment in the problems of the aged, shall be recorded periodically in a continuum beginning with the establishment of the individual's treatment plan. A rehabilitation evaluation shall be included in the summary of patient's care and treatment at time of discharge.

There shall be a continuing evaluation and control established of each individual's special disabilities in relation to his varying levels of functioning.

14.4.11. Medical Responsibility - All medical and related treatments and services shall be ordered by a physician, in writing, dated and signed in the medical chart of each disabled individual under treatment.

14.5. Medical Records

(a) There shall be a medical record maintained for each patient admitted for rehabilitation services to the rehabilitation center;

(b) The medical records shall be maintained in compliance with Section 8.15 of these regulations, where applicable;

(c) The evaluations and revisions of patients' plans of treatment by the professional staff conference shall be recorded in each patient's medical record, dated, and signed by the patient's physician.

14.06. Physical Facility and Safety

14.6.1. The regulations for licensing hospitals of the state department of health, where applicable, shall be met for licensure of rehabilitation centers.

14.6.2. The rehabilitation facility shall be structurally constituted in a manner that protects the lives and ensures the physical safety of disabled individuals admitted for treatment, its personnel, and its visitors.

14.6.3. The rehabilitation facility shall be equipped, operated and maintained so as to sustain its safe and sanitary characteristics and to minimize all health hazards in the facility for the protection of inpatients, residents, visitors, and employees.

14.6.4. Housekeeping, laundry, and maintenance and central service functions shall be effectively organized, directed, and staffed by qualified personnel.

14.6.5. Responsibility for the control of infection within the rehabilitation facility, and for the evaluation of the infection potential of the related environment, shall be vested in a multi-disciplinary committee of the rehabilitation center and professional staff.

14.6.6. The rehabilitation facility shall have written plans for the proper and timely care of casualties arising from both external and internal disasters, and shall periodically rehearse these plans.

Section 15. Voluntary Hospitalization

15.1. Voluntary Admissions

15.1.1. The chief medical officer of a mental health facility, subject to the availability of suitable accommodations, shall admit for diagnosis, care and treatment any individual:

(a) Over eighteen (18) years of age who is mentally ill, mentally retarded, or addicted, or who manifests symptoms of mental illness, mental retardation or addiction, who makes application therefor; or

(b) Under eighteen (18) years of age who is mentally ill, mentally retarded, or addicted, or who manifests symptoms of mental illness, mental retardation or addiction, when application is made by:

(1) Parents;

(2) One (1) parent, if only one parent is living;

(3) One (1) parent, if parents are living separate, by the one parent who has custody; or

(4) Legal guardian.

Subject however, to consent of the prospective patient if the patient is sixteen (16) years of age or over. (Recent court decision lowers age limit in this section to twelve (12) years of age. Next revision of these regulations will reflect this change.);

(c) Persons under eighteen (18) years of age shall only be admitted to a state hospital after a review and evaluation by a local mental health facility and recommended for admission by said mental health facility;

(d) Review and evaluations by local mental health facilities shall be performed by those facilities published by the director of mental health (see Exhibit D).

15.1.2. Release of Voluntary Patients (27-4-2) - The chief medical officer of a mental health facility shall release any voluntary patient:

(a) Who has recovered; or

(b) Whose hospitalization is no longer advisable; provided however, every effort is made to arrange supportive after-care.

15.1.3. Release on Application (27-4-3) - A voluntary patient who was admitted on his own application shall be released upon request, except when:

(a) Release is requested by a person other than the patient and patient does not approve the release; or

(b) An application for involuntary commitment is filed with the clerk of the circuit court or mental hygiene commissioner of the county where the facility is located, within ninety-six (96) hours by the chief medical officer postponing release for twenty (20) days pending a finding in

accord with legal proceedings under Article 5, Section 4, Chapter 27, Code of West Virginia, 1931, as amended;

(c) Legal proceedings for change from voluntary status to involuntary commitment shall not be commenced unless release of voluntary patient has been requested by patient or individual or individuals who applied for his admission.

15.2. Trial Visits - Patients of a mental health facility on a voluntary basis may have the privilege of trial visit upon recommendation of his attending physician that his condition does not indicate that he is likely to cause serious harm to himself or others.

15.2.1. After Care During Trial Visit - During trial visits, the mental facility shall continue interest and assistance in the review and updating of the individual's treatment plan on a non-hospital basis on a consultation basis through the community mental health center designated for the area by the director of the department of mental health, if practical, or other person or persons to whom the patient is released.

15.2.2. Discharge from Trial Visit - Any voluntary patient on continued trial visit for a period exceeding one (1) year shall be automatically discharged from the hospital.

Section 16. Involuntary Hospitalization

16.1. Involuntary Commitment, 27-5-1, 27-5-4 (e)

16.1.1. No individual shall be involuntarily committed to a mental health facility:

(a) Except by order by circuit court of county of residence or county wherein individual resides or is found; and then

(b) Only after full hearing on the issues relating to the necessity of committing an individual to a mental health facility; and

(c) Findings based upon clear cogent and convincing proof that the individual is mentally ill, mentally retarded or addicted and that he is likely to cause serious harm to himself or others.

A finding of mere mental illness, mental retardation or addiction is not itself sufficient to justify involuntary hospitalization.

16.1.2. Involuntary Medical Certification Admissions, 27-5-2 - Any individual may be admitted to a mental health facility designated for the area by the director of the department of mental health upon (see Exhibit A):

(a) Written application under oath to the facility by:

(1) Parent;

(2) Guardian;

(3) Spouse;

(4) Adult next of kin;

(5) A friend;

(6) A health officer;

(7) A case worker familiar with case; or

(8) Head of any institution where such individual may be; and

(b) Written certification by two physicians that they have examined the individual and are of the opinion that:

(1) Individual is mentally ill, mentally retarded or addicted; and

(2) Individual is likely to cause serious harm to himself or others if he is allowed to remain at liberty.

16.1.3. Involuntary Emergency Admission, 27-5-2 - Any individual may be admitted to a mental health facility designated for the area by the director of the department of mental health upon (See Exhibit A);

(a) Written application under oath to the facility by:

(1) Health officer;

(2) Caseworker; or

(3) Law-enforcement officer,

upon statement that in his belief individual, because of symptoms of mental illness, mental retardation or addiction is likely to cause serious harm to himself or others if not immediately restrained, and so certified by at least one (1) physician that he has examined the individual and that he is of the opinion that:

(1) Individual is mentally ill, mentally retarded, or addicted; and

(2) Individual is likely to cause serious harm to himself or others if he is not immediately restrained.

16.1.4. Medical Certifications Time Limit, 27-5-2(b)

(a) No individual may be admitted to a mental health facility by process of an emergency admission after the expiration of three (3) days from date of required medical certification;

(b) No individual may be admitted to a mental health facility by process of medical certification after expiration of fifteen (15) days from date of first required medical certification.

16.1.5. Medical Certification Content, 27-5-(b) - The required certification by physicians that they are of the opinion an individual is mentally ill, mentally retarded or addicted for admission to a mental health facility shall include:

(a) The date, time, and place of examination;

(b) What behavior indicative of mental illness, mental retardation, or addiction is evidenced in the individual by the physician;

(c) Findings and conclusions of the mental examination;

(d) Facts upon which such findings and conclusion are based including facts underlying or reason for the belief of imminent harm;

(e) That because of such findings and conclusions, the individual is likely to cause serious harm to himself or others if he is allowed to remain at liberty or if he is not immediately restrained.

16.1.6. Transfer to State Hospital, 27-5-2(b)

(a) The chief medical officer may, with the approval of the director of the department of mental health, transfer an individual for admission to a state hospital or to another similar type of mental health facility after determining that no less restrictive alternative is suitable or available;

(b) When an individual is admitted to a mental facility pursuant to Chapter 27, Article 5, Section 2, Code of West Virginia, 1931, as amended, the chief medical officer of a mental health facility shall forthwith make a report thereof to the director of the department of mental health.

(c) A transfer of an individual from a local mental health facility to a state hospital must be accompanied by a certificate from the local mental health facility that the individual has been observed or examined by the local mental health facility designated for the area by the director of department of mental health. Such certificate shall state what type of treatment is suggested and an explanation of why a less restrictive alterna-

tive is not suitable or available for such individual.

16.1.7. Notice of Medical Certification or Emergency Admission, 27-5-2(b) - When an individual is admitted to a mental health facility pursuant to Chapter 27, Article 5, Section 2, Code of West Virginia, 1931, as amended, the chief medical officer of the mental health facility admitting the individual shall immediately give notice to the individual's spouse, if any, and the individual's parents or parent, guardian, or, if there be no such spouse, parents, parent, or guardian, to two of the individual's adult next of kin. The notice shall be in writing and shall be transmitted to such persons or persons at his, her or their last known address by certified or registered mail, return receipt requested.

16.1.8. Confirmation of Need for Hospitalization, 27-5-2(c) - After an individual's admission to a mental health facility by medical or emergency certification procedure, he shall not be detained more than three (3) days unless:

(a) Two (2) staff physicians concur that the individual is mentally ill, mentally retarded or addicted; and

(b) There is likelihood that the individual will cause serious harm to himself or others.

16.1.9. Independent Evaluations - Physicians may jointly examine an individual for medical or emergency certification admission, but each must make separate, independent and signed evaluations of patient's condition.

16.1.10. Request for Hearing, 27-5-2(d) - If on the basis of examinations by the two mental health facility staff physicians, the chief medical officer determines that the individual should continue to be hospitalized, a written request for a hearing shall be:

(a) Sent to the clerk of the circuit court of the county where he was found; and

(b) Sent to such circuit court within five days after the individual's admission.

16.1.11. Release of Individuals Admitted Involuntarily by Medical Certification or Emergency Certification Procedures, 27-5-2(e) - An individual admitted involuntarily to a mental health facility by medical or emergency certification who does not choose to change his status to voluntary hospitalization shall be released without fail:

(a) Within three (3) days after his admission unless he has been examined by two staff physicians both of whom confirm in writing that the individual is likely to cause serious harm to himself or others if he is allowed to remain at liberty or if not immediately restrained;

(b) Within five (5) days after his admission unless the chief medical officer has sent a written request within such time to the clerk of the circuit court of the county of which the individual is a resident of where he was found, for a hearing on the question of his mental condition and need for further hospitalization;

(c) Within twenty (20) days after his admission unless a hearing has been conducted pursuant to the provisions regarding legal proceedings for involuntary hospitalization and a determination and order made as prescribed therein on the question of the individual's mental condition;

(d) Upon demand for release - An individual, or his spouse, relative, guardian or friend, may at any time after an emergency admission or medical certification admission demand in writing that such individual be

released from the mental health facility. Upon receipt of such demand, the chief medical officer shall:

(1) Release such person; or

(2) Within ninety-six (96) hours institute legal proceedings for involuntary hospitalization by mailing to the clerk of the circuit court of mental hygiene commission the requisite application for involuntary hospitalization.

Any person who makes such demand orally shall be immediately taken to the chief medical officer's or registrar's office for the purpose of completing the written form.

16.2. Examination Under Custody, 27-5-3

16.2.1. Procedures for Mental Examination Under Custody - Any individual who is unwilling to submit to an examination who evidences symptoms of mental illness, mental retardation, or addiction and it appears that the individual is likely to cause serious harm to himself or others while awaiting examination may be taken for examination only after:

(a) One of the persons named in Section 16.1 of these regulations makes a sworn statement showing the facts upon which the belief is based;

(b) Such person presents the sworn statement to the circuit court or mental hygiene commissioner;

(c) The circuit court or mental hygiene commissioner concludes that the facts justify an order and enters an order that the individual be taken into custody;

(d) A copy of such order is presented to such person at the time he is taken into custody and comfortably detained at a location other than a

jail or penal institution under the supervision of a responsible person or persons.

16.2.2. Examination Under Custody Time Limited - No later than fourteen (14) hours after an individual is taken into custody, he shall be released for voluntary admission to a mental health facility if care and treatment is needed; or proceedings shall be instituted for medical or emergency certification admission to a mental health facility if he is likely to cause serious harm to himself or others; or he shall be transported to a state hospital where the order originated to determine need for readmission.

16.2.3. Procedures Following Involuntary Examination

(a) If an individual is determined not to be mentally ill, mentally retarded or addicted, such individual shall be released:

(b) If an individual is determined upon clinical findings to be mentally ill, mentally retarded or addicted but there is insufficient evidence to ascertain that the individual is likely to injure himself or others, such individual shall be released;

(c) If such individual is determined to be mentally ill, mentally retarded or addicted and that, based upon recent evidence, such individual is determined likely to injure himself or others then the following procedures shall be taken:

Firstly, the individual shall be given the privilege of voluntary admission to a mental health facility designated by the director of department of mental health for the area which is appropriate for the care and treatment indicated by medical certification.

Secondly, after giving the individual the privilege of voluntary treat-

ment and he refuses submission to such treatment, then medical or emergency procedures for involuntary hospitalization may be activated.

Thirdly, in no event shall an individual for whom physician certification has been issued be involuntary confined in a jail or penal institution awaiting transportation to a mental health facility.

16.3. Confidentiality of Commitment Procedure Information, 27-5-4(a)

16.3.1. Confidentiality of All Commitment Records - No records relating to the involuntary hospitalization of an individual shall be open to inspection by any person other than the individual unless authorized by such individual or his legal representative or by order of court, nor shall such records be published except upon authorization of the individual or his legal representative.

16.3.2. Confidentiality of Certification and Examination Records - All findings of an examination by a physician or psychologist as the result of an individual voluntarily or involuntarily submitting himself or herself to a mental health facility, or other physician or psychologist for an examination shall be confidential and absolutely privileged. Such information may be released only with the individual's consent or the consent of his other legal counsel, and only to the persons and for the purpose specified. All information obtained from a person taken into custody for an examination shall be confidential and privileged; except however, statements made to physicians in the process of such involuntary examination may be given into evidence by the physician's testimony in involuntary commitment proceedings without the individual's consent.

16.4. Commitments for Indeterminate Period, 27-5-4(d)

16.4.1. Indeterminate Period Commitment Time Limited - If the court orders an individual committed to a mental health facility for an indeterminate period, such commitment shall expire at the end of two(2) years from the date of last order of commitment. If in the opinion of the chief medical officer of a mental health facility the indeterminate period commitment should be repeated, proceedings for such re-commitment should be initiated by the chief medical officer not sooner than ninety (90) days before expiration of period, but not later than ten (10) days before legal discharge.

16.4.2. Temporary Observation Period Time Limited - After a finding that an individual is mentally ill, mentally retarded or addicted, if the court orders the individual admitted for a temporary observation period, such period shall not exceed six (6) months.

16.5. Court Commitments to Responsible Individuals

(a) Whenever the court orders a person committed to a responsible individual under bond to take care of the person committed and to restrain individual if necessary, such persons shall report to the community mental health center designated in the area of the director of the department of mental health periodically at least once every three (3) months to review the individual's treatment plan for needed revision or recommendation for discharge;

(b) Community mental health centers shall immediately give notice to the director of the department of mental health of cases under court bond being supervised on an out-patient basis.

16.6. Out-of-State Resident Commitments, 27-5-4(f) - If an individual found to be mentally ill, mentally retarded, or addicted is a resident of

another state, such information shall, upon consent of the individual, be given to the director of the department of mental health for appropriate arrangements for transfer except as qualified by the interstate compact on mental health.

16.7. Periodic Review of Persons Orders to a Mental Health Facility, 27-5-8 - The chief medical officer of a mental health facility shall periodically review the treatment of persons admitted to a mental health facility by medical or emergency certification or committed by the court.

(a) All such persons shall receive psychiatric examinations as frequently as the chief medical officer of the mental health facility considers desirable, but intervals between examinations shall not exceed three (3) months;

(b) Reports of such psychiatric examination shall be:

(1) Placed in individual's medical record;

(2) Given to the chief medical officer for review, recommendations, or appropriate action; and

(3) The chief medical officer shall notify patient as to his continued hospitalization or recommendations for release.

16.8. Trial Visit, 27-7-2 - The chief medical officer of a mental health facility may release an improved patient on trial visit when he believes such release is in the best interest of the patient.

16.8.1. Eligibility for Trial Visits - A patient in a mental health hospital by medical or emergency certification procedures may have privileges of trial visit with prior notification to the clerk of the circuit court ordering the commitment to the mental health facility with certification of

facts recorded in patient's medical record that he is not likely to cause serious harm to himself or others.

16.8.2. Individual's Not Eligible for Trial Visits - Patients admitted for observation or improvement periods under West Virginia Code 27-6A-1 (b) and 27-6A-2 (b), shall not be eligible for trial visits.

16.8.3. Hospital Responsibility During Trial Visit - During trial visits, the mental health facility shall:

(a) Continue responsibility for the individual and his treatment plan on a non-hospital basis through the community mental health center designated for the area by the director of the department of mental health, if practical, or other person or persons to whom the patient is released;

(b) Provide for periodic examination of the facts relating to the needs of the patient on trial visit by the chief medical officer of a mental health facility monthly for the first four (4) months and at least annually thereafter; and

(c) Review additional facts regarding the patient's mental health during such trial visit to determine need for further hospitalization.

16.9. Release as Unimproved, 27-7-3 - The chief medical officer of a state hospital may release a patient as unimproved when any responsible person requests the patient's release and is willing and able to take proper care of the patient outside the state hospital by:

(a) Taking from such responsible person a bond in the penalty of at least five hundred ($500.00) dollars with sufficient security to be approved by the chief medical officer, payable to the State of West Virginia, conditioned to restrain and take proper care of such patient until further order of such officer;

(b) Those in charge of said patient reporting at least once every six (6) months to the chief medical officer of the state hospital as to the condition of the patient.

16.10. Notification of Releases as Unimproved, 27-7-3 - When patients are released from a state hospital as unimproved, notifications shall be given to:

(a) Director of the department of mental health; and

(b) Clerk of the court of record ordering involuntary hospitalization and clerk of court of the county of which the patient is a resident.

16.11. Readmission of Involuntary Patients on Trial Visit, 27-7-4

(a) While any involuntarily committed patient is on trial visit he may be at any time readmitted to the hospital on the basis of the original commitment;

(b) If there is reason to believe that it is to the best interest of the patient to be hospitalized, the chief medical officer of the state hospital may issue an order to the clerk of the court of record and to the clerk of the county court of the patient's county of residence;

(c) Upon receipt of such order and without further endorsement, the clerk shall authorize any health officer or police officer to take the patient into custody and follow procedures set forth in Section 15.2. of these regulations entitled "Examination Under Custody."

16.12. Return of Escapee, 27-7-5

(a) If any individual confined in a mental health facility escapes therefrom, the chief medical officer thereof shall issue a notice, giving the name and description of the person escaping, and request his apprehension and return to the mental health facility;

(b) The chief medical officer of a mental health facility may issue a warrant directed to the sheriff of the county in which the patient is a resident, commanding arrest and transport of such person back to the mental health facility. Such warrant may be executed in any part of the state by the sheriff;

(c) If an excapee goes to another state, the chief medical officer shall notify the director of the department of mental health for appropriate action;

(d) An escapee may be readmitted at time of being apprehended on the basis or original commitment even though his absence may exceed the period of one (1) year and the hospital has discharged him.

16.13. Discharge of Involuntary Patients, 27-5-8, 27-7-1, 27-7-2, and 27-7-3

16.13.1. Discharge After Periodic Review, 27-5-8 - Whenever it is determined by the chief medical officer of a mental health facility that the condition of an individual justifying admission or commitment no longer exists, the chief medical officer shall:

(a) Discharge the patient; and

(b) Immediately notify, in writing, the clerk of the court of record ordering the admission or commitment.

16.3.2. Discharge From Trial Visit, 27-7-2 - A patient involuntarily committed to a mental health facility who is on trial visit for a period exceeding one (1) year shall be discharged by notifying court of record ordering commitment.

16.13.3. Discharge of Escapees - A patient who elopes or escapes

from a state hospital not apprehended and not returned within one (1) year shall be discharged, but may be readmitted at any time upon being apprehended on the basis of his original commitment.

16.14. Appeals for Review by Involuntary Patients, 27-5-8

16.4.1. Review Board of Appeal - The director of the department of mental health shall appoint a state review board of appeal of three members, one of whom shall be a psychiatrist. Its powers and duties shall be:

(a) To review appeals of patients promptly;

(b) Review reports of examination and findings of the chief medical officers of mental health facilities relating to patient appeals;

(c) Review patient's total clinical record if indicated;

(d) Order a patient's continued hospitalization;

(e) Order a patient's discharge;

(f) Conduct reviews and report findings within seven (7) days of patient's appeal.

16.14.2. Appeal for Discharge

(a) If an individual is not discharged after he has been notified by the chief medical officer that his condition justifying admission or commitment to a mental health facility no longer exists, or that he does not need continued hospitalization, he may appeal to the chief medical officer for discharge;

(b) If within three (3) days the chief medical officer has not discharged patient, or has taken unfavorable action to his appeal for discharge, patient may appeal to the state review board of appeal;

(c) The chief medical officer or his designee shall assist a patient

in making an appeal to the state review board of appeal and provide the board with a report which shall include:

(1) Date and time of last examination;

(2) Symptoms of mental illness, mental retardation or addiction still in evidence;

(3) Findings and conclusions of the last psychiatric examination and review of patient's condition;

(4) Facts underlying or reason(s) for the belief of imminent harm to himself of others if released;

(d) The chief medical officer shall provide a copy of patient's complete clinical record to the state review board of appeal upon request;

(e) If within seven (7) days the review board of appeal takes no action, or takes unfavorable action, against the patient's appeal, the patient shall be assisted in making appeal to the circuit court of county of residence or county where hospitalized.

16.14.3. Appeal for Discharge to Court

(a) If a patient appeals for discharge to the chief medical officer of a mental health facility who takes no action or takes action against appeal; and

(b) Patient further appeals to the state review board of appeals which takes no action or refuses to order discharge; then

(c) Patient shall be assisted, if he so desires, to appeal for review for discharge to the circuit court of his county or residence or county where hospitalized.

Section 17. Involuntary Hospitalization for Persons Under Criminal Juris-

diction

17.1. Examination of Persons Under Criminal Jurisdiction

17.1.1. Examinations to Ascertain Competency to Stand Trial, 27-6A-1(a)

(a) Whenever a court orders an examination to determine competency to stand trial and/or criminal responsibility, the examination shall be conducted where possible by personnel from the community mental health facility designed for the area by the director of mental health;

(b) Examinations to determine competency to stand trial and/or criminal responsibility shall be conducted by one or more psychiatrists, or a psychiatrist and psychologist who may jointly examine the individual, but must make separate, independent and signed evaluations of the individual's condition;

(c) If the appropriate professional staff for the examination is not available in the community mental health facility, the examination may be conducted by the professional staff members of the state hospital designated for the area by the director of the department of mental health;

(d) The examination for any such person shall be completed within forty-eight (48) hours of the time the individual is brought to the mental health facility for such examination;

(e) The individual's counsel shall be notified of the time of the examination and shall be entitled to be present if he is able to attend at the scheduled time.

17.1.2. Observation Period, 27-6A-1(b)

(a) After an examination to determine competency to stand trial, if

the court orders an individual to be admitted to a state hospital or a local mental health facility for a twenty (20) day observation period, the individual shall be sent to a state hospital or local mental health facility designated by the director of the department of mental health for further examination and observation in order to determine whether mental illness, mental retardation, or addiction have so affected a person that he is not competent to stand trial; and

(b) If before the expiration of such twenty (20) day period the examining physician believes that observation for more than twenty (20) days is necessary, he shall make a written request to the court of record for an extension of the twenty (20) day period not to exceed an additional twenty (20) days, specifying the reason or reasons for which such further observation is necessary.

17.1.3. Content of Report of Examination - At the end of each examination or observation period, and any other time a report is required under Article 6A of Chapter 27, the examining psychiatrist or psychologist shall give the court of record a report.

(a) Report of examination to determine competency to stand trial shall contain:

(1) A statement as to whether or not the individual is in need of care and treatment;

(2) Whether individual has sufficient present ability to consult with a lawyer with a reasonable degree of rational and factual understanding of the proceedings against him;

(3) An opinion as to competency to stand trial; and

(4) Clinical facts to support such opinions.

(b) Report of examination to determine criminal responsibility shall contain:

(1) A statement as to whether or not the individual is in need of care and treatment;

(2) Whether or not the individual at time of alleged criminal conduct as a result of mental illness, mental retardation, or addiction lacked the substantial capacity to:

a. Appreciate the wrongfulness of his conduct; or

b. Conform his conduct to the requirements of the law.

(3) Clinical facts to support such opinions.

7.1.4. Improvement Period Orders by Court, 27-6A-2(b)

(a) If there is substantial likelihood that an individual will attain competency within the next ensuing six (6) months, and the court orders a six (6) month improvement period; and

(b) If in the opinion of the chief medical officer of the mental health facility, additional time is needed to attain competency, he shall make written request to court of record for an extension, not to exceed an additional three (3) months, specifying the reason or reasons such further observation is necessary.

17.1.5. Civil Commitment for Persons Incompetent to Stand Trial, 27-6A-2(c) - If an individual ordered to a mental health facility for examination or observation is found to be incompetent to stand trial with no substantial likelihood of obtaining competency and the criminal charges are dismissed, the chief medical officer of the mental health facility shall within five (5)

days after the case is dismissed file application for involuntary hospitalization as provided in Section 4, Article 5, Chapter 27, Code of West Virginia, 1931, as amended.

17.1.6. Periodic Review of Persons Found Incompetent to Stand Trial, 27-6A-5

(a) Each individual admitted to a mental health facility for periods of observation or for improvement periods shall be examined as frequently as the chief medical officer of the mental health facility considers desirable, but intervals between examinations shall not exceed three (3) months;

(b) Each periodic review shall include a clinical opinion with regard to the person's competence to stand trial which is made a part of the individual's medical record;

(c) If an individual previously found incompetent to stand trial is later determined to be competent within the observation period or improvement period, a report shall be made promptly to the director of the department of mental health for required notification to the court of record.

17.1.7. Content of Post-Conviction Examination or Observation Periods, 27-6A-1(e) - If the court orders the pre-sentence examination or observation period after conviction and prior to sentencing (not to exceed forty days), the chief medical officer shall at the conclusion thereof make a report to the court in writing which shall include:

(a) The individual's mental illness, mental retardation, or addiction;

(b) The individual's dangerousness to self or others;

(c) The individual's need for treatment; and

(d) The underlying facts upon which each of the above opinions is based.

17.1.8. Comunication of Intention to Discharge, 27-6A-4 - An individual who is committed to a state hospital or other mental health facility under the second (2nd) paragraph of Code 27-6A-1(c), whose condition justifying hospitalization no longer exists, may be discharged by the physician in charge. The following procedures shall be followed:

(a) Prior to discharge, the physician in charge shall communicate his intention to discharge patient to the committing court, and to the prosecuting attorney of the county within which the alleged crime occurred by certified mail return receipt requested;

(b) If within twenty (20) days after receipt of such communication, the committing court makes no written objection to the discharge, the physician in charge may discharge the patient;

(c) In the event of a written objection within the twenty (20) days waiting period by the committing court, unless a hearing is held within ten (10) days and commitment procedures initiated pursuant to Chapter 27-5-4, Code of West Virginia, 1931, as amended, the chief medical officer of the mental health facility shall discharge the patient;

(d) If following an objection, the court orders the commitment of an individual pursuant to Code 27-5-4 the commitment shall in all respects be treated as an involuntary commitment pursuant to said section, including the discharge and release provisions contained in Article 7 of Chapter 27, and the accompanying regulations.

17.1.9. Examinations or Observation Periods for Juveniles,

27-6A-1(f) - Whenever a juvenile court orders a psychiatric examination or period of observation for an alleged delinquent or neglected juvenile in a mental health facility, the procedures for such examinations and observations shall be the same as those set forth in Chapter 27, Article 6A, Sections 1(a), (b), and (c) and shall not exceed forty (40) days.

17.1.10. Patient's Rights - Individuals committed to mental health facilities under Article 6A, Chapter 27, shall have the same rights, treatment, and privileges as all other patients and persons as set forth in Section 8 of these regulations, and otherwise except as otherwise specifically provided by law.