Chapter 11 Addendum A

Standards For Psychiatric Partial Hospitalization Programs (PHPs)

1.0 ORGANIZATION AND ADMINISTRATION

1.1 Definition

Partial hospitalization is a time-limited, ambulatory, active treatment that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic milieu. Psychiatric Partial Hospitalization Programs (PHPs) may be either freestanding or part of a broader mental health or medical system. Nevertheless, a partial hospital should be conceived as a separate, identifiable, organized unit.

PHPs serve patients who exhibit psychiatric symptoms, disturbances of conduct, and decompensating conditions affecting their mental health. The emotional/behavioral problems exhibited must be manageable outside an inpatient environment. Patients suitable for partial hospitalization should present no imminent harm to themselves or others; have a community based network of support; and have a consistent place of residence.

A PHP is capable of providing an interdisciplinary program of medical and therapeutic services a minimum of three hours per day, five days per week. Full-day, half-day, evening, and weekend programs may be included. Coordinated, intensive comprehensive treatment is provided. A PHP may be appropriate for crisis stabilization and transition from an inpatient program when medically necessary.

Crisis management is available 24 hours a day, seven days a week. PHPs have a written agreement with at least one authorized hospital to provide emergency mental health and medical/surgical care.

1.2 Eligibility

1.2.1 To be eligible for certification, the facility is required to be licensed and fully operational for a period of at least six months, with a minimum patient census of at least 30% of bed capacity.

1.2.2 The facility is currently accredited by the Joint Commission under the current edition of the **Manual for Mental Health, Chemical Dependency, and Mental Retardation/ Developmental Disabilities Services**.

1.2.3 The facility has a written participation agreement with TRICARE Management Activity (TMA). The PHP is not an authorized provider and benefits are not paid for services provided until the date upon which a participation agreement is signed by the Deputy Director, TMA, or a designee. Retroactive approval is not given.

1.2.4 Where different certification, accreditation, or licensing standards exist, the more exacting standard applies. Regulations take precedence over standards and standards take precedence over participation agreements.

1.3 Governing Body

1.3.1 A governing body is responsible for the policies, bylaws, and activities of the facility. If the PHP is owned by a partnership or single owner, the partners or single owner is regarded as the governing body.

1.3.2 The governing body or Chief Executive Officer (CEO) provides written notification to TMA of any significant changes in: CEO; medical director or clinical director; purpose or philosophy; volume of services; licensure, certification, or accreditation status by a state, local agency, or national organization; and location. The written notice must be submitted 30 days prior to the proposed changes.

1.3.3 The governing body provides leadership and sufficient resources to ensure that appropriate and adequate services are delivered to all patients. To accomplish this, the governing body:

1.3.3.1 Specifies the qualifications, authority, and responsibilities of its members;

1.3.3.2 Establishes bylaws, rules, regulations, policies, and procedures in accordance with legal requirements and standards;

1.3.3.3 Conducts regular meetings and maintains minutes of all deliberations and actions;

1.3.3.4 Conducts business based upon its rules, regulations, and defined responsibilities;

1.3.3.5 Establishes a mission statement that provides the basis for strategic planning;

1.3.3.6 Adopts a plan of operation consistent with the mission statement with goals and objectives that reflect the long-range direction of the facility;

1.3.3.7 Appoints a CEO to implement policies and procedures and oversee the day-to-day operation of the facility;

1.3.3.8 Appoints a medical director to oversee the medical care provided in the facility and a clinical director to oversee the clinical program;

1.3.3.9 Authorizes the establishment of a medical or professional staff organization to oversee and direct patient care services;

1.3.3.10 Establishes bylaws, rules, and regulations to govern the activities of the medical or professional staff organization;

1.3.3.11 Ensures that sufficient clinical staff are available to provide necessary and appropriate patient care services;

1.3.3.12 Ensures that sufficient administrative and support staff are available to maintain the administrative, health, and safety aspects of the facility;

1.3.3.13 Oversees the system of financial management and accountability;

1.3.3.14 Ensures that the physical, financial, and staffing resources of the facility are adequately insured;

1.3.3.15 Approves the initiation, expansion, or modification of programs, services, and resources; and

1.3.3.16 Evaluates the performance of the CEO, clinical director and medical director on an annual basis, using specific performance criteria.

1.3.4 The governing body is responsible for the continuing development and improvement of patient care. The governing body:

1.3.4.1 Reviews, and as necessary, revises and updates the plan of operation on at least an annual basis;

1.3.4.2 Approves all policy changes for the facility as documented in the minutes of the governing body meetings;

1.3.4.3 Appoints members to the medical or professional staff and grants clinical privileges on the basis of verified expertise and practice;

1.3.4.4 Reappoints medical or professional staff and renews clinical privileges on the basis of continued competence, adherence to staff rules and regulations, and quality-of-care reviews;

1.3.4.5 Approves a system to ensure that direct care staff are supervised by a qualified health care professional;

1.3.4.6 Approves a system of quality assessment and improvement which evaluates the efficiency, appropriateness, and effectiveness of programs and services provided;

1.3.4.7 Approves admission criteria that clearly confirm the medical and/or psychological necessity for treatment at the partial hospitalization level of care;

1.3.4.8 Reviews reports from various evaluation activities to determine that identified problems are appropriately addressed and that care is improved;

1.3.4.9 Ensures that the facility maintains continued compliance with state-licensing regulations and national accreditation standards; and

1.3.4.10 Establishes an organizational structure to facilitate communication between the CEO, clinical director, medical director, administrative staff, medical or professional staff, and the governing body.

1.3.5 If a business relationship exists between a governing body member and the facility, a conflict-of-interest policy defines the member's authority, responsibilities, and restrictions.

1.3.6 Orientation and continuing-education programs are provided to members of the governing body to enhance their awareness of the facility and its services.

1.3.7 The governing body conducts an annual review of its documented performance in meeting its purposes, responsibilities, goals, and objectives.

1.4 Chief Executive Officer (CEO)

1.4.1 The CEO is appointed by the governing body and meets the following minimum qualifications:

1.4.1.1 Has a master's degree in business administration, public health, hospital administration, behavioral science, or health care; or

1.4.1.2 Meets similar educational requirements prescribed by TMA; and

1.4.1.3 Has five years of administrative experience in the field of mental health.

1.4.2 The CEO assumes overall administrative responsibility for the operation of the facility according to governing body policies.

1.4.3 The CEO plans, develops, and implements programs and services, recruits and directs staff, and ensures the appropriate utilization of resources. The CEO:

1.4.3.1 Implements an organizational structure that facilitates communication, delineates responsibility, and specifies lines of clinical and administrative supervision;

1.4.3.2 Prepares a manual of policies and procedures which is reviewed annually and revised as necessary;

1.4.3.3 Develops a strategic plan that specifies long- and short-term goals and objectives. The plan is evaluated annually and the results reported to the governing body;

1.4.3.4 Ensures the development of an effective evaluation program to analyze and report patterns and trends in clinical performance and service delivery; and

1.4.3.5 Prepares detailed reports for the governing body regarding the facility's operations and pertinent findings related to the quality of patient care.

1.4.4 The CEO, along with the medical director and clinical director, establishes a plan of operation that is approved by the governing body, reviewed annually, and revised as necessary. The plan provides an overview of service delivery and differentiates between adolescent and adult programs. The plan describes the:

1.4.4.1 Theoretical orientation of the PHP;

1.4.4.2 Clinical characteristics of the population served;

1.4.4.3 Admission, continued-stay, and discharge criteria;

1.4.4.4 Process for determining the eligibility and medical necessity for admission;

1.4.4.5 Interdisciplinary treatment planning, review, and revision processes;

1.4.4.6 Specific services provided;

1.4.4.7 Therapeutic modalities offered;

1.4.4.8 Outside resources providing services that are not available within the facility;

1.4.4.9 Qualifications of staff for each service and therapeutic modality;

1.4.4.10 Responsibilities of each professional discipline and their relationships with each other;

1.4.4.11 Supervision provided to staff who are not eligible to practice independently;

1.4.4.12 Methods to involve family members; and

1.4.4.13 Processes for transition, discharge, and follow-up care.

1.5 Clinical Director

1.5.1 The clinical director is appointed by the governing body and meets the following qualifications:

1.5.1.1 Is a psychiatrist or doctoral level clinical psychologist who meets applicable requirements for individual professional providers and is licensed to practice in the state where the facility is located; and

1.5.1.2 Possesses requisite experience, credentials applicable under state practice and licensing laws appropriate to the professional discipline; and

1.5.1.3 Has a minimum of five years' clinical experience in the treatment of mental disorders specific to the ages and disabilities of the population served.

1.5.2 The clinical director is responsible for:

1.5.2.1 Overseeing the clinical program;

1.5.2.2 Participating in the planning, development, and implementation of programs and services;

1.5.2.3 Serving as a liaison to the medical or professional staff to ensure that matters of clinical importance are conveyed to the CEO and the governing body;

1.5.2.4 Developing, in conjunction with the medical director, medical and professional staff, the behavior management plan;

1.5.2.5 Submitting regular reports to the governing body about clinical affairs, including unusual occurrences;

1.5.2.6 Developing and implementing a peer review system that monitors professional practice; and

1.5.2.7 Developing, in consultation with the medical director, medical and professional staff, an effective quality assessment and improvement program.

1.6 Medical Director

1.6.1 The medical director is appointed by the governing body and meets the following qualifications:

1.6.1.1 Is a graduate of an accredited school of medicine or osteopathy who is licensed to practice medicine in the state where the facility is located; and

1.6.1.2 Has completed an approved residency in psychiatry and has a minimum of five years' clinical experience in treating mental disorders specific to the ages and disabilities of the population served.

1.6.2 The medical director is responsible for:

1.6.2.1 Overseeing all the medical care provided;

1.6.2.2 Participating in the planning, development, and implementation of programs and services;

1.6.2.3 Serving as a liaison to the medical or professional staff to ensure that matters of medical importance are conveyed to the CEO and the governing body;

1.6.2.4 Developing, in conjunction with the clinical director, medical and professional staff, the behavior management plan;

1.6.2.5 Submitting regular reports to the governing body about medical affairs, including unusual occurrences;

1.6.2.6 Developing and implementing a peer review system that monitors professional practice; and

1.6.2.7 Developing, in consultation with the clinical director, medical and professional staff, an effective quality assessment and improvement program.

1.6.3 If qualified, the medical director may also serve as the clinical director.

1.7 Medical or Professional Staff Organization

1.7.1 The medical or professional staff organization is established by the governing body. The organized staff is accountable for patient care and is responsible for:

1.7.1.1 Making recommendations to the governing body concerning appointments and reappointments to the medical or professional staff;

1.7.1.2 Determining the specific clinical privileges that may be granted and the training and experience required for each;

1.7.1.3 Defining clinical privileges based upon the services provided and the ages, disabilities, and clinical needs of the patients served; e.g., specialty groups for trauma victims;

1.7.1.4 Maintaining rules and regulations that support the goals and objectives of the PHP;

1.7.1.5 Ensuring the ethical conduct of individual staff members;

1.7.1.6 Establishing position requirements and verifying the qualifications of all staff providing direct patient care;

1.7.1.7 Implementing a system to evaluate the performance and current competence of its members; and

1.7.1.8 Overseeing the patient care responsibilities of staff who are not members of the medical or professional staff.

1.8 Personnel Policies and Records

1.8.1 The facility maintains written personnel policies, updated job descriptions, and comprehensive personnel records.

1.8.2 Job descriptions for full-time, part-time and contracted employees are criteria-based and clearly contain:

1.8.2.1 Position title, required education and training, prior work experience, and other qualifications;

1.8.2.2 lines of supervision, responsibility, authority, and communication;

1.8.2.3 Duties and responsibilities corresponding to education, training, and experience; and

1.8.2.4 Annual performance appraisals with objective evaluation criteria, ratings, and comments.

1.8.3 Individual personnel records contain:

1.8.3.1 Application for employment;

1.8.3.2 Verification of the qualifications for the position;

1.8.3.3 Criteria-based job description;

1.8.3.4 Pre-employment reference checks;

1.8.3.5 Signed acknowledgment that the employee understands policies on patient abuse and neglect and confidentiality;

1.8.3.6 Pre-employment health examinations to ensure that all employees are able, physically and mentally, to perform their duties;

1.8.3.7 Annual performance appraisals;

1.8.3.8 Documented attendance at educational and training programs, including orientation and in-service courses;

1.8.3.9 Any complaints, allegations, inquiries or findings of patient abuse or neglect; and

1.8.3.10 Warnings or disciplinary actions.

1.9 Staff Development

1.9.1 The facility provides appropriate training and development programs for administrative, professional, support, and direct care staff.

1.9.1.1 Orientation and training programs are relevant to the care and treatment of PHP patients. The programs are specific to the skills, responsibilities, and duties of the staff.

1.9.1.2 Instruction in life safety, disaster planning, and fire safety including the proper use of fire extinguishers, is provided at orientation and annually thereafter.

1.9.1.3 Instruction in cardiopulmonary resuscitation is required to maintain current certification.

1.9.1.4 All direct care staff receive relevant in-service education in emergency first aid, human growth and development, behavioral management, clinical observation, and clinical record documentation.

1.9.1.5 Staff training and development activities are provided by individuals who are qualified by education, training, and experience.

1.9.1.6 Staff training and development programs are influenced by the results of evaluation activities and are documented on a regular basis.

1.10 Fiscal Accountability

1.10.1 The facility maintains complete and accurate financial records of income and disbursements which are open to inspection upon reasonable notice by the United States Government or its authorized agents. The facility:

1.10.1.1 Has a schedule of public rates and charges for all services provided, and makes this available to all referral sources and families;

1.10.1.2 Has an independent audit performed at least annually; and

1.10.1.3 Maintains insurance coverage on all buildings, equipment, physical resources, and vehicles. Adequate comprehensive liability insurance protects patients, staff, and visitors.

1.11 Designated Teaching Facilities

1.11.1 Students, residents, interns, or fellows providing direct clinical care are under the supervision of a qualified staff member approved by an accredited university or medical school.

1.11.2 The teaching program is approved by the Deputy Director, TMA or a designee. To be an approved teaching program the facility has:

1.11.2.1 A written contract or letter of agreement between the accredited university and the governing body. The contract or letter of agreement designates:

1.11.2.1.1 The qualified health care professional providing supervision;

1.11.2.1.2 The nature and extent of supervision required; and

1.11.2.1.3 The supervisor's medical and legal responsibilities for all clinical care provided by the student, resident, intern, or fellow.

1.11.2.2 A description of the training program within the plan of operation, specifying the assignments, supervision, and documentation required;

1.11.2.3 A medical or professional staff organization to recommend the privileges granted, under supervision, to students, interns, residents, or fellows; and

1.11.2.4 A medical director or clinical director as appropriate to oversee the training program and provide regular reports to the governing body.

1.12 Emergency Reports and Records

1.12.1 The facility notifies TMA of any serious occurrence involving beneficiaries.

1.12.1.1 Reportable occurrences include life-threatening accidents, a patient death, patient disappearances, suicide attempts, cruel or abusive treatment, physical or sexual abuse, or any equally dangerous situation.

1.12.1.2 The occurrence is reported by telephone to the Deputy Director, TMA or a designee, on the next business day; a full written account is sent within seven days.

1.12.1.3 The occurrence and contact with TMA are documented in the patient's clinical record.

1.12.1.4 Notification is provided to the next of kin or legal guardian and, if required by state or commonwealth law, the appropriate legal authorities.

1.12.2 Any disaster or emergency situation, natural or man made, such as fire or severe weather, is reported by telephone within 72 hours, followed by a written report within seven days, to TMA.

1.12.3 All of the facility financial and clinical records are available for review by TMA during announced or unannounced on-site reviews and inspections. The on-site review includes an examination of any clinical records, regardless of the source of payment.

2.0 TREATMENT SERVICES

2.1 Staff Composition

2.1.1 A written plan defines the number and composition of staff required to meet the medical and clinical needs of patients.

2.1.1.1 Staffing patterns are based upon the characteristics and special needs of the population served, the patient census, and the type(s) and intensity of services required.

2.1.1.2 Sufficient full-time professional staff provide clinical assessments, active therapeutic interventions, and ongoing program evaluation.

2.1.1.3 All clinicians providing individual, group, and family therapy meet requirements for professional providers of care, and operate within the scope of their license.

2.1.1.4 A professional staff member is on-site during service hours to supervise and direct the milieu.

2.1.1.5 To meet the medical and clinical needs of patients, professional staff coverage is provided during service hours.

2.1.1.5.1 Physicians are available during service hours to respond to medical and psychiatric problems.

2.1.1.5.2 A Registered Nurse (RN) is on duty during service hours to provide psychiatric nursing care.

2.1.1.5.3 RNs and other treatment staff are assigned depending upon the number, location, and acuity level of the patients.

2.1.1.5.4 Medical and professional consultation and supervision are readily available during service hours.

2.1.1.5.5 The facility maintains liaison relationships with other psychiatric and human service providers for emergency services.

2.1.1.6 The management of medical care is vested in a physician.

2.1.1.6.1 A physician or psychologist member on active duty in the military medical corps or United States Public Health Services does not meet the compliance requirement.

2.1.1.6.2 A resident, intern, or fellow does not meet the compliance requirement.

2.1.1.7 Professionals who perform assessments and/or treat children and adolescents understand human growth and development and can identify age-related treatment needs.

2.1.1.8 The qualifications, training, and experience necessary to assume specific clinical responsibilities are specified in writing and verified prior to employment.

2.2 Staff Qualifications

2.2.1 Within the scope of its programs and services, the facility has a sufficient number of professional, administrative, and support staff to address the medical and clinical needs of patients and to coordinate the services provided.

2.2.1.1 Qualified mental health providers meet state licensure, registration, or certification requirements.

2.2.1.2 PHP staff meet the following educational and experience requirements:

2.2.1.2.1 A physician, other than a psychiatrist, has a medical or osteopathic degree from an accredited university, and is licensed by the state in which he/she is practicing;

2.2.1.2.2 A psychiatrist has a medical or osteopathic degree from an accredited university, is licensed by the state, and has completed an approved psychiatric residency;

2.2.1.2.3 A psychologist has a doctoral degree from an accredited university, and has two years of clinically supervised experience in psychological health services, with one year postdoctoral and one year in an organized psychological services program;

2.2.1.2.4 A Certified Psychiatric Nurse Specialist (CPNS) has a master's degree from an accredited school of nursing with a specialty in psychiatric or mental health nursing, or addiction treatment. The nurse has two years of post-master's degree practice in the field of psychiatric or mental health nursing;

2.2.1.2.5 A social worker has a master's degree in social work from a graduate school accredited by the Council on Social Work Education, and has two years of post-master's degree, supervised clinical social work practice;

2.2.1.2.6 A staff nurse has a minimum of a diploma or an associate degree in nursing, and is licensed by the state in which he/she is practicing;

2.2.1.2.7 A professional counselor, marriage and family counselor, or pastoral counselor has a master's degree in mental health or behavioral sciences from an accredited university, has two years of supervised, post-master's degree practice;

2.2.1.2.8 An occupational therapist, recreational therapist, or expressive art therapist has at least a bachelor's degree from an accredited college or university, is nationally registered or certified, and is licensed or certified in his/her respective field when this is offered or required by the state where the facility is located;

2.2.1.2.9 A teacher has a bachelor's degree from an accredited university and is certified as a teacher in the respective state;

2.2.1.2.10 An addiction therapist has a master's degree in mental health or behavioral sciences from an accredited university, three years of experience in alcohol and/or drug abuse counseling;

2.2.1.2.11 An addiction counselor has a bachelor's degree from an accredited university, five years of experience in alcohol and/or drug abuse counseling, and is supervised at least weekly by a qualified member of the professional staff; and

2.2.1.2.12 Direct service staff, e.g., patient care assistants, have at least a high school diploma or equivalent. These staff offer support and assistance to patients but do not provide therapy, e.g., individual, family, couples, or group. They receive documented supervision from qualified health care professionals.

2.2.2 PHPs that employ master's or doctoral level mental health staff who are not qualified mental health providers must have a supervision program to oversee and monitor their provision of clinical care.

2.2.2.1 All care provided is the responsibility of a licensed or certified mental health professional, as previously defined in this section.

2.2.2.2 To provide services, non-licensed clinicians:

2.2.2.2.1 Have a master's or doctoral degree from an accredited university;

2.2.2.2.2 Practice under a licensed or certified mental health professional for up to two years during which time the non-licensed clinician is actively working toward licensure or certification.

2.2.2.2.3 Meet the credential requirements of the facility to provide clinical services.

2.2.2.3 Supervision provided to non-licensed clinicians is specified in writing and meets the following requirements:

2.2.2.3.1 The supervisor is employed by the facility and provides clinical supervision only in privileged areas;

2.2.2.3.2 The supervisor meets at least weekly on an individual basis with the supervisee and provides additional on-site supervision as needed;

2.2.2.3.3 Supervisory sessions are regularly documented by the supervisor;

2.2.2.3.4 Clinical documentation meets medical records and quality assessment and improvement standards; and

2.2.2.3.5 All clinical entries by the supervisee are reviewed and countersigned by the supervisor.

2.3 Patient Rights

2.3.1 The facility protects all individual patient rights, including civil rights, under applicable federal and state laws.

2.3.1.1 Policies and procedures clearly describe the rights of the patients and the facility's methods to guarantee these rights.

2.3.1.2 Patients and families are informed of their rights in language that they understand.

2.3.1.3 All patients are treated with dignity and respect, and are afforded full protection of their basic personal and privacy rights.

2.3.1.4 The facility maintains a safe environment; patients are protected from physical or emotional harm by other patients, staff, and visitors.

2.3.1.5 The facility protects the right of confidentiality for all patients, their families, and significant others. Personal pictures, video tapes, or audio recordings are not obtained without written consent.

2.3.1.6 Informed consent is obtained from the patient, family, or legal guardian authorizing emergency medical care, including surgical procedures.

2.3.1.7 If the patient is a minor, the parents or guardians are informed of the patients treatment progress at regular intervals.

2.3.1.8 The patient, family, or significant others have the right to present complaints or grievances about the facility or the care received. The facility has procedures for responding to these complaints.

2.3.1.9 The patient and family, when appropriate, are provided with written descriptions of the principles, methods, and interventions used in behavior management.

2.3.1.10 When food services are provided, patients receive adequate and nutritious meals with accommodations for special diets, and are not denied food as a method of behavioral management.

2.3.1.11 The patient and family, when appropriate, receive education regarding all medications prescribed, including benefits, side effects, and risks.

2.3.1.11.1 Patients have the right to refuse treatment and medications. If a patient or family refuses treatment, the facility makes documented, reasonable efforts to understand the issues involved and resolve the conflict. If the conflict cannot be resolved, the facility:

2.3.1.11.1.1 terminates treatment on reasonable notification of patient, family, or legal guardian; or

2.3.1.11.1.2 seeks legal alternatives to ensure that the patient's safety and treatment needs are met.

2.3.1.12 Any research involving beneficiaries has prior approval and complies with the regulations protecting human subjects of the Department of Health and Human Services (45 CFR Part 46).

2.3.2 The facility has a written policy regarding patient abuse and neglect.

2.3.2.1 All facility staff, patients, and families as appropriate, are informed of the policy.

2.3.2.2 All incidents of suspected abuse and neglect are reported promptly to the appropriate state agencies.

2.3.3 Facility marketing and advertising meets professional standards.

2.4 Behavior Management

2.4.1 Behavior management is based on a comprehensive, written plan that describes a full range of interventions utilizing positive reinforcement methods and clear implementation guidelines.

2.4.2 Policies and procedures for behavior management are developed by the medical director, the clinical director and medical/professional staff and approved by the governing body. They are implemented on the basis of the following considerations:

2.4.2.1 Behavior management is individualized to ensure appropriate consideration of the patient's developmental level, psychological state, cognitive capacity, and other clinically relevant factors;

2.4.2.2 Time-out is a brief, voluntary separation from program, activities, or other patients, and is initiated by the patient or at the request of staff to help the patient regain self-control;

2.4.2.3 Physical holding is a brief, involuntary procedure initiated by the staff to enable a patient to regain self-control; and

2.4.2.4 Restraint or seclusion are considered extraordinary interventions to be used only by professional staff in an emergency.

2.4.2.4.1 Such interventions imply a severity of dysfunction and the need for a level of care beyond the scope of a facility.

2.4.2.4.2 A physician's order is obtained within the hour and the patient is assessed for transfer to an appropriate level of care.

2.5 Admission Process

2.5.1 The admission process helps the patient to fully use the medical, clinical, and program services of the facility. The patient, family and significant others as appropriate, are familiarized

with the treatment program and how the PHP services address patient capabilities and medical/ clinical needs.

2.5.1.1 Preadmission information is obtained to evaluate the medical and/or psychological necessity for admission. Recent psychiatric, psychological, and psychosocial evaluations are reviewed.

2.5.1.2 Written admission criteria describe the clinical circumstances under which admission to partial hospitalization is considered appropriate:

2.5.1.2.1 The patient is in need of crisis stabilization and treatment of partial stabilized mental health disorders;

2.5.1.2.2 The patient exhibits psychiatric symptoms that cause significant impairment in day-to-day social, vocational, and/or educational functioning;

2.5.1.2.3 The patient is able to exhibit adequate control over his/her behavior and is judged not to be immediately dangerous to self or others;

2.5.1.2.4 The patient has established social supports that help to maintain him/her in the least restrictive environment;

2.5.1.2.5 The patient has the physical and intellectual capacity to actively participate in all aspects of the therapeutic program;

2.5.1.2.6 The patient has not made sufficient clinical gains within an outpatient setting, or the severity of his/her presenting symptoms is such that success in outpatient treatment is doubtful; or

2.5.1.2.7 The patient is ready for discharge from an inpatient setting, but is assessed as needing daily monitoring, support, and ongoing therapeutic interventions.

2.5.1.3 A qualified mental health professional, who meets requirements for individual professional providers and who is permitted by law and by the facility to refer patients for admission, shall render medical and/or psychological necessity determinations for admission.

2.5.1.4 The facility accepts only those patients who meet the conditions outlined in the admission criteria, and for whom the facility has an operational program.

2.5.1.5 The facility observes and maintains compliance with the conditions of licensure under which it operates, including age, sex, type, and number of patients accepted.

2.5.1.6 No one is denied admission on the basis of race, religion, national origin, or sexual orientation.

2.5.1.7 Patients and families who are not accepted for treatment are provided with alternative recommendations and referrals as needed.

2.5.1.7.1 Referral policies and procedures specify needs and services the facility cannot provide.

2.5.1.7.2 Referrals for examination, assessment, and consultation are discussed with the patient and/or family prior to admission.

2.5.1.8 During the admission process, the patient, family or significant others, when appropriate, are clearly apprised of the expectations for treatment and the services provided.

2.5.1.8.1 Written and signed documentation verifies that patients and family members understand the treatment that will be provided.

2.5.1.8.2 The policies and procedures for emergency medical and psychiatric care are explained, including transfer or referral and the means of transfer, e.g., family, facility staff, or ambulance service.

2.5.1.9 All admissions are preauthorized by TMA.

2.6 Assessments

2.6.1 Professional staff are responsible for current assessments of all patients. Consideration is given to the fundamental clinical needs of patients including, but not limited to, their physical, psychological, social, developmental, family, educational, environmental, and recreational needs.

2.6.2 Assessments conducted within 30 days prior to admission may be used if reviewed and approved for treatment planning purposes by the responsible physician or doctoral level clinical psychologist.

2.6.2.1 A physical examination is completed by a qualified physician, qualified physician assistant, or nurse practitioner within 24 hours of admission. When the examination is conducted by a physician assistant or nurse practitioner, a physician must countersign. the physical examination includes: a complete medical history; a general physical examination; sensorimotor development and functioning; physical development; vision and hearing; immunization status; serology; urinalysis, and other routine laboratory studies as indicated; and a tuberculin test with results or a chest X-ray to rule out tuberculosis.

2.6.2.2 A mental health evaluation is completed by a qualified psychiatrist or doctoral level psychologist within 24 hours of admission. A mental health evaluation includes: reason for admission; present clinical presentation; psychosocial stressors related to the present illness; current potential risk to self or others; history of present illness; past psychiatric history; developmental assessment; presence or absence of physical disorders or conditions affecting the present illness; alcohol and drug history; the mental status examination. A diagnosis on all five axes is given, based on the current addition of the **Diagnostic and Statistical Manual of Mental Disorders** of the American Psychiatric Association.

2.6.2.3 A nursing assessment is completed by a registered nurse within 24 hours of admission. The nursing assessment documents a general history of patient and family health, and includes a history of current medications, allergies, pertinent medical problems requiring nursing attention, current risk and safety factors, nutritional patterns, immunization status, and sleep patterns.

2.6.2.4 A social history is completed by a qualified mental health professional prior to the development of the master treatment plan. The social history includes: present problems;

childhood and family history; current living situation; family dynamics and relationships; relationships with significant others; history of physical, sexual, and/or substance abuse; impact of any medical conditions on the patient; and the impact of financial, religious, ethnic, cultural, legal, and environmental influences upon the patient or family. The social history includes family goals and recommendations for family involvement in treatment.

2.6.2.5 A skills assessment is completed by a licensed or certified activity, occupational, or rehabilitation therapist prior to the development of the master treatment plan. The assessment includes activity patterns prior to admission, aptitudes and/or limitations, activities of daily living, perceptual-motor skills, sensory integration factors, cognitive skills, communication skills, social interaction skills, creative abilities, vocational skills, and impact of physical limitations.

2.6.2.6 A psychological evaluation, if clinically indicated, is completed by a doctoral level licensed clinical psychologist. The psychological evaluation includes a comprehensive clinical assessment and recommendations multidisciplinary treatment plan. Testing may include: intellectual, cognitive, and perceptual functioning; stressors and coping mechanisms; neuropsychological functioning; and personality assessment. Psychological testing completed within the past 12 months may be added to the patient's clinical record if reviewed and approved by the responsible physician or clinical psychologist.

2.6.2.7 For children and adolescent patients, an educational or vocational assessment is completed by a certified teacher. The educational assessment includes an evaluation of the patient's educational history, current classroom observations, achievement testing, and identification of learning disabilities and needs. If an educational assessment has been completed within the past 12 months, it may be added to the patient's record if reviewed and approved by the facility's director of education.

2.6.2.8 A comprehensive alcohol and drug history evaluation, if clinically indicated, is completed by a qualified addiction professional. The evaluation consists of a history of substance use, including the patient's past and current use of psychoactive substances, age of onset, the duration, methods, patterns, circumstances, and consequences of use, biopsychosocial antecedents and influences, family and peer substance use patterns, and the types of, and responses to, previous substance use treatment.

2.6.2.9 Additional assessments include legal, nutritional, neuropsychological, neurological, speech, hearing and language, and any others that may be clinically indicated.

2.7 Clinical Formulation

2.7.1 A clinical formulation is developed on all patients by a qualified mental health provider. The clinical formulation is reviewed and approved by the responsible physician or doctoral level licensed clinical psychologist. The clinical formulation is generally organized into a Descriptive Section including the nature, severity, and precipitant of the individual's mental health disorder; an Explanatory Section including the rationale for the development and maintenance of the symptoms and dysfunctional life patterns; and the Treatment-Prognostic Section serving as the explicit blueprint governing treatment interventions and prognosis. The clinical formulation:

2.7.1.1 Is completed prior to the development of the master treatment plan;

2.7.1.2 Incorporates significant clinical interpretations from each of the multidisciplinary assessments;

2.7.1.3 Identifies patient strengths and limitations, current psychosocial stressors, present level of functioning, developmental issues to be considered, degree of risk to self or others, and significant treatment issues;

2.7.1.4 Interrelates the assessment material and indicates the focus of treatment strategies;

2.7.1.5 Clearly describes the clinical problems to be addressed in treatment, including plans for discharge; and

2.7.1.6 Substantiates Axes I through V diagnoses, using the current **Diagnostic Statistical Manual of Mental Disorders** of the American Psychiatric Association.

2.8 Treatment Planning

2.8.1 A qualified mental health care professional shall be responsible for the development, implementation, supervision, and assessment of an individualized, interdisciplinary treatment plan.

2.8.1.1 A comprehensive treatment plan is completed by the seventh treatment day. The comprehensive plan:

2.8.1.1.1 Clearly articulates the clinical problems that are the focus of treatment;

2.8.1.1.2 Identifies individual treatment goals that correspond to each identified problem;

2.8.1.1.2.1 Goals and objectives are specific outcome statements based on the anticipated response to treatment.

2.8.1.1.2.2 Treatment goals and clinical needs are discussed with the patient and, in the case of adolescents, with the parent and/or legal guardian.

2.8.1.1.3 Identifies individualized and observable or measurable objectives that represent incremental progress toward attaining goals;

2.8.1.1.4 Describes strategies of treatment, responsible clinicians, and related interventions that address individual needs and assist the patient in achieving identified objectives and goals;

2.8.1.1.5 Includes specific, individualized discharge criteria, which identify essential goals and objectives to be met prior to termination of treatment;

2.8.1.1.6 Identifies needed services that are not provided directly by the facility; and

2.8.1.1.7 For children and adolescents, as well as for adult patients as appropriate, specific goals, objectives, and treatment strategies are developed for the family.

2.8.1.2 The treatment plan is reviewed at least every two weeks, or when major changes occur in treatment. The results of the treatment plan review are recorded in the clinical record.

2.9 Discharge and Transition Planning

2.9.1 Transition planning addresses anticipated patient needs at discharge. The planning involves: determining necessary modifications in the treatment plan, facilitating the termination of treatment, and identifying resources for maintaining therapeutic stability following discharge.

2.9.1.1 The patient's living situation, placement needs, ongoing treatment needs, and educational/vocational needs are assessed.

2.9.1.2 The treatment plan includes strategies to facilitate termination and transition to outpatient care.

2.9.1.3 Community and therapeutic resources are identified to help the patient and family to maintain therapeutic gains.

2.10 Clinical Documentation

2.10.1 Clinical records are maintained on each patient to plan care and treatment and to provide ongoing evaluation of the patient's progress in treatment.

2.10.2 All care provided to the patient is documented in the clinical record. Each clinical record contains all pertinent clinical information and at least the following:

2.10.2.1 Demographic data, including name, date of birth, sex, next of kin, occupation (in the case of children and adolescents, occupation of parents or legal guardian, school, grade) date of initial contact, legal status, religion, current home address, telephone number, referral source, and reason for referral;

2.10.2.2 Consent forms;

2.10.2.3 Pertinent legal documents;

2.10.2.4 Reports of all assessments and clinical formulations;

2.10.2.5 Treatment plans and treatment plan reassessments;

2.10.2.6 Consultation reports;

2.10.2.7 Laboratory reports;

2.10.2.8 Doctor's orders;

2.10.2.9 Progress notes; and

2.10.2.10a Discharge summary.

2.11 Progress Notes

2.11.1 Progress notes clearly document the course of treatment for the patient and family. The entries provide information for review, analysis, and modification of the treatment plan. Progress notes include:

2.11.1.1 A description of the interventions made by the provider in accordance with the treatment plan and the patient's response in measurable, observable and/or quantifiable behavioral terms;

2.11.1.2 Interpretations of the responses to treatment;

2.11.1.3 Justification, implementation, and interpretation of the effectiveness of interventions for behavior management;

2.11.1.4 Justification for changes in medication, and a description of any side effects and adverse reactions; and

2.11.1.5 Date and length of the therapy session.

2.11.2 At a minimum, the following assessments and documentation are required:

2.11.2.1 A weekly note by the responsible psychiatrist or doctoral level clinical psychologist and a monthly evaluation of the patient's response to all treatment provided;

2.11.2.2 A nursing note by a registered nurse evaluating the patient's progress every 10 visits;

2.11.2.3 Progress notes on individual and family therapy sessions, to be written within 48 hours of each session;

2.11.2.4 Weekly progress notes on group therapy, therapeutic activities, educational, vocational, and ancillary services;

2.11.2.5 A review of the interdisciplinary treatment plan at least every two weeks; and

2.11.2.6 A discharge summary completed within two weeks and signed by a qualified mental health provider.

2.12 Therapeutic Services

2.12.1 The facility provides therapeutic services that include, but are not limited to, clinical therapies, psychoeducational groups, focus groups, and therapeutic activities. Services are adapted to the ages, disabilities, individual developmental stages, and comprehensive levels of the patients.

2.12.2 All PHP patients are provided with individual, group, and family therapy as indicated in the treatment plan. These clinical therapies are provided by or under the supervision of qualified mental health professions practicing within the scope of their licenses and clinical privileges. Unless clinically contraindicated and waived by TMA or designee, each patient and family, when appropriate, participate at least weekly in family therapy with a qualified mental health provider.

2.12.3 The facility provides or makes arrangements for educational services that meet the special needs of children, adolescents, and adult patients.

2.12.3.1 When the facility provides educational services, the services:

2.12.3.1.1 Are provided by qualified and certified teachers;

2.12.3.1.2 Sustain the educational/ intellectual development and, when indicated provide remedial opportunities;

2.12.3.1.3 Integrate elements from the individual treatment plan and are coordinated with other services;

2.12.3.1.4 Are documented regularly in the clinical record; and

2.12.3.1.5 Are accredited or approved by a state agency. If the school program is not accredited as part of the local school system, the facility makes this clear in its policies, brochures, and applicant information.

2.12.3.2 When the facility does not provide educational services, it ensures that patients do no fall behind academically while receiving partial hospital treatment.

2.12.4 The facility offers a range of therapeutic activities which are provided by qualified activity therapy professionals.

2.12.4.1 The therapeutic activity services is supervised by a qualified activity therapy professional.

2.12.4.2 The facility provides the necessary resources to support therapeutic activities for both full-day and half-day programs.

2.13 Ancillary Services

2.13.1 Emergency Services

The facility has policies and procedures for emergency services that identify the facilities to be used and the staff qualified and responsible for assessing the situation and arranging transfers, when indicated.

2.13.1.1 The facility has a written agreement with at least one backup authorized hospital to accept patients for emergency mental health or medical/surgical care.

2.13.1.2 The facility has a written emergency transportation agreement with at least one ambulance company, which specifies the estimated time to reach each backup hospital.

2.13.1.3 Appropriate information is exchanged between the referring and receiving facilities.

2.13.1.4 In accordance with written policy and legal requirements, parents, legal guardians, or significant others are notified in an emergency.

2.13.2 Physical Health Services

The facility makes available during service hours, either directly or through contractual arrangement, the physical health services necessary for patient evaluation and treatment.

2.13.2.1 Physical health services include, but are not limited to: complete medical history and physical examinations; pathology and laboratory services; vision, hearing, and dental services; and radiology services.

2.13.2.2 Contractual agreements include a description of the services provided and the reporting requirements.

2.13.3 Pharmacy Services

When appropriate, the facility provides, or contracts for, all pharmacy services. Written policies and procedures govern the safe storage and administration of drugs and meet applicable federal, state, and local laws and regulations.

2.13.3.1 Monthly inspections are made of all drug storage areas, including emergency boxes, emergency carts, and stock medications.

2.13.3.2 Medication orders are written only by authorized physicians and are an integral part of the patient's treatment plan. Monitoring verifies effectiveness of the medicine.

2.13.3.3 Medications are administered by registered nurses or by licensed practical nurses supervised a physician or registered nurse. All medications administered are documented.

2.13.3.4 If the self-administration of medication is ordered, the administration of that medication is supervised and documented by qualified, licensed staff member.

2.13.3.5 The patient and family receive education regarding medications prescribed including the benefits, side effects, and risks.

2.13.3.6 When medications are prescribed in a manner that is not approved by the Food and Drug Administration, their use requires approval by the medical director and special justification in the clinical record.

2.13.3.7 A medication administration training program is provided for the nursing staff members authorized to administer drugs.

2.13.4 Dietary Services

The facility meets all applicable federal, state, and local rules and regulations regarding the safe storage, handling, preparation, and distribution of food.

2.13.4.1 Supplies are clearly labeled and nonfood supplies, including cleaning materials, are stored separately.

2.13.4.2 Food is protected from contamination and spoilage.

2.13.4.3 Food preparation areas, utensils, and equipment are thoroughly cleaned and sanitized after use.

2.13.4.4 All food items are stored above floor level in covered containers that are insect and vermin proof.

2.13.4.5 Perishable foods are stored at proper temperatures.

2.13.4.6 All reusable eating and drinking utensils are sanitized after use. Broken or chipped dishes, glasses, and cooking utensils are discarded.

2.13.4.7 Garbage is disposed of in a sanitary manner to prevent disease transmission.

2.13.4.8 Dining areas are attractive and clean, and the furnishings are in good repair.

3.0 PHYSICAL PLANT AND ENVIRONMENT

3.1 Physical Environment

3.1.1 The buildings and grounds of the facility are maintained, repaired, and cleaned so that they are not hazardous to the health and safety of patients, staff, and visitors.

3.1.1.1 All space, supplies, equipment, motor vehicles, and facilities, both within and outside the facility, meet applicable federal, state, and local requirements for safety, fire, health, and sanitation.

3.1.1.2 Equipment and furniture are of safe and sturdy construction and are not hazardous for patients and staff. Furniture is comfortable, attractive, and age appropriate.

3.1.1.3 The facility has sufficient staff to carry out preventive maintenance and regular housekeeping services.

3.1.1.4 Repairs to, or replacement of, broken items are made promptly.

3.1.1.5 Windows and doors used for ventilation are screened.

3.1.2 The physical environment is appropriate to the nature of the services provided and the patients served.

3.1.2.1 Adequate space is provided for patient activities.

3.1.2.2 Recreational areas and equipment are available to, and consistent with, the ages of the patients and their developmental and clinical needs.

3.1.3 Privacy is provided for personal hygiene.

3.1.3.1 All toilets have secured seats, are kept clean, are good working order, and have partitions and doors.

3.1.3.2 Bathrooms are thoroughly cleaned each day.

3.1.3.3 Good-quality mirrors are furnished in each bathroom.

3.1.4 A comprehensive smoking policy is established for patients, staff, and visitors.

3.2 Physical Plant Safety

3.2.1 The facility is of permanent construction and maintained in a manner that protects the lives and safety of patients, staff, and visitors.

3.2.2 The facility complies with all applicable building codes, fire, health and safety laws, ordinances, and regulations in the state in which it is located. Current inspection reports are retained for TMA review.

3.2.2.1 The fire inspection meets or exceeds the regulations set by the local fire marshal (as governed by local ordinances), and may never be less than those regulations set by the state fire marshal.

3.2.2.2 Buildings in which patients receive treatment are in compliance with the appropriate provisions of the **Life Safety Code of the National Fire Protection Association** or equivalent protection is provided and documented.

3.2.2.3 The health inspection meets or exceeds the regulations set by the local health ordinances (where applicable) but may never be less than those regulations set by the state health department.

3.2.2.4 Levels of lighting are maintained throughout the facility that are appropriate for the purpose of the designated area.

3.2.3 The number, type, capacity, and location of fire extinguishers and/or smoke detectors comply with all applicable local or state fire regulations. All staff are instructed in the use of fire extinguishers. Fire extinguishers are inspected and serviced as required.

3.2.4 All fire safety systems are kept in good operating condition. Fire safety systems are inspected regularly and records are kept on file. An electronic fire alarm system automatically notifies the fire department. If such a system is not available, an alternative method is implemented.

3.2.5 Regular safety inspections are conducted by a safety committee. The personnel responsible for safety evaluations receive appropriate training. Monthly safety inspections are documented and maintained on file.

3.2.6 Specific safety measures are provided for areas of the facility that present unusual hazards to patients, staff, or visitors. Special consideration is given to building and campus features that may cause harm such as “invisible glass doors” and recreation equipment. All stairways have handrails.

3.3 Disaster Planning

3.3.1 The facility has written plans and policies for taking care of casualties arising from internal and external disasters. The plans are rehearsed at least every six months.

3.3.2 The facility is prepared to handle internal and external disasters such as explosions, fires, or tornadoes. The plan incorporates evacuation procedures approved by qualified fire, safety, and other appropriate experts.

3.3.3 The plans for internal and external disasters include instructions on the use of alarm and smoke detection systems, methods of fire containment, plans for notifying appropriate personnel, and posted evacuation routes.

3.3.4 Disaster plans are made available to all facility personnel, and evacuation routes are posted in appropriate areas within the facility.

3.3.5 Records are maintained regarding the disaster training offered to employees.

3.3.6 Regular fire drills are conducted for each shift and on each patient unit. At least one drill is conducted monthly.

3.3.7 An evaluation of all drills concerning internal and external disasters is made at least every six months.

4.0 EVALUATION SYSTEM

4.1 Evaluation Activities

4.1.1 The facility has a written plan of evaluation to examine the overall quality of patient care and services. Evaluation activities include, but are not limited to, quality assessment and improvement, utilization review, patient records, drug utilization review, risk management, infection control, safety, and facility evaluation.

4.1.2 The system of evaluation meets guidelines set forth by accrediting bodies, such as the Joint Commission, and regulatory agencies of local, state, and federal government.

4.2 Quality Assessment and Improvement

4.2.1 The facility has a program that monitors the quality, appropriateness, and effectiveness of the care, treatment, and services provided for patients and their families.

4.2.2 Quality assessment and improvement activities include, but are not limited to, clinical peer review, outcome studies, incident reporting, and the attainment of programmatic, clinical, and administrative goals.

4.2.2.1 The evaluation system involves all of the disciplines, services, and programs of the facility, including administrative and support staff activities.

4.2.2.2 The evaluation system identifies opportunities for improving the effectiveness and efficiency of patient care.

4.2.3 The quality monitoring process uses explicit clinical indicators, i.e., well-defined, measurable variables related to the provision and outcome of patient care.

4.2.3.1 The clinical indicators identify high-volume, high-risk, and problem-prone areas of clinical practice.

4.2.3.2 The clinical indicators focus on structural, process, and outcome measures.

4.2.3.3 Each clinical indicator requires the establishment of a threshold to determine when a problem or opportunity to improve care exists.

4.2.4 The clinical director, in consultation with the medical director and professional staff organization, is responsible for developing and implementing quality assessment and improvement activities throughout the facility. A similar methodology is applied to services, departments, disciplines, programs, and patient populations.

4.3 Utilization Review

4.3.1 Utilization review process will be pursuant to a written plan.

4.3.2 Utilization review activities include, but are not limited to, concurrent and retrospective studies examining the distribution of services as well as the clinical necessity of treatment.

4.3.3 The utilization review process identifies the appropriateness of admission, continued stay, and timeliness of discharge as part of the effort to provide quality patient care in a cost-effective manner.

4.3.4 The utilization review process identifies the under-utilization, over-utilization, and inefficient use of the facility's resources, both concurrently and retrospectively.

4.3.5 A conflict-of-interest policy applies to all staff involved in the utilization review process.

4.3.6 A confidentiality policy protects both the patients and clinical staff involved in the utilization review activity and maintains the confidentiality of the findings and recommendations.

4.3.7 The source of payment is not used as the basis for determining patient reviews.

4.3.8 Review information is reported to the relevant departments, services, and disciplines for further recommendations and corrective actions as appropriate.

4.3.9 The findings of the utilization review process are used as a basis for revising the plan of operation, including a review of staff qualifications and staff composition.

4.3.10 The CEO is responsible for the utilization review process.

4.4 Patient Records

4.4.1 To ensure proper maintenance and control of clinical records, the facility provides or contracts for the services of a registered record administration or accredited record technician who supervises records and maintains their quality.

4.4.1.1 Written policies and procedures concerning records maintenance ensure that records are current, accurate, and confidential.

4.4.1.2 Policies and procedures describe methods to lock, store, and safeguard records.

4.4.1.3 Current records are kept in patient care areas and are immediately accessible to staff.

4.4.1.4 Policies and procedures reflect federal confidentiality guidelines for the release of confidential information.

4.4.2 The facility monitors and evaluates the completeness of patient records, including timeliness of entries, appropriate signatures, the pertinence of clinical entries.

4.4.3 Qualified health care professionals review a representative sample of patient records on a monthly basis.

4.4.4 Conclusions, recommendations, actions taken, and the results of actions are monitored and reported.

4.5 Drug Utilization Review

4.5.1 The facility establishes objective criteria for monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs.

4.5.2 The monitoring of drug usage ensures that medications are administered appropriately, safely, and effectively.

4.5.3 Data are collected on the drugs most frequently prescribed, those prescribed for other than FDA-approved use, and those with known or suspected adverse reactions or interactions with other drugs.

4.5.4 The review process involves physicians, nurses, pharmacists, administrative and management staff, and other personnel as needed.

4.5.5 Minutes document the classes of drugs reviewed, the findings, conclusions, recommendations, and actions taken.

4.5.6 The results of drug evaluations are disseminated to nursing and medical staff, and are incorporated into other data in the evaluation system involving practice patterns, clinical performance, and staff competence.

4.6 Risk Management

4.6.1 A risk management program is implemented to prevent and control risks to patients and staff, and to minimize costs to the facility associated with patient care and safety.

4.6.2 Risk management activities are coordinated with other evaluation programs including safety monitoring, utilization review, infection control, drug utilization review, and patient record reviews.

4.6.3 The risk management findings are reviewed quarterly to identify clinical problems or opportunities to improve patient care.

4.6.3.1 Minutes are maintained that include conclusions, recommendations, and the corrective action(s) taken to reduce patient/staff risk and cost.

4.6.3.2 The findings related to risk management are included in the facility evaluation.

4.6.3.3 A summary report is submitted to the governing body indicating the findings and results of risk management activities.

4.7 Infection Control

4.7.1 The facility implements policies and procedures for the surveillance, prevention, and control of infections.

4.7.2 A qualified staff person is assigned responsibility for the management of infection surveillance, prevention, and control.

4.7.3 All staff involved in direct patient care and patient care support are involved in infection control activities.

4.7.3.1 Training is provided for all new employees on infection control, personal hygiene, and their responsibility to prevent and control infection.

4.7.3.2 Education on the prevention and control of infection is provided at least annually for staff in all the departments, services, and programs involved in patient care.

4.7.4 Records and reports of actual and potential infections among patients and staff are documented. Patterns and trends are monitored through the use of aggregated data.

4.8 Safety

4.8.1 The facility implements a safety monitoring system as described below:

4.8.1.1 An incident reporting system reviews all accidents, injuries, and safety hazards. Incidents are investigated and evaluated, and follow-up actions are documented and tracked.

4.8.1.2 Disaster training, safety orientation, and continuing safety education are monitored through a review of reports and an evaluation of drills.

4.8.1.3 A continuous safety surveillance system exists that detects and reports safety hazards related to patients, staff, or visitors.

4.8.1.4 A multidisciplinary safety committee evaluates the safety monitoring activities, with the authority to take action when conditions pose a threat to people, equipment or buildings.

4.9 Facility Evaluation

4.9.1 The CEO and other administrative staff develop a strategic plan with specific goals and objectives to evaluate the various functions of the PHP.

4.9.2 The annual goals and objectives for each program component or service are related to the patient population served.

4.9.3 The strategies to meet the objectives are defined.

4.9.4 The criteria by which the programs and services are to be evaluated are specified.

4.9.5 The programs, services, and organization are evaluated annually.

4.9.5.1 An explanation is given of any variance or failure to meet the goals and objectives.

4.9.5.2 The findings of this evaluation are documented and reported to the governing body.

- END -